ORIGINAL

10-014

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

RECEIVED

MAR 18 2010

HEALTH FACILITIES & SERVICES REVIEW BOARD

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	West Suburban Medical Center	
Street Address:	3 Erie Court	
City and Zip Code:	Oak Park, IL 60302	
County:	Health Service Area	Health Planning Area:

Applicant Identification
[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name:	Vanguard Health Management, Inc.
Address:	20 Burton Hills Blvd Nashville, TN 37212
Name of Registered Agent:	National Registered Agents, Inc.
Name of Chief Executive Officer:	Charles N. Martin, Jr.
CEO Address:	20 Burton Hills Blvd Nashville, TN 37212
Telephone Number:	615/665-6000

APPEND DOCUMENTATION AS ATTACHMENT-1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Type of Ownership

☐	Non-profit Corporation	☐	Partnership		
X	For-profit Corporation	☐	Governmental		
☐	Limited Liability Company	☐	Sole Proprietorship	☐	Other

- Corporations and limited liability companies must provide an Illinois certificate of good standing.
- Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.

Primary Contact
[Person to receive all correspondence or inquiries during the review period]

Name:	Trip Pilgrim
Title:	Chief Development Officer
Company Name:	Vanguard Health Systems
Address:	20 Burton Hills Blvd Nashville, TN 37212
Telephone Number:	615/665-6151
E-mail Address:	tpilgrim@vanguardhealth.com
Fax Number:	

Additional Contact
[Person who is also authorized to discuss the application for permit]

Name:	Nicolette Curth
Title:	System Director, Strategic Integration
Company Name:	Resurrection Health Care Corporation
Address:	7447 W. Talcott Ave. Suite 260 Chicago, IL 60631
Telephone Number:	773-594-8553
E-mail Address:	NCurth@Reshealthcare.org
Fax Number:	773-594-7984

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
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County:	Health Service Area	Health Planning Area:

Applicant Identification
[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name:	Vanguard Health Financial Corporation, LLC
Address:	20 Burton Hills Blvd Nashville, TN 37212
Name of Registered Agent:	National Registered Agents, Inc.
Name of Chief Executive Officer:	Charles N. Martin, Jr.
CEO Address:	20 Burton Hills Blvd Nashville, TN 37212
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Applicant Identification

[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name:	VHS West Suburban Medical Center, Inc.
Address:	20 Burton Hills Blvd Nashville, TN 37212
Name of Registered Agent:	National Registered Agents, Inc.
Name of Chief Executive Officer:	Charles N. Martin, Jr.
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Title:	Chief Development Officer
Company Name:	Vanguard Health Systems
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Telephone Number:	615/665-6151
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Fax Number:	

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Company Name:	Resurrection Health Care Corporation
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City and Zip Code:	Oak Park, IL 60302	
County:	Health Service Area	Health Planning Area:

Applicant Identification
[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name:	Resurrection Health Care Corporation
Address:	7435 West Talcott Chicago, IL 60631
Name of Registered Agent:	Ms. Sandra Bruce
Name of Chief Executive Officer:	Ms. Sandra Bruce
CEO Address:	7435 West Talcott Chicago, IL 60631
Telephone Number:	773/792-5555

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Title:	Chief Development Officer
Company Name:	Vanguard Health Systems
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Telephone Number:	615/665-6151
E-mail Address:	tpilgrim@vanguardhealth.com
Fax Number:	

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[Person who is also authorized to discuss the application for permit]

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Title:	System Director, Strategic Integration
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Applicant Identification

[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name:	West Suburban Medical Center
Address:	3 Erie Court Oak Park, IL 60302
Name of Registered Agent:	Ms. Sandra Bruce
Name of Chief Executive Officer:	Ms. Patricia Shehorn
CEO Address:	3 Erie Court Oak Park, IL 60302
Telephone Number:	708/681-7201

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E-mail Address:	NCurth@reshealthcare.org
Fax Number:	773-594-7984

West Suburban Medical Center
3 Erie Court
Oak Park, Illinois 60302
708.763.6200
www.reshealth.org

Resurrection Health Care

RESOLUTION
West Suburban Medical Center
Medical Executive Committee

WHEREAS, West Suburban Medical Center (WSMC) has asked the West Suburban Medical Center's Medical Staff to support a "Certificate of Need" (CON) approval by the Illinois Department of Public Health's Health Facilities and Services Review Board for the sale of WSMC to an affiliate of Vanguard Health Systems, Inc. (Vanguard); and,

WHEREAS, the West Suburban Medical Center's Medical Staff is a self governing body responsible to the West Suburban Medical Center Board of Directors for the quality of medical care and for the credentialing of Practitioners who practice medicine at West Suburban Medical Center: and,

WHEREAS, the West Suburban Medical Center's Medical Staff accomplishes these responsibilities through its Medical Executive Committee; and,

WHEREAS, the over 300 members of the Medical Staff of West Suburban Medical Center are committed to continuing the nearly 100 year tradition of medical excellence provided at West Suburban Medical Center for the people of Oak Park, River Forest, Austin and the surrounding communities; and

WHEREAS, WSMC is one of the leading health care institutions in the community that provides quality medical services for the people of Oak Park, the City of Chicago and the surrounding suburban communities; and,

WHEREAS, WSMC is the largest employer in Oak Park and provides substantial economic support for the welfare of the community; and,

WHEREAS, through the financial support of Resurrection Health Care, WSMC has made substantial economic investments in improving the quality of its medical services, providing significant free care to the community and recently constructing a state-of-the-art Emergency Department; and,

WHEREAS, despite the quality of care the Medical Center has provided and the significant investments the institution has made, WSMC has faced financial pressures caused by the weakened national economy and increasing costs of operations, and the WSMC Medical Staff believes that the long term viability of the Medical Center can best be sustained by transferring ownership of WSMC to Vanguard; and,

Resurrection Health Care

WHEREAS, Vanguard operates 15 hospitals in California, Arizona, Massachusetts and Illinois, two of which are in the greater Chicago community, MacNeal Memorial Hospital and Louis A. Weiss Memorial Hospital; and,

WHEREAS, in fiscal year 2009, Vanguard reported $3.2 billion in revenue, $28.6 million in net income and had 18,500 employees and 4,135 beds in its 15 hospitals; and,

WHEREAS, Vanguard has committed to continue to operate WSMC as an acute care hospital for at least two years and has committed to provide health care services, Medicare, charity care and employment opportunities, as WSMC currently provides; and,

WHEREAS, Vanguard as a for-profit corporation may substantially increase tax payments to the community beyond what has been payable by WSMC as a not-for-profit organization; now therefore,

LET IT BE RESOLVED that the West Suburban Medical Center's Medical Executive Committee recommends that the Health Facilities and Services Review Board of the Illinois Department of Public Health approve a Certificate of Need for the sale of West Suburban Medical Center to Vanguard Health Systems, Inc.

Date: March 3, 2010

Authorized by:

Michael DeHaan, M.D.
President

John Kiriklakis, M.D.
Vice President

Victor Romano, M.D.
Secretary-Treasurer

Kevin Cullinane, M.D.
Immediate Past President

CO-SPONSORS
Sisters of the Holy Family of Nazareth & Sisters of the Resurrection

Post Permit Contact

[Person to receive all correspondence subsequent to permit issuance]

Name:	Trip Pilgrim
Title:	Chief Development Officer
Company Name:	Vanguard Health Systems
Address:	20 Burton Hills Blvd. Nashville, TN 37212
Telephone Number:	615/665-6151
E-mail Address:	tpilgrim@vanguardhealth.com
Fax Number:	

Site Ownership---please see following page

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:
Address of Site Owner:
Street Address or Legal Description of Site:

APPEND DOCUMENTATION AS ATTACHMENT-2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee---proposed

[Provide this information for each applicable facility, and insert after this page.]

Exact Legal Name: VHS West Suburban Medical Center, Inc.

Address: 20 Burton Hills Blvd. Nashville, TN 37212

☐	Non-profit Corporation	☐	Partnership		
X	For-profit Corporation	☐	Governmental		
☐	Limited Liability Company	☐	Sole Proprietorship	☐	Other

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- Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.

Organizational Relationships

Provide (for each co-applicant) an organizational chart containing the name and relationship of any person who is related (as defined in Part 1130.140). If the related person is participating in the development or funding of the project, describe the interest and the amount and type of any financial contribution.

APPEND DOCUMENTATION AS ATTACHMENT-3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Flood Plain Requirements

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2005-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at www.FEMA.gov or www.illinoisfloodmaps.org. **This map must be in a readable format**. In addition please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2005-5 **(http://www.idph.state.il.us/about/hfpb.htm)**.

APPEND DOCUMENTATION AS ATTACHMENT 4, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Site Ownership---current

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	West Suburban Medical Center
Address of Site Owner:	3 Erie Court Oak Park, IL 60302
Street Address or Legal Description of Site:	3 Erie Court Oak Park, IL 60302

Site Ownership---proposed

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	Vanguard Health Systems, Inc.
Address of Site Owner:	20 Burton Hills Blvd. Nashville, TN 37215
Street Address or Legal Description of Site:	3 Erie Court Oak Park, IL 60302

Historic Resources Preservation Act Requirements

[Refer to application instructions.]

Provide documentation regarding compliance with the requirements of the Historic Resources Preservation Act.

APPEND DOCUMENTATION AS ATTACHMENT-5, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

DESCRIPTION OF PROJECT

1. Project Classification

[Check those applicable - refer to Part 1110.40 and Part 1120.20(b)]

Part 1110 Classification:	Part 1120 Applicability or Classification: [Check one only.]
☐ Substantive	☐ Part 1120 Not Applicable
X Non-substantive	☐ Category A Project
	X Category B Project
	☐ DHS or DVA Project

2. Project Outline

In the chart below, indicate the proposed action(s) for each clinical service area involved by writing the number of beds, stations or key rooms involved:

Clinical Service Areas	Establish	Expand	Modernize	Discontinue	No. of Beds, Stations or Key Rooms
Medical/Surgical, Obstetric, Pediatric and Intensive Care	X				140
Acute/Chronic Mental Illness					
OB/Gyn	X				20
Open Heart Surgery	X				
Cardiac Catheterization	X				
Intensive Care	X				24
Non-Hospital Based Ambulatory Surgery					
General Long Term Care	X				50
Specialized Long Term Care					
Selected Organ Transplantation					
Kidney Transplantation					
Subacute Care Hospital Model					
Post Surgical Recovery Care Center					
Children's Community-Based Health Care Center					
Community-Based Residential Rehabilitation Center					
Long Term Acute Care Hospital Bed Projects					
Clinical Service Areas Other Than Categories of Service:					
• Surgery	X				8
• Ambulatory Care Services (organized as a service)	X				
• Diagnostic & Interventional Radiology/Imaging	X				23
• Therapeutic Radiology	X				
• Laboratory	X				
• Pharmacy	X				
• Occupational Therapy	X				
• Physical Therapy	X				
• Major Medical Equipment					
Freestanding Emergency Center Medical Services					
Master Design and Related Projects					
Mergers, Consolidations and Acquisitions	X				

APPEND DOCUMENTATION AS ATTACHMENT-6, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

3. Narrative Description

Provide in the space below, a brief narrative description of the project. Explain **WHAT** is to be done in **State Board defined terms**, **NOT WHY** it is being done. If the project site does NOT have a street address, include a legal description of the site. Include the rationale regarding the project's classification as substantive or non-substantive.

The proposed project is limited to a change of ownership of West Suburban Medical Center, a 234-bed community hospital located in Oak Park, Illinois. Through the same transaction, Westlake Hospital in Melrose Park, Illinois will also be acquired, and a separate Certificate of Need application addressing that change of ownership has been filed with the Illinois Health Facilities and Services Review Board (IHFSRB). A copy of the Asset Purchase Agreement is attached.

All programs and services currently provided by West Suburban Medical Center will continue to be provided following the change of ownership, and consistent with IHFSRB requirements, access to the hospital's services will not be diminished.

The proposed project, consistent with Section 1110.40.a, is classified as being "non-substantive" as a result of the scope of the project being limited to a change of ownership.

Please refer to the "Project Overview" for a summary of the transaction.

Project Costs and Sources of Funds

Complete the following table listing all costs (refer to Part 1120.110) associated with the project. When a project or any component of a project is to be accomplished by lease, donation, gift, or other means, the fair market or dollar value (refer to Part 1130.140) of the component must be included in the estimated project cost. If the project contains non-clinical components that are not related to the provision of health care, complete the second column of the table below. See 20 ILCS 3960 for definition of non-clinical. Note, the use and sources of funds must equal.

Project Costs and Sources of Funds			
USE OF FUNDS	**CLINICAL**	**NON-CLINICAL**	**TOTAL**
Preplanning Costs			
Site Survey and Soil Investigation			
Site Preparation			
Off Site Work			
New Construction Contracts			
Modernization Contracts			
Contingencies			
Architectural/Engineering Fees			
Consulting and Other Fees			$739,500
Movable or Other Equipment (not in construction contracts)			
Bond Issuance Expense (project related)			
Negotiated Purchase Price of Hospital Pursuant to Asset Sale Agreement			$20,400,000
Fair Market Value of Leased Space or Equipment			
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS			$21,139,500
SOURCE OF FUNDS	**CLINICAL**	**NON-CLINICAL**	**TOTAL**
Cash and Securities			$21,139,500
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS			$21,139,500

NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT-7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Related Project Costs

Provide the following information, as applicable, with respect to any land related to the project that will be or has been acquired during the last two calendar years:

Land acquisition is related to project X Yes ☐ No
Purchase Price: $_____
Fair Market Value: $_____ included in acquisition cost of the hospital

The project involves the establishment of a new facility or a new category of service
X Yes ☐ No

If yes, provide the dollar amount of all non-capitalized operating start-up costs (including operating deficits) through the first full fiscal year when the project achieves or exceeds the target utilization specified in Part 1100.

Estimated start-up costs and operating deficit cost is $ **none**.

Project Status and Completion Schedules

Indicate the stage of the project's architectural drawings:

X None or not applicable ☐ Preliminary

☐ Schematics ☐ Final Working

Anticipated project completion date (refer to Part 1130.140): _____

Indicate the following with respect to project expenditures or to obligation (refer to Part 1130.140):

☐ Purchase orders, leases or contracts pertaining to the project have been executed.
☐ Project obligation is contingent upon permit issuance. Provide a copy of the contingent "certification of obligation" document, highlighting any language related to CON contingencies.
X Project obligation will occur after permit issuance.

State Agency Submittals

Are the following submittals up to date as applicable:

X Cancer Registry
X APORS
X All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
X All reports regarding outstanding permits

Cost Space Requirements not applicable

Provide in the following format, the department/area GSF and cost. The sum of the department costs **MUST** equal the total estimated project costs. Indicate if any space is being reallocated for a different purpose. Include outside wall measurements plus the department's or area's portion of the surrounding circulation space. **Explain the use of any vacated space.**

		Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
Dept. / Area	**Cost**	**Existing**	**Proposed**	**New Const.**	**Modernized**	**As Is**	**Vacated Space**
CLINICAL							
Medical Surgical							
Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical							
NON CLINICAL							
Administrative							
Parking							
Gift Shop							
Total Non-clinical							
TOTAL							

APPEND DOCUMENTATION AS ATTACHMENT-8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Facility Bed Capacity and Utilization

Complete the following chart, as applicable. Complete a separate chart for each facility that is a part of the project and insert following this page. Provide the existing bed capacity and utilization data for the latest **Calendar Year for which the data are available**. Any bed capacity discrepancy from the Inventory will result in the application being deemed **incomplete**.

FACILITY NAME: West Suburban Medical Center	**CITY: Oak Park**				
REPORTING PERIOD DATES:	**From: January 1, 2009**	**to: December 31, 2009**			
Category of Service	**Authorized Beds**	**Admissions**	**Patient Days**	**Bed Changes**	**Proposed Beds**
Medical/Surgical	135	5,696	23,310	none	135
Obstetrics	20	2,272	5,093	none	20
Pediatrics	5	75	174	none	5
Intensive Care	24	1,469	5,209	none	24
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness					
Neonatal Intensive Care					
General Long Term Care	50	793	12,061	none	50
Specialized Long Term Care					
Long Term Acute Care					
Other ((identify)					
TOTALS:	234	10,305	45,847	none	234

CERTIFICATION

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) are:

- in the case of a corporation, any two of its officers or members of its Board of Directors;
- in the case of a limited liability company, any two of its managers or members (or the sole manger or member when two or more managers or members do not exist);
- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

This Application for Permit is filed on the behalf of ___Vanguard Health Management, Inc._____* in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the permit application fee required for this application is sent herewith or will be paid upon request.

SIGNATURE

CHARLES N. MARTIN
PRINTED NAME

CEO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me this 8th day of March 2010

Signature of Notary

mce: 11.07.12
Seal

PAMELA LARSON
STATE OF TENNESSEE
NOTARY PUBLIC
DAVIDSON COUNTY, TN

SIGNATURE

HAROLD H. PILGRIM, III
PRINTED NAME

SENIOR VICE PRESIDENT
PRINTED TITLE

Notarization:
Subscribed and sworn to before me this 8th day of March 2010

Signature of Notary

mce: 11.07.12
Seal

PAMELA LARSON
STATE OF TENNESSEE
NOTARY PUBLIC
DAVIDSON COUNTY, TN

*Insert EXACT legal name of the applicant

CERTIFICATION

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SIGNATURE

CHARLES N. MARTIN

PRINTED NAME

CEO

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 8th day of MARCH 2010

Signature of Notary

MCE: 11-07-12

Seal

PAMELA L. LAXSON
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY, TN

SIGNATURE

HAROLD A. PILGRIM, III

PRINTED NAME

SENIOR VICE PRESIDENT

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 8th day of MARCH 2010

Signature of Notary

MCE: 11-07-12

Seal

PAMELA L. LAXSON
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY, TN

*Insert EXACT legal name of the applicant

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- in the case of a limited liability company, any two of its managers or members (or the sole manger or member when two or more managers or members do not exist);
- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

This Application for Permit is filed on the behalf of __VHS West Suburban Medical Center, Inc.___* in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the permit application fee required for this application is sent herewith or will be paid upon request.

SIGNATURE

CHARLES N. MARTIN
PRINTED NAME

CEO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 8th day of MARCH 2010

Signature of Notary
MCE: 11-07-12
Seal

TENNESSEE NOTARY PUBLIC DAVIDSON COUNTY, TN

SIGNATURE

HAROLD H. PILGRIM, III
PRINTED NAME

SENIOR VICE PRESIDENT
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 8th day of MARCH 2010

Signature of Notary
MCE: 11-07-12
Seal

PAMELA L. LAXSON STATE OF TENNESSEE NOTARY PUBLIC DAVIDSON COUNTY, TN

*Insert EXACT legal name of the applicant

CERTIFICATION

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) are:

- in the case of a corporation, any two of its officers or members of its Board of Directors;
- in the case of a limited liability company, any two of its managers or members (or the sole manger or member when two or more managers or members do not exist);
- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

This Application for Permit is filed on the behalf of ___Resurrection Health Care Corporation___* in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the permit application fee required for this application is sent herewith or will be paid upon request.

Sandra Bruce
SIGNATURE

Sandia Bruce
PRINTED NAME

President * CEO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 15th day of March

Florita DeJesus-Ortiz
Signature of Notary

Seal

OFFICIAL SEAL
FLORITA DEJESUS-ORTIZ
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 8-26-2010

Jeannie C. Frey
SIGNATURE

Jeannie C. Frey
PRINTED NAME

Secretary
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 11th day of March

Linda M Noyola
Signature of Notary

Seal

OFFICIAL SEAL
LINDA M NOYOLA
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES 06/08/13

*Insert EXACT legal name of the applicant

CERTIFICATION

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) are:

- in the case of a corporation, any two of its officers or members of its Board of Directors;
- in the case of a limited liability company, any two of its managers or members (or the sole manger or member when two or more managers or members do not exist);
- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

This Application for Permit is filed on the behalf of _____West Suburban Medical Center___* in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the permit application fee required for this application is sent herewith or will be paid upon request.

Sandra Bruce
SIGNATURE

Sandra Bruce
PRINTED NAME

President
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 15th day of March

Florita DeJesus-Ortiz
Signature of Notary

Seal

OFFICIAL SEAL
FLORITA DEJESUS-ORTIZ
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 8-26-2010

Jeannie C. Frey
SIGNATURE

Jeannie C. Frey
PRINTED NAME

Secretary
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 11th day of March

Linda M Noyola
Signature of Notary

Seal

OFFICIAL SEAL
LINDA M NOYOLA
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:06/08/13

*Insert EXACT legal name of the applicant

SECTION III. - PROJECT PURPOSE, BACKGROUND AND ALTERNATIVES - INFORMATION REQUIREMENTS

This Section is applicable to all projects except those that are solely for discontinuation with no project costs.

Criterion 1110.230 - Project Purpose, Background and Alternatives

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

1. A listing of all health care facilities owned or operated by the applicant, including licensing, certification and accreditation identification numbers, if applicable.

2. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant during the three years prior to the filing of the application.

3. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to: official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**

4. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest the information has been previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.

APPEND DOCUMENTATION AS ATTACHMENT-10, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

PURPOSE OF PROJECT

1. Document that the project will provide health services that improve the health care or well-being of the market area population to be served.

2. Define the planning area or market area, or other, per the applicant's definition.

3. Identify the existing problems or issues that need to be addressed, as applicable and appropriate for the project. [See 1110.230(b) for examples of documentation.]

4. Cite the sources of the information provided as documentation.

5. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.

6. Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals.

For projects involving modernization, describe the conditions being upgraded. For facility projects, include statements of age and condition and regulatory citations. For equipment being replaced, include repair and maintenance records.

NOTE: The description of the "Purpose of the Project" should not exceed one page in length. Information regarding the "Purpose of the Project" will be included in the State Agency Report.

APPEND DOCUMENTATION AS ATTACHMENT-11, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

ALTERNATIVES

Document **ALL** of the alternatives to the proposed project:

Examples of alternative options include:

A) Proposing a project of greater or lesser scope and cost;

B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes;

C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and

2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of cost, patient access, quality and financial benefits in both the short term (within one to three years after project completion) and long term. This may vary by project or situation.

3) The applicant shall provide empirical evidence, including quantified outcome data, that verifies improved quality of care, as available.

APPEND DOCUMENTATION AS ATTACHMENT-12, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION VI. MERGERS, CONSOLIDATIONS AND ACQUISITIONS/CHANGES OF OWNERSHIP

This Section is applicable to projects involving merger, consolidation or acquisition/change of ownership.

A. Criterion 1110.240(b), Impact Statement

Read the criterion and provide an impact statement that contains the following information:

1. Any change in the number of beds or services currently offered.
2. Who the operating entity will be.
3. The reason for the transaction.
4. Any anticipated additions or reductions in employees now and for the two years following completion of the transaction.
5. A cost-benefit analysis for the proposed transaction.

B. Criterion 1110.240(c), Access

Read the criterion and provide the following:

1. The current admission policies for the facilities involved in the proposed transaction.
2. The proposed admission policies for the facilities.
3. A letter from the CEO certifying that the admission policies of the facilities involved will not become more restrictive.

C. Criterion 1110.240(d), Health Care System

Read the criterion and address the following:

1. Explain what the impact of the proposed transaction will be on the other area providers.
2. List all of the facilities within the applicant's health care system and provide the following for each facility.
   a. the location (town and street address);
   b. the number of beds;
   c. a list of services; and
   d. the utilization figures for each of those services for the last 12 month period.
3. Provide copies of all present and proposed referral agreements for the facilities involved in this transaction.
4. Provide time and distance information for the proposed referrals within the system.
5. Explain the organization policy regarding the use of the care system providers over area providers.
6. Explain how duplication of services within the care system will be resolved.
7. Indicate what services the proposed project will make available to the community that are not now available.

APPEND DOCUMENTATION AS ATTACHMENT-18, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

T. Financial Feasibility

This section is applicable to all projects subject to Part 1120.

REVIEW CRITERIA RELATING TO FINANCIAL FEASIBILITY (FIN)

Does the applicant (or the entity that is responsible for financing the project or is responsible for assumin applicant's debt obligations in case of default) have a bond rating of "A" or better?
Yes 9 No 9.

If yes is indicated, submit proof of the bond rating of "A" or better (that is less than two years old) from Fitch's, Moody's or Standard and Poor's rating agencies and go to Section XXVI. **If no is indicated, submit the most recent three years' audited financial statements including the following:**

1. **Balance sheet**
2. **Income statement**
3. **Change in fund balance**
4. **Change in financial position**

A. Criterion 1120.210(a), Financial Viability

1. Viability Ratios **Vanguard Health Management, Inc.**

If proof of an "A" or better bond rating has not been provided, read the criterion and complete the following table providing the viability ratios for the most recent three years for which audited financial statements are available. Category B projects must also provide the viability ratios for the first full fiscal year after project completion or for the first full fiscal year when the project achieves or exceeds target utilization (per Part 1100), whichever is later.

Provide Data for Projects Classified as:	**Category A or Category B (last three years)**			**Category B (Projected)**
Enter Historical and/or Projected Years:	2007	2008	2009	2012
Current Ratio	1.43	1.57	1.52	1.21
Net Margin Percentage	(5.1%)	(0.0%)	0.9%	1.3%
Percent Debt to Total Capitalization	72.9%	72.7%	72.1%	81.5%
Projected Debt Service Coverage	0.89	1.99	2.29	2.32
Days Cash on Hand	21	22	41	17
Cushion Ratio	1.0	1.1	2.6	1.1

Provide the methodology and worksheets utilized in determining the ratios detailing the calculation and applicable line item amounts from the financial statements. Complete a separate table for each co-applicant and provide worksheets for each. Insert the worksheets after this page.

2. Variance

Compare the viability ratios provided to the Part 1120 Appendix A review standards. If any of the standards for the applicant or for any co-applicant are not met, provide documentation that a person or organization will assume the legal responsibility to meet the debt obligations should the applicant default. The person or organization must demonstrate compliance with the ratios in Appendix A when proof of a bond rating of "A" or better has not been provided.

U. Financial Feasibility

This section is applicable to all projects subject to Part 1120.

REVIEW CRITERIA RELATING TO FINANCIAL FEASIBILITY (FIN)

Does the applicant (or the entity that is responsible for financing the project or is responsible for assumin applicant's debt obligations in case of default) have a bond rating of "A" or better?
Yes 9 No 9.

If yes is indicated, submit proof of the bond rating of "A" or better (that is less than two years old) from Fitch's, Moody's or Standard and Poor's rating agencies and go to Section XXVI. **If no is indicated, submit the most recent three years' audited financial statements including the following:**

1. **Balance sheet**
2. **Income statement**
3. **Change in fund balance**
4. **Change in financial position**

A. Criterion 1120.210(a), Financial Viability

1. Viability Ratios **Vanguard Health Financial Corporation, LLC**

If proof of an "A" or better bond rating has not been provided, read the criterion and complete the following table providing the viability ratios for the most recent three years for which audited financial statements are available. Category B projects must also provide the viability ratios for the first full fiscal year after project completion or for the first full fiscal year when the project achieves or exceeds target utilization (per Part 1100), whichever is later.

Provide Data for Projects Classified as:	**Category A or Category B (last three years)**			**Category B (Projected)**
Enter Historical and/or Projected Years:	2007	2008	2009	2012
Current Ratio	1.43	1.57	1.52	1.21
Net Margin Percentage	(3.8%)	2.1%	3.4%	2.4%
Percent Debt to Total Capitalization	72.9%	72.7%	72.1%	81.5%
Projected Debt Service Coverage	1.17	2.51	3.01	2.60
Days Cash on Hand	21	22	42	17
Cushion Ratio	1.0	1.2	2.6	1.1

Provide the methodology and worksheets utilized in determining the ratios detailing the calculation and applicable line item amounts from the financial statements. Complete a separate table for each co-applicant and provide worksheets for each. Insert the worksheets after this page.

2. Variance

Compare the viability ratios provided to the Part 1120 Appendix A review standards. If any of the standards for the applicant or for any co-applicant are not met, provide documentation that a person or organization will assume the legal responsibility to meet the debt obligations should the applicant default. The person or organization must demonstrate compliance with the ratios in Appendix A when proof of a bond rating of "A" or better has not been provided.

U. Financial Feasibility

This section is applicable to all projects subject to Part 1120.

REVIEW CRITERIA RELATING TO FINANCIAL FEASIBILITY (FIN)

Does the applicant (or the entity that is responsible for financing the project or is responsible for assumin applicant's debt obligations in case of default) have a bond rating of "A" or better?
Yes No **X**.

If yes is indicated, submit proof of the bond rating of "A" or better (that is less than two years old) from Fitch's, Moody's or Standard and Poor's rating agencies and go to Section XXVI. **If no is indicated, submit the most recent three years' audited financial statements including the following:**

1. **Balance sheet**
2. **Income statement**
3. **Change in fund balance**
4. **Change in financial position**

A. Criterion 1120.210(a), Financial Viability

1. Viability Ratios Resurrection Health Care Corporation (consolidated)

If proof of an "A" or better bond rating has not been provided, read the criterion and complete the following table providing the viability ratios for the most recent three years for which audited financial statements are available. Category B projects must also provide the viability ratios for the first full fiscal year after project completion or for the first full fiscal year when the project achieves or exceeds target utilization (per Part 1100), whichever is later.

Provide Data for Projects Classified as:	**Category A or Category B (last three years)**			**Category B (Projected)**
Enter Historical and/or Projected Years:	2007	2008	2009	2012
Current Ratio	1.17	1.02	1.00	1.05
Net Margin Percentage	2.54%	-4.33%	-6.57%	-5.63%
Percent Debt to Total Capitalization	53.26%	52.62%	60.41%	65.28%
Projected Debt Service Coverage	3.83	1.10	0.05	0.45
Days Cash on Hand	224.31	181.52	156.39	206.68
Cushion Ratio	20.68	20.68	18.351.05	19.84

Provide the methodology and worksheets utilized in determining the ratios detailing the calculation and applicable line item amounts from the financial statements. Complete a separate table for each co-applicant and provide worksheets for each. Insert the worksheets after this page.

2. Variance

Compare the viability ratios provided to the Part 1120 Appendix A review standards. If any of the standards for the applicant or for any co-applicant are not met, provide documentation that a person or organization will assume the legal responsibility to meet the debt obligations should the applicant default. The person or organization must demonstrate compliance with the ratios in Appendix A when proof of a bond rating of "A" or better has not been provided.

T. Financial Feasibility

This section is applicable to all projects subject to Part 1120.

REVIEW CRITERIA RELATING TO FINANCIAL FEASIBILITY (FIN)

Does the applicant (or the entity that is responsible for financing the project or is responsible for assumin applicant's debt obligations in case of default) have a bond rating of "A" or better?
Yes No **X**.

If yes is indicated, submit proof of the bond rating of "A" or better (that is less than two years old) from Fitch's, Moody's or Standard and Poor's rating agencies and go to Section XXVI. **If no is indicated, submit the most recent three years' audited financial statements including the following:**

1. **Balance sheet**
2. **Income statement**
3. **Change in fund balance**
4. **Change in financial position**

A. Criterion 1120.210(a), Financial Viability

1. Viability Ratios VHS West Suburban Medical Center, Inc.

If proof of an "A" or better bond rating has not been provided, read the criterion and complete the following table providing the viability ratios for the most recent three years for which audited financial statements are available. Category B projects must also provide the viability ratios for the first full fiscal year after project completion or for the first full fiscal year when the project achieves or exceeds target utilization (per Part 1100), whichever is later.

Provide Data for Projects Classified as:	**Category A or Category B (last three years)**			**Category B (Projected)**
Enter Historical and/or Projected Years:				2012
Current Ratio				1.12
Net Margin Percentage				0.2%
Percent Debt to Total Capitalization				37.4%
Projected Debt Service Coverage				16.26
Days Cash on Hand				0.2
Cushion Ratio				0.2

Provide the methodology and worksheets utilized in determining the ratios detailing the calculation and applicable line item amounts from the financial statements. Complete a separate table for each co-applicant and provide worksheets for each. Insert the worksheets after this page.

2. Variance

Compare the viability ratios provided to the Part 1120 Appendix A review standards. If any of the standards for the applicant or for any co-applicant are not met, provide documentation that a person or organization will assume the legal responsibility to meet the debt obligations should the applicant default. The person or organization must demonstrate compliance with the ratios in Appendix A when proof of a bond rating of "A" or better has not been provided.

REVIEW CRITERIA RELATING TO FINANCIAL FEASIBILITY (FIN)

T. Financial Feasibility

This section is applicable to all projects subject to Part 1120.

REVIEW CRITERIA RELATING TO FINANCIAL FEASIBILITY (FIN)

Does the applicant (or the entity that is responsible for financing the project or is responsible for assumin applicant's debt obligations in case of default) have a bond rating of "A" or better?
Yes 9 No 9.

If yes is indicated, submit proof of the bond rating of "A" or better (that is less than two years old) from Fitch's, Moody's or Standard and Poor's rating agencies and go to Section XXVI. **If no is indicated, submit the most recent three years' audited financial statements including the following:**

1. **Balance sheet**
2. **Income statement**
3. **Change in fund balance**
4. **Change in financial position**

A. Criterion 1120.210(a), Financial Viability

1. Viability Ratios Resurrection Health Care Corporation (consolidated)

If proof of an "A" or better bond rating has not been provided, read the criterion and complete the following table providing the viability ratios for the most recent three years for which audited financial statements are available. Category B projects must also provide the viability ratios for the first full fiscal year after project completion or for the first full fiscal year when the project achieves or exceeds target utilization (per Part 1100), whichever is later.

Provide Data for Projects Classified as:	**Category A or Category B (last three years)**			**Category B (Projected)**
Enter Historical and/or Projected Years:	2007	2008	2009	2012
Current Ratio	1.17	1.02	1.00	1.05
Net Margin Percentage	2.54%	-4.33%	-6.57%	-5.63%
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Projected Debt Service Coverage	3.83	1.10	0.05	0.45
Days Cash on Hand	224.31	181.52	156.39	206.68
Cushion Ratio	20.68	20.68	18.351.05	19.84

Provide the methodology and worksheets utilized in determining the ratios detailing the calculation and applicable line item amounts from the financial statements. Complete a separate table for each co-applicant and provide worksheets for each. Insert the worksheets after this page.

2. Variance

Compare the viability ratios provided to the Part 1120 Appendix A review standards. If any of the standards for the applicant or for any co-applicant are not met, provide documentation that a person or organization will assume the legal responsibility to meet the debt obligations should the applicant default. The person or organization must demonstrate compliance with the ratios in Appendix A when proof of a bond rating of "A" or better has not been provided.

REVIEW CRITERIA RELATING TO FINANCIAL FEASIBILITY (FIN) (continued)

B. Criterion 1120.210(b), Availability of Funds

If proof of an "A" or better bond rating has not been provided, read the criterion and document that sufficient resources are available to fund the project and related costs including operating start-up costs and operating deficits. Indicate the dollar amount to be provided from the following sources:

$21,139,500 Cash & Securities
Provide statements as to the amount of cash/securities available for the project. Identify any security, its value and availability of such funds. Interest to be earned or depreciation account funds to be earned on any asset from the date of application submission through project completion are also considered cash.

_____ Pledges
For anticipated pledges, provide a letter or report as to the dollar amount feasible showing the discounted value and any conditions or action the applicant would have to take to accomplish goal. The time period, historical fund raising experience and major contributors also must be specified.

_____ Gifts and Bequests
Provide verification of the dollar amount and identify any conditions of the source and timing of its use.

_____ Debt Financing (indicate type(s) _____)
For general obligation bonds, provide amount, terms and conditions, including any anticipated discounting or shrinkage) and proof of passage of the required referendum or evidence of governmental authority to issue such bonds;
For revenue bonds, provide amount, terms and conditions and proof of securing the specified amount;
For mortgages, provide a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated;
For leases, provide a copy of the lease including all terms and conditions of the lease including any purchase options.

_____ Governmental Appropriations
Provide a copy of the appropriation act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, provide a resolution or other action of the governmental unit attesting to such future funding.

_____ Grants
Provide a letter from the granting agency as to the availability of funds in terms of the amount, conditions, and time or receipt.

_____ Other Funds and Sources
Provide verification of the amount, terms and conditions, and type of any other funds that will be used for the project.

$21,139,500 TOTAL FUNDS AVAILABLE

C. Criterion 1120.210(c), Operating Start-up Costs

If proof of an "A" or better bond rating has not been provided, indicate if the project is classified as a Category B project that involves establishing a new facility or a new category of service? Yes **X** No ___. If yes is indicated, read the criterion and provide in the space below the amount of operating start-up costs (the same as reported in Section I of this application) and provide a description of the items or components that comprise the costs. Indicate the source and amount of the financial resources available to fund the operating start-up costs (including any initial operating deficit) and reference the documentation that verifies sufficient resources are available.

APPEND DOCUMENTATION AS ATTACHMENT 75, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

U. Economic Feasibility

This section is applicable to all projects subject to Part 1120.

SECTION XXVI. REVIEW CRITERIA RELATING TO ECONOMIC FEASIBILITY (ECON)

A. Criterion 1120.310(a), Reasonableness of Financing Arrangements

Is the project classified as a Category B project? Yes **X** No _. If no is indicated this criterion is not applicable. If yes is indicated, has proof of a bond rating of "A" or better been provided? Yes No **X**. If yes is indicated this criterion is not applicable, go to item B. If no is indicated, read the criterion and address the following:

Are all available cash and equivalents being used for project funding prior to borrowing? **X** Yes No

If no is checked, provide a notarized statement signed by two authorized representatives of the applicant entity (in the case of a corporation, one must be a member of the board of directors) that attests to the following:

1. a portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order that the current ratio does not fall below 2.0 times; or
2. borrowing is less costly than the liquidation of existing investments and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

B. Criterion 1120.310(b), Conditions of Debt Financing **Not Applicable, No Debt**

Read the criterion and provide a notarized statement signed by two authorized representatives of the applicant entity (in the case of a corporation, one must be a member of the board of directors) that attests to the following as applicable:

1. The selected form of debt financing the project will be at the lowest net cost available or if a more costly form of financing is selected, that form is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional debt, term (years) financing costs, and other factors;
2. All or part of the project involves the leasing of equipment or facilities and the expenses incurred with such leasing are less costly than constructing a new facility or purchasing new equipment.

B. Criterion 1120.310(c), Reasonableness of Project and Related Costs

Read the criterion and provide the following:

1. Identify each department or area impacted by the proposed project and provide a cost and square footage allocation for new construction and/or modernization using the following format (insert after this page).

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE

Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Cost/Square Foot Mod.	Gross Sq. Ft. New	Gross Sq. Ft. Circ.*	Gross Sq. Ft. Mod.	Gross Sq. Ft. Circ.*	Const. $ (A x C)	Mod. $ (B x E)	
Contingency									
TOTALS									

* Include the percentage (%) of space for circulation

2. For each piece of major medical equipment included in the proposed project, the applicant must certify one of the following:

REVIEW CRITERIA RELATING TO ECONOMIC FEASIBILITY (ECON) (continued)

a. that the lowest net cost available has been selected; or

b. that the choice of higher cost equipment is justified due to such factors as, but not limited to, maintenance agreements, options to purchase, or greater diagnostic or therapeutic capabilities.

3. List the items and costs included in preplanning, site survey, site preparation, off-site work, consulting, and other costs to be capitalized. If any project line item component includes costs attributable to extraordinary or unusual circumstances, explain the circumstances and provide the associated dollar amount. When fair market value has been provided for any component of project costs, submit documentation of the value in accordance with the requirements of Part 1190.40.

D. Criterion 1120.310(d), Projected Operating Costs

Read the criterion and provide in the space below the facility's projected direct annual operating costs (in current dollars per equivalent patient day or unit of service, as applicable) for the first full fiscal year of operation after project completion or for the first full fiscal year when the project achieves or exceeds target utilization pursuant to 77 Ill. Adm. Code 1100, whichever is later. If the project involves a new category of service, also provide the annual operating costs for the service. Direct costs are the fully allocated costs of salaries, benefits, and supplies. Indicate the year for which the projected operating costs are provided.

E. Criterion 1120.310(e), Total Effect of the Project on Capital Costs

Is the project classified as a category B project? Yes **X** No . If no is indicated, go to item F. If yes is indicated, provide in the space below the facility's total projected annual capital costs as defined in Part 1120.130(f) (in current dollars per equivalent patient day) for the first full fiscal year of operation after project completion or for the first full fiscal year when the project achieves or exceeds target utilization pursuant to 77 Ill. Adm. Code 1100, whichever is later. Indicate the year for which the projected capital costs are provided.

F. Criterion 1120.310(f), Non-patient Related Services

Is the project classified as a category B project and involve non-patient related services? Yes No **X** . If no is indicated, this criterion is not applicable. If yes is indicated, read the criterion and document that the project will be self-supporting and not result in increased charges to patients/residents or that increased charges are justified based upon such factors as, but not limited to, a cost benefit or other analysis that demonstrates the project will improve the applicant's financial viability.

APPEND DOCUMENTATION AS ATTACHMENT -76, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

File Number 6087-292-9

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

VANGUARD HEALTH MANAGEMENT, INC., INCORPORATED IN DELAWARE AND LICENSED TO TRANSACT BUSINESS IN THIS STATE ON FEBRUARY 04, 2000, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE BUSINESS CORPORATION ACT OF THIS STATE RELATING TO THE PAYMENT OF FRANCHISE TAXES, AND AS OF THIS DATE, IS A FOREIGN CORPORATION IN GOOD STANDING AND AUTHORIZED TO TRANSACT BUSINESS IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 26TH *day of* FEBRUARY *A.D.* 2010 .

Jesse White

SECRETARY OF STATE

Authentication #: 1005702452

Authenticate at: http://www.cyberdriveillinois.com

ATTACHMENT 1

File Number 0294476-6

To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

VANGUARD HEALTH FINANCIAL COMPANY, LLC, A DELAWARE LIMITED LIABILITY COMPANY HAVING OBTAINED ADMISSION TO TRANSACT BUSINESS IN ILLINOIS ON MARCH 08, 2010, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A FOREIGN LIMITED LIABILITY COMPANY ADMITTED TO TRANSACT BUSINESS IN THE STATE OF ILLINOIS.

Authentication #: 1008702238

Authenticate at: http://www.cyberdriveillinois.com

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 8TH *day of* MARCH *A.D.* 2010 .

Jesse White

SECRETARY OF STATE

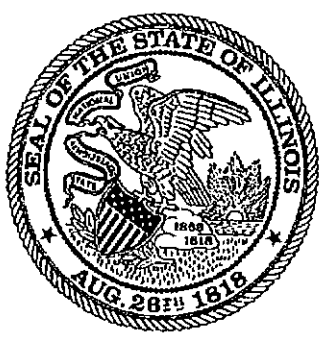
ATTACHMENT 1

File Number 6704-411-8

To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

VHS WEST SUBURBAN MEDICAL CENTER, INC., INCORPORATED IN DELAWARE AND LICENSED TO TRANSACT BUSINESS IN THIS STATE ON MARCH 04, 2010, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE BUSINESS CORPORATION ACT OF THIS STATE RELATING TO THE PAYMENT OF FRANCHISE TAXES, AND AS OF THIS DATE, IS A FOREIGN CORPORATION IN GOOD STANDING AND AUTHORIZED TO TRANSACT BUSINESS IN THE STATE OF ILLINOIS.



Authentication #: 1006401588

Authenticate at: http://www.cyberdrivеillinois.com

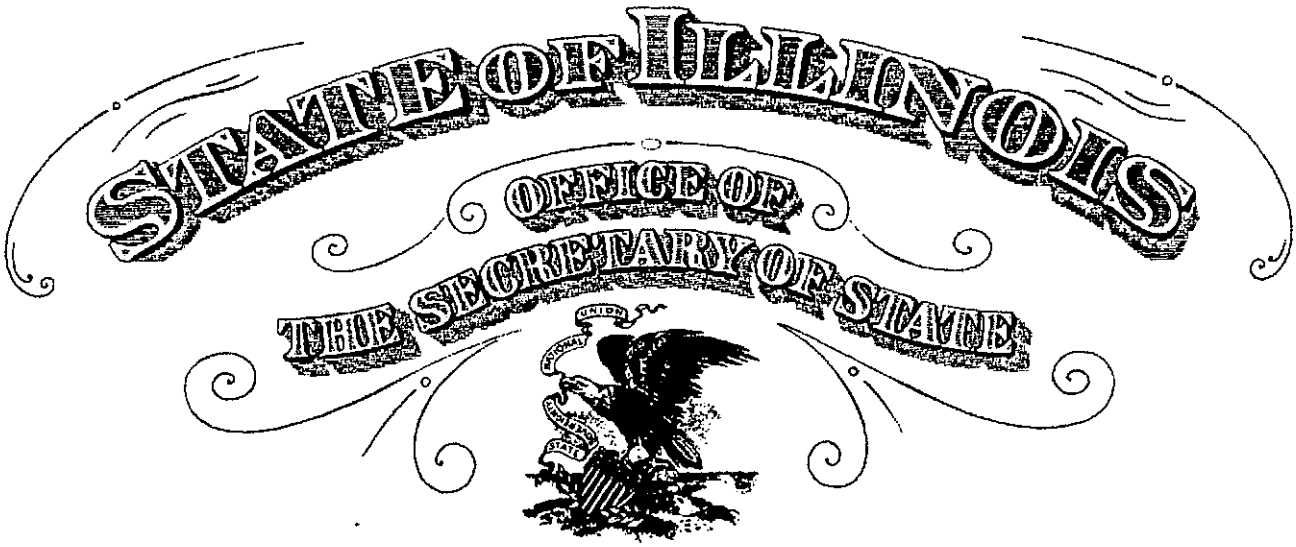
In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 5TH *day of* MARCH *A.D.* 2010 .

Jesse White

SECRETARY OF STATE

ATTACHMENT 1

File Number 3128-198-9



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

RESURRECTION HEALTH CARE CORPORATION, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON APRIL 27, 1949, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

Authentication #: 1000401416

Authenticate at: http://www.cyberdriveillinois.com

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 4TH *day of* JANUARY *A.D.* 2010 .

Jesse White

SECRETARY OF STATE

ATTACHMENT 1

File Number 2389-305-3

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

WEST SUBURBAN MEDICAL CENTER, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON FEBRUARY 12, 1935, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 4TH *day of* JANUARY *A.D.* 2010 .

Jesse White

SECRETARY OF STATE

Authentication #: 1000401434

Authenticate at: http://www.cyberdriveillinois.com

ATTACHMENT 1

James M. Houlihan
Cook County Assessor

Cook County Assessor's Office
118 North Clark Street Chicago, IL 60602
Phone: 312.603.5300 Fax: 312.603.3352
Website: www.cookcountyassessor.com

2009 AFFIDAVIT

Agency Number: 8548 Agency Name: WEST SUBURBAN HOSPITAL

Having been duly sworn, upon my oath, I Robert M. Hauptman, as authorized agent for the agency listed above, swear that I have reviewed the attached Property List and the following is true and correct:

1. The agency listed above is the owner of each of the properties on the attached Property List, unless indicated as set forth below;

2. If any property has experienced a "change in ownership" (as defined under the Property Tax Code 35 ILCS 200/1-1 et seq.) since the Illinois Department of Revenue granted the exemption, I have checked the appropriate blank on the attached Property List and completed an Exempt Property Information Sheet for each such property;

3. If any property has experienced a "change in use" (as defined under the Property Tax Code 35 ILCS 200/1-1 et seq.) since the Illinois Department of Revenue granted the exemption, I have checked the appropriate blank on the attached Property List and completed an Exempt Property Information Sheet for each such property;

4. If any property has been leased, licensed or is otherwise used by others, I have checked the appropriate blank on the attached Property List, and if the property has been leased within the last year I have checked the appropriate blank, and completed an Exempt Property Information Sheet for each such property;

5. If the code listed under "Basis for Exemption" is incorrect, I have crossed out the incorrect code and written the correct code; and

6. This Affidavit is given to the Cook County Assessor's Office to induce it to maintain the exemptions of the properties on the attached Property List.

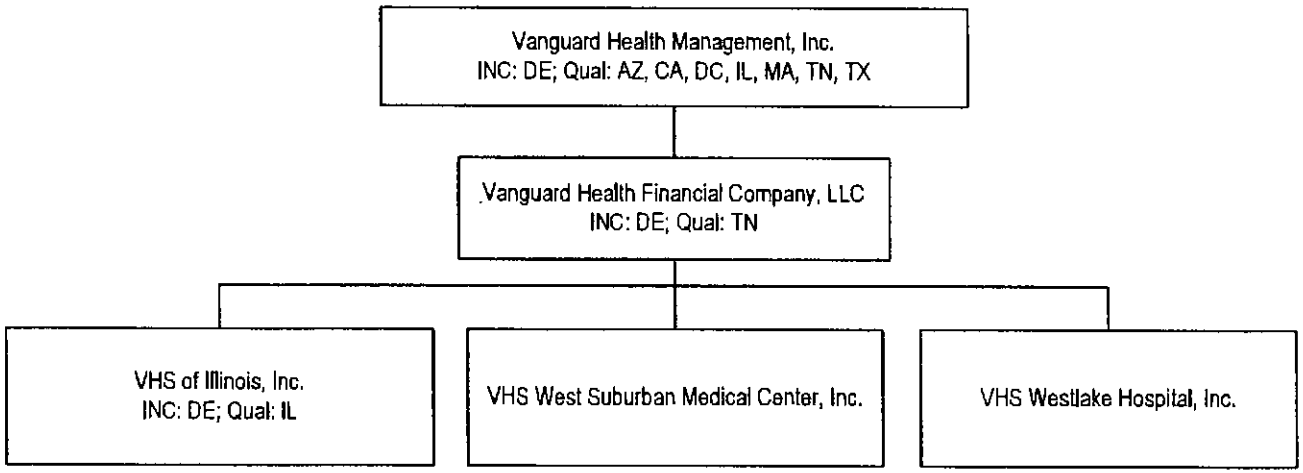
Further affiant sayeth not.

Signature: Robert M. Hauptman
Print Name: Robert M. Hauptman
Title: Vice President, Construction Facility Svcs
Phone: 773-594-8646

Subscribed and sworn to before me this 17 day of December, 2009

Julie C. Kaufman
NOTARY PUBLIC

"OFFICIAL SEAL"
JULIE C. KAUFMAN
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 11/30/2011

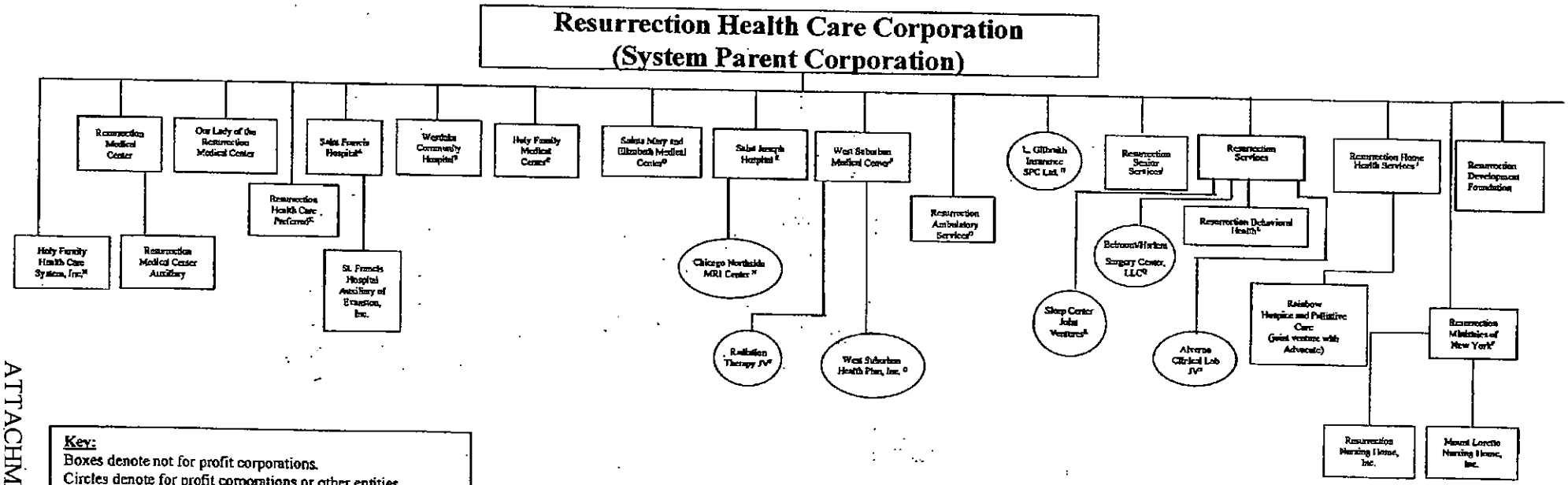


ATTACHMENT 3

Resurrection Health Care Corporation

Corporate Organizational and Governance Structure

March 1, 2010



Key:
Boxes denote not for profit corporations.
Circles denote for profit corporations or other entities.
Text of footnotes A through P are on the next page.

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ATTACHMENT 3

Resurrection Health Care Corporation
Legal Organizational Structure
As of March 1, 2010
Footnotes

A Formerly named Saint Francis Hospital of Evanston (name change effective November 22, 2004)

B D/B/A Westlake Hospital

C Became part of the Resurrection system effective March 1, 2001; as part of the agreement of co-sponsorship between the Sisters of the Resurrection, Immaculate Conception Province and the Sisters of the Holy Family of Nazareth, Sacred Heart Province

D Created from merger of Saint Elizabeth Hospital into Saint Mary of Nazareth Hospital Center, and name change of latter (surviving) corporation, both effective 12/1/03. Saint Mary of Nazareth Hospital Center (now part of Saints Mary and Elizabeth Medical Center) became part of Resurrection system under the co-sponsorship agreement referenced in Footnote C above

E Saint Joseph Hospital, f/k/a Cana Services Corporation, f/k/a Westlake Health System

F Became part of the Resurrection system on March 10, 2004

G Formerly known as West Suburban Health Services, this 501(c)(3) corporation had been the parent corporation of West Suburban Medical Center prior to the hospital corporation becoming part of the Resurrection Health Care system. Effective January 1, 2010, Resurrection Ambulatory Services assumed the assets and liabilities of Resurrection Services' ambulatory care services division.

H A Cayman Islands corporation registered to do business as an insurance company

I Corporation formerly known as Westlake Nursing and Rehabilitation Center (also f/k/a Leyden Community Extended Care Center, Inc.)

J Resurrection Home Health Services, f/k/a Health Connections, Inc., is the combined operations of Extended Health Services, Inc., Community Nursing Service West, Resurrection Home Care, and St. Francis Home Health Care (the assets of all of which were transferred to Health Connections, Inc. as of July 1, 1999).

K Operates under the d/b/a names of Resurrection Health Preferred, St. Francis Health Preferred, Holy Family Health Preferred, and Saint Joseph Health Preferred

L D/B/A name for Proviso Family Services, a/k/a ProCare Centers, a/k/a Employee Resource Centers

M Former parent of Holy Family Medical Center; non-operating 501(c)(3) "shell" available for future use

N An Illinois general partnership between Saint Joseph Hospital and Advocate Northside Health System, an Illinois not for profit corporation

O Illinois business (for profit) corporation, d/b/a West Suburban Health Providers; managed care contracting organization, with 50% of shares held by West Suburban Medical Center and 50% by Physicians

P Resurrection Health Care is the Corporate Member of RMNY, with extensive reserve powers, including appointment/removal of all Directors and approval of amendments to the Corporation's Articles and Bylaws. The Sponsoring Member of the Corporation is the Sisters of the Resurrection New York, Inc.

Q Resurrection Services owns over 50% of the membership interests of Belmont/Harlem, LLC, an Illinois limited liability company, which owns and operates an ambulatory surgery center

R Resurrection Services owns a majority interest in the following Illinois limited liability companies which own and operate sleep disorder diagnostic centers: RES-Health Sleep Care Center of River Forest, LLC; RES-Health Sleep Care Center of Lincoln Park, LLC; RES-Health Sleep Care Center of Evanston, LLC; RES-Health Sleep Care Center of Chicago Northwest, LLC

S Joint Venture for clinical lab services for 2 other Catholic health care systems, Provena and Sisters of Saint Francis Health Services, Inc., consisting of an Indiana limited liability company of which Resurrection Services is a 1/3 member, and a tax-exempt cooperative hospital service corporation, of which all Resurrection tax-exempt system hospitals collectively have a 1/3 interest

T Joint Venture with affiliates of US Oncology Inc., consisting of two Illinois limited liability companies, RFCC Asset, LLC, and RFCC Support, LLC, relating to the provision of radiation therapy services at the River Forest ambulatory care campus

ATTACHMENT 3

IDENTIFICATION and ALLOCATION OF PROJECT COSTS

The changes of ownership of West Suburban Medical Center and Westlake Hospital are being addressed through a single transaction and Asset Sale Agreement. Consistent with the direction given to the co-applicant's representative by State Agency staff, for purposes of the required Certificate of Need applications, the project costs are allocated between the two applications consistent with the distribution of beds. Specifically, as of the December 17, 2009 update to the IDPH Bed Inventory, West Suburban Medical Center is approved for 234 beds and Westlake Hospital is approved for 225 beds, and as such, 459 approved beds are included in the changes of ownership. 51% (234/459) of the beds are located at West Suburban Medical Center, and 49% (225/459) are located at Westlake Hospital. Project costs, for purposes of the Certificate of Need applications have been apportioned, consistent with those percentages.

The purchase price for the two hospitals was identified through a negotiation process between the buyer and seller, with a price of $40,000,000 being agreed upon for all assets included in the acquisition and as identified in the attached Asset Sale Agreement. Individual acquisition prices were not assigned to the various components of the transaction (i.e. land, buildings, equipment, etc.).

The "Consulting and Other Fees" include an estimate of the costs associated with outside legal and accounting services, community relations-related consulting, CON development, CON-related review fees, and miscellaneous costs associated with the acquisition.

ATTACHMENT 7

VANGUARD
HEALTH SYSTEMS

February , 2010

Illinois Health Facilities
and Services Review Board
525 West Jefferson
Springfield, IL 62761

To Whom It May Concern:

In accordance with Review Criterion 1110.230.b, Background of the Applicant, we are submitting this letter assuring the Illinois Health Facilities and Services Review Board (IHFSRB) that:

1. Neither Vanguard Health Management, Inc. nor any wholly-affiliated corporation that owns or operates a facility subject to the IHFSRB's jurisdiction has had any adverse actions (as defined in Section 1130.140) taken against any facility during the three (3) year period prior to the filing of this application, and
2. Vanguard Health Management, Inc. authorizes the State Board and State Agency access to information to verify documentation or information submitted in response to the requirements of Review Criterion 1110.230.b or to obtain any documentation or information which the State Board or State Agency finds pertinent to this application.

If we can in any way provide assistance to your staff regarding these assurances or any other issue relative to this application, please do not hesitate to call me.

Sincerely,

Charles N. Martin, Jr.
Chief Executive Officer

Notarized:

EXPIRES 11-07-12

Resurrection Health Care®

7435 West Talcott Avenue
Chicago, Illinois 60631
773.774.8000
www.reshealth.org

March 15, 2010

Illinois Health Facilities
and Services Review Board
525 West Jefferson
Springfield, IL 62761

To Whom It May Concern:

In accordance with Review Criterion 1110.230.b, Background of the Applicant, we are submitting this letter assuring the Illinois Health Facilities and Services Review Board (IHFSRB) that:

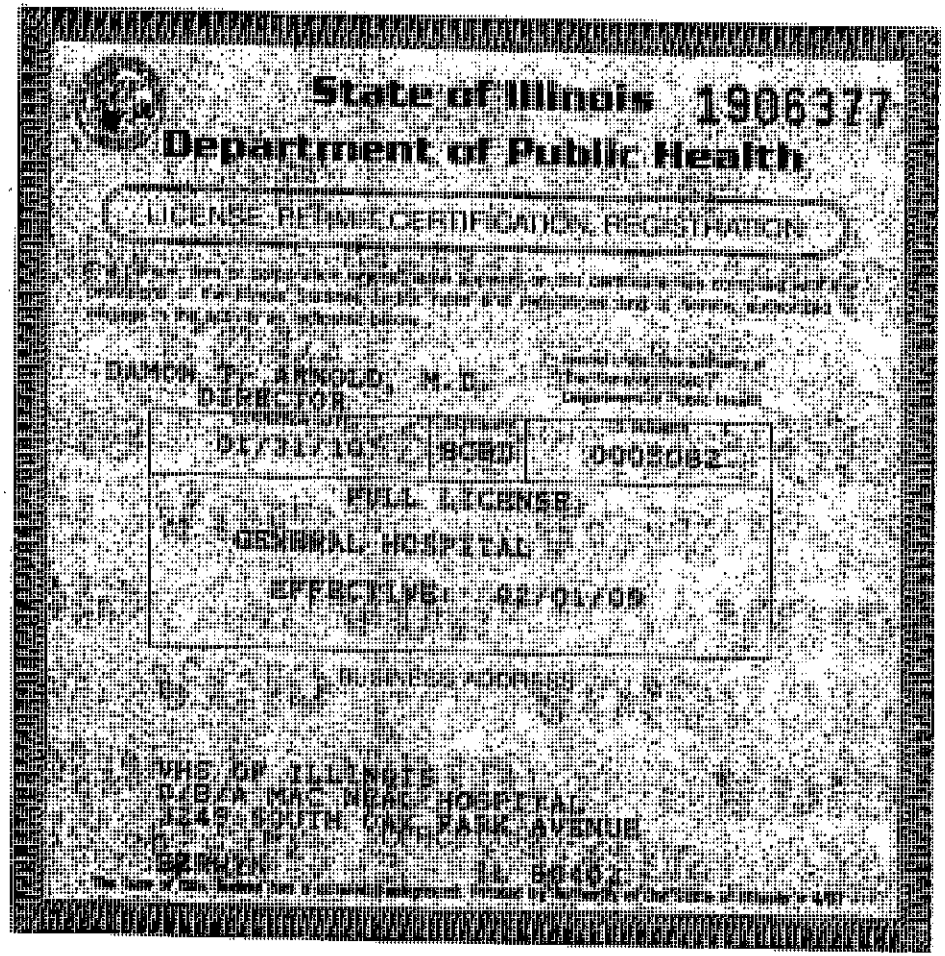
1. Neither Resurrection Health Care Corporation ("Resurrection") nor any wholly-affiliated corporation that owns or operates a facility subject to the IHFSRB's jurisdiction has had any adverse actions (as defined in Section 1130.140) taken against any facility during the three (3) year period prior to the filing of this application, and

2. Resurrection authorizes the State Board and State Agency access to information to verify documentation or information submitted in response to the requirements of Review Criterion 1110.230.b or to obtain any documentation or information which the State Board or State Agency finds pertinent to this application.

If we can in any way provide assistance to your staff regarding these assurances or any other issue relative to this application, please do not hesitate to contact me.

Sincerely,

Sandra Bruce
President and Chief Executive Officer


State of Illinois 1906377
Department of Public Health
LICENSE, PERMIT, CERTIFICATION, REGISTRATION
DAMON T. ARNOLD, M.D.
DIRECTOR
02/31/10 | BGBD | 0005082
FULL LICENSE
GENERAL HOSPITAL
EFFECTIVE: 02/01/09
VHS OF ILLINOIS
D/B/A MAC NEAL HOSPITAL
3249 SOUTH OAK PARK AVENUE
BERWYN IL 60402

DISPLAY THIS PART IN A CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION

State of Illinois 1906377
Department of Public Health
LICENSE, PERMIT, CERTIFICATION, REGISTRATION

VHS OF ILLINOIS

EXPIRATION DATE	CATEGORY	I.D. NUMBER
02/31/10	BGBD	0005082

FULL LICENSE
GENERAL HOSPITAL
EFFECTIVE: 02/01/09

12/06/08

VHS OF ILLINOIS
D/B/A MAC NEAL HOSPITAL
3249 SOUTH OAK PARK AVENUE
BERWYN IL 60402

FEE RECEIPT NO.

94

ATTACHMENT 10

State of Illinois 1923356
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

DAMON T. ARNOLD, M.D.
DIRECTOR

Issued under the authority of
The State of Illinois
Department of Public Health

EXPIRATION DATE	CATEGORY	I.D. NUMBER
05/31/10	BGBD	0005249

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 06/01/09

BUSINESS ADDRESS

VHS ACQUISITION SUBSIDIARY NUMBER 3, IN
D/B/A LOUIS A. WEISS MEMORIAL HOSPITAL
4646 N. MARINE DRIVE

CHICAGO IL 60640

The face of this license has a colored background. Printed by Authority of the State of Illinois • 4/97 •

← DISPLAY THIS PART IN A CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION

↓

State of Illinois 1923356
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

VHS ACQUISITION SUBSIDIARY NUMBER 3,

EXPIRATION DATE	CATEGORY	I.D. NUMBER
05/31/10	BGBD	0005249

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 06/01/09

04/04/09

VHS ACQUISITION SUBSIDIARY NO. 3
D/B/A LOUIS A. WEISS MEM'L HOSP.
4646 N. MARINE DRIVE
CHICAGO IL 60640

FEE RECEIPT NO.

ATTACHMENT 10

4/6

The Joint Commission

April 23, 2008

Frank Molinaro, FACHE
CEO & President
Louis A. Weiss Memorial Hospital
4646 North Marine Drive
Chicago, IL 60640

Joint Commission ID #: 7286
Accreditation Activity: Evidence of Standards Compliance
Accreditation Activity Completed: 4/23/2008

Dear Mr. Molinaro:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- Comprehensive Accreditation Manual for Hospitals

This accreditation cycle is effective beginning March 01, 2008. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 39 months.

Please visit Quality Check® on the Joint Commission web site for updated information related to your accreditation decision.

We encourage you to share this accreditation decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the Centers for Medicare and Medicaid Services (CMS), state or regional regulatory services, and the public you serve of your organization's accreditation decision.

Please be assured that the Joint Commission will keep the report confidential, except as required by law. To ensure that the Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Linda S. Murphy-Knoll
Interim Executive Vice President
Division of Accreditation and Certification Operations

ATTACHMENT 10

The Joint Commission

December 11, 2008

Brian Lemon
CEO
MacNeal Hospital
3249 South Oak Park Avenue
Berwyn, IL 60402

Joint Commission ID #: 7246
Accreditation Activity: Measure of Success
Accreditation Activity Completed: 12/11/2008

Dear Mr. Lemon:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- Comprehensive Accreditation Manual for Behavioral Health Care
- Comprehensive Accreditation Manual for Home Care
- Comprehensive Accreditation Manual for Hospitals
- Comprehensive Accreditation Manual for Long Term Care

This accreditation cycle is effective beginning May 08, 2008. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 39 months.

Please visit Quality Check® on the Joint Commission web site for updated information related to your accreditation decision.

We encourage you to share this accreditation decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the Centers for Medicare and Medicaid Services (CMS), state or regional regulatory services, and the public you serve of your organization's accreditation decision.

Please be assured that the Joint Commission will keep the report confidential, except as required by law. To ensure that the Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Ann Scott Blouin RN, PhD

Ann Scott Blouin, RN, Ph.D.
Executive Vice President
Accreditation and Certification Operations

ATTACHMENT 10

The Joint Commission

MacNeal Hospital
3249 South Oak Park Avenue
Berwyn, IL 60402

Organization Identification Number: 7246

Measure of Success Received: 12/11/2008

PROGRAM(S)
Hospital Accreditation Program
Home Care Program

Executive Summary

There is no follow-up due to The Joint Commission as a result of the accreditation activity conducted on the above date.

The results of this accreditation activity do not affect any other Requirement(s) for Improvement that may exist on your current accreditation decision.

State of Illinois 1954467
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

DAMON T. ARNOLD, M.D.
DIRECTOR

Issued under the authority of
The State of Illinois
Department of Public Health

EXPIRATION DATE	CATEGORY	I.D. NUMBER
12/31/10	BGBD	0002907

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 01/01/10

BUSINESS ADDRESS

WEST SUBURBAN MEDICAL CENTER

ERIE AT AUSTIN

OAK PARK IL 60302

The face of this license has a colored background. Printed by Authority of the State of Illinois • 4/97 •

DISPLAY THIS PART IN A CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION

State of Illinois 1954467

Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

WEST SUBURBAN MEDICAL CENTER

EXPIRATION DATE	CATEGORY	I.D. NUMBER
12/31/10	BGBD	0002907

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 01/01/10

11/07/09

WEST SUBURBAN MEDICAL CENTER
ERIE AT AUSTIN

OAK PARK IL 60302

FEE RECEIPT NO.

EXHIBIT 10

AMERICAN OSTEOPATHIC ASSOCIATION
BUREAU OF HEALTHCARE FACILITIES ACCREDITATION
HEALTHCARE FACILITIES ACCREDITATION PROGRAM (HFAP)
CERTIFIED #: 7004 2510 0000 1977 6331
142 East Ontario Street, Chicago, IL 60611-2864 ph 312 202 8060 | 800 621 1773 | fx 312 202 8206

June 13, 2008

Jay Kreuzerd
Chief Executive Officer
West Suburban Hospital
Three Erie Court
Oak Park, IL 60302

Dear Mr. Kreuzerd:

The American Osteopathic Association's Bureau of Healthcare Facilities Accreditation at its meeting May 31, 2008, reviewed the survey report for:

West Suburban Hospital
Oak Park, IL
Medicare Provider # 140049

and granted ACCREDITATION with resurvey within 3 years. The accreditation is effective as of the date of your survey December 3-5, 2007.

Sincerely,

George A. Reuther

George A. Reuther
Secretary

GAR/pmh

cc: President, Governing Body
Chief of Staff
Laura Weber, Health Insurance Specialist, CMS
Region V, CMS

54

ATTACHMENT 10

State of Illinois 1954468
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

DAMON T. ARNOLD, M.D.
DIRECTOR

Issued under the authority of
The State of Illinois
Department of Public Health

EXPIRATION DATE	CATEGORY	I.D. NUMBER
12/31/10	BGBD	0002915

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 01/01/10

BUSINESS ADDRESS

WESTLAKE HOSPITAL
1225 LAKE STREET
MELROSE PARK IL 60160

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← DISPLAY THIS PART IN A CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION

↓

State of Illinois 1954468
Department of Public Health
LICENSE, PERMIT, CERTIFICATION, REGISTRATION

WESTLAKE HOSPITAL

EXPIRATION DATE	CATEGORY	I.D. NUMBER
12/31/10	BGBD	0002915

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 01/01/10

11/07/09

WESTLAKE COMMUNITY HOSPITAL
1225 LAKE STREET

MELROSE PARK IL 60160

FEE RECEIPT NO.

55

ATTACHMENT 10

AMERICAN OSTEOPATHIC ASSOCIATION

BUREAU OF HEALTHCARE FACILITIES ACCREDITATION
HEALTHCARE FACILITIES ACCREDITATION PROGRAM (HFAP)

142 East Ontario Street, Chicago, IL 60611-2864 312 202 8060 | 800 621 1773 | 312 202 8206

June 13, 2008

JUN 20 2008

Patrick Shehorn
Chief Executive Officer
Westlake Hospital
1225 W. Lake Street
Melrose Park, IL 60160

Dear Mr. Shehorn:

The American Osteopathic Association's Bureau of Healthcare Facilities Accreditation at its meeting May 31, 2008, reviewed the survey report for:

Westlake Hospital
Melrose Park, IL
Medicare Provider # 140240

and granted ACCREDITATION with resurvey within 3 years. The accreditation is effective as of the date of your survey November 19-21, 2007.

Sincerely,

George A. Reuther

George A. Reuther
Secretary

GAR/prnh

cc: President, Governing Body
Chief of Staff
Laura Weber, Health Insurance Specialist, CMS
Region V, CMS

ATTACHMENT 10

Healthcare Facilities Accreditation Program

grants this

CERTIFICATE OF ACCREDITATION

to

Westlake Hospital

Melrose Park, IL

This Facility has met the applicable HFAP accreditation requirements and is therefore fully accredited by the Healthcare Facilities Accreditation Program

2005-2008

Executive Director
American Osteopathic Association

President
American Osteopathic Association

Chairman
Illinois Healthcare Facilities Accreditation

57

ATTACHMENT 10

State of Illinois 1923356
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

DAMON T. ARNOLD, M.D.
DIRECTOR

Issued under the authority of
The State of Illinois
Department of Public Health

EXPIRATION DATE	CATEGORY	I.D. NUMBER
05/31/10	BGBD	0005249

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 06/01/09

BUSINESS ADDRESS

VHS ACQUISITION SUBSIDIARY NUMBER 3, INC
D/B/A LOUIS A. WEISS MEMORIAL HOSPITAL
4646 N. MARINE DRIVE

CHICAGO IL 60640

The face of this license has a colored background. Printed by Authority of the State of Illinois • 4/97 •

5 of

ATTACHMENT 10

← DISPLAY THIS PART IN A CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION

↓

State of Illinois 1923356
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

VHS ACQUISITION SUBSIDIARY NUMBER 3,

EXPIRATION DATE	CATEGORY	I.D. NUMBER
05/31/10	BGBD	0005249

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 06/01/09

04/04/09

VHS ACQUISITION SUBSIDIARY NO. 3
D/B/A LOUIS A. WEISS MEM'L HOSP.
4646 N. MARINE DRIVE
CHICAGO IL 60640

FEE RECEIPT NO.

The Joint Commission

April 23, 2008

Frank Molinaro, FACHE
CEO & President
Louis A. Weiss Memorial Hospital
4646 North Marine Drive
Chicago, IL 60640

Joint Commission ID #: 7286
Accreditation Activity: Evidence of Standards Compliance
Accreditation Activity Completed: 4/23/2008

Dear Mr. Molinaro:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- Comprehensive Accreditation Manual for Hospitals

This accreditation cycle is effective beginning March 01, 2008. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 39 months.

Please visit Quality Check® on the Joint Commission web site for updated information related to your accreditation decision.

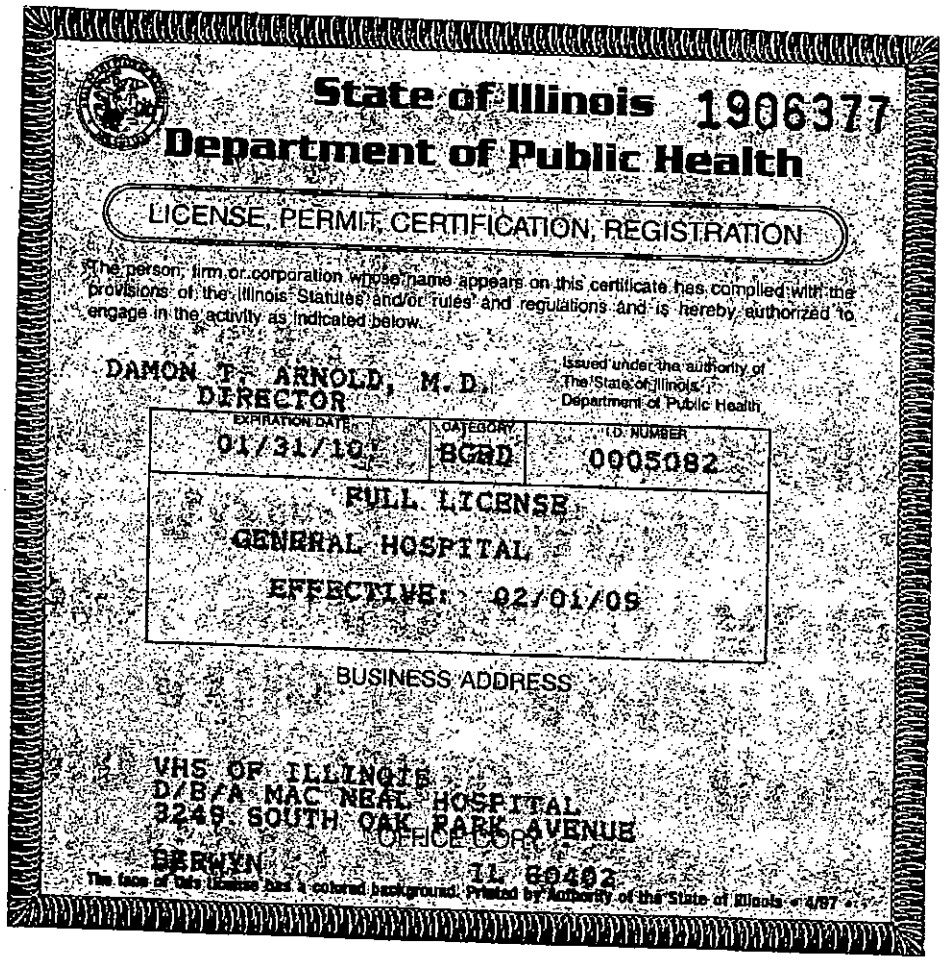
We encourage you to share this accreditation decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the Centers for Medicare and Medicaid Services (CMS), state or regional regulatory services, and the public you serve of your organization's accreditation decision.

Please be assured that the Joint Commission will keep the report confidential, except as required by law. To ensure that the Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Linda S. Murphy-Knoll
Interim Executive Vice President
Division of Accreditation and Certification Operations

ATTACHMENT 10



State of Illinois 1906377
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

DAMON T. ARNOLD, M.D.
DIRECTOR

Issued under the authority of
The State of Illinois
Department of Public Health

EXPIRATION DATE	CATEGORY	I.D. NUMBER
01/31/10	BGBD	0005082

FULL LICENSE
GENERAL HOSPITAL
EFFECTIVE: 02/01/09

BUSINESS ADDRESS

VHS OF ILLINOIS
D/B/A MAC NEAL HOSPITAL
3249 SOUTH OAK PARK AVENUE
BERWYN IL 60402

OFFICE COPY

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← DISPLAY THIS PART IN A CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION

State of Illinois 1906377
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

VHS OF ILLINOIS

EXPIRATION DATE	CATEGORY	I.D. NUMBER
01/31/10	BGBD	0005082

FULL LICENSE
GENERAL HOSPITAL
EFFECTIVE: 02/01/09

12/06/08

VHS OF ILLINOIS
D/B/A MAC NEAL HOSPITAL
3249 SOUTH OAK PARK AVENUE
BERWYN IL 60402

FEE RECEIPT NO.

ATTACHMENT 10

The Joint Commission

December 11, 2008

Brian Lemon
CEO
MacNeal Hospital
3249 South Oak Park Avenue
Berwyn, IL 60402

Joint Commission ID #: 7246
Accreditation Activity: Measure of Success
Accreditation Activity Completed: 12/11/2008

Dear Mr. Lemon:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- Comprehensive Accreditation Manual for Behavioral Health Care
- Comprehensive Accreditation Manual for Home Care
- Comprehensive Accreditation Manual for Hospitals
- Comprehensive Accreditation Manual for Long Term Care

This accreditation cycle is effective beginning May 08, 2008. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 39 months.

Please visit Quality Check® on the Joint Commission web site for updated information related to your accreditation decision.

We encourage you to share this accreditation decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the Centers for Medicare and Medicaid Services (CMS), state or regional regulatory services, and the public you serve of your organization's accreditation decision.

Please be assured that the Joint Commission will keep the report confidential, except as required by law. To ensure that the Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Ann Scott Blouin RN, PhD

Ann Scott Blouin, RN, Ph.D.
Executive Vice President
Accreditation and Certification Operations

ATTACHMENT 10

The Joint Commission

MacNeal Hospital
3249 South Oak Park Avenue
Berwyn, IL 60402

Organization Identification Number: 7246

Measure of Success Received: 12/11/2008

PROGRAM(S)
Hospital Accreditation Program
Home Care Program

Executive Summary

There is no follow-up due to The Joint Commission as a result of the accreditation activity conducted on the above date.

The results of this accreditation activity do not affect any other Requirement(s) for Improvement that may exist on your current accreditation decision.

1954444

DAMON T. ARNOLD, M.D.
DIRECTOR

12/31/10 BGBD 0301974

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 01/01/10

RESURRECTION MEDICAL CENTER

7435 WEST TALCOTT AVENUE

CHICAGO IL 60631

1954444

RESURRECTION MEDICAL CENTER

12/31/10 BGBL 0001974

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 01/01/10

RESURRECTION MEDICAL CENTER
7435 WEST TALCOTT AVENUE

CHICAGO IL 60631

63

ATTACHMENT 10

State of Illinois 1954498
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

DAMON T. ARNOLD, M.D.
DIRECTOR

Issued under the authority of
The State of Illinois
Department of Public Health

EXPIRATION DATE	CATEGORY	I.D. NUMBER
12/31/10	BGBD	0005314

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 01/01/10

BUSINESS ADDRESS

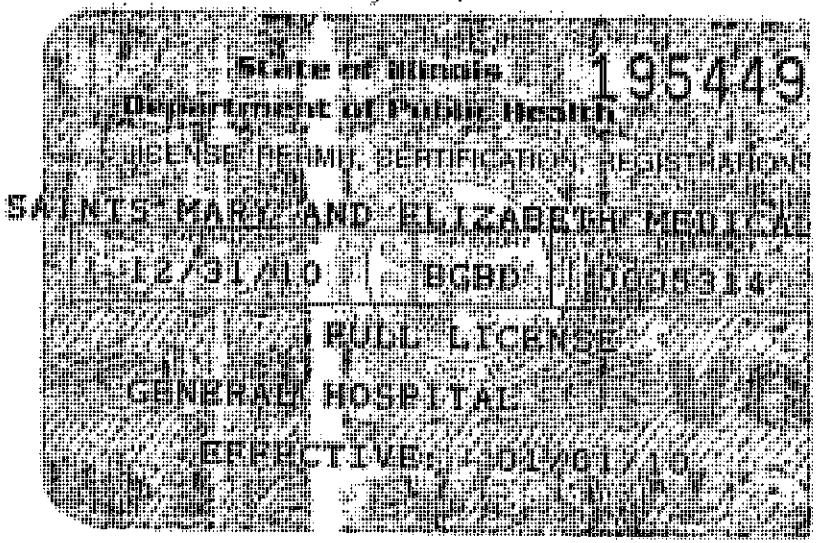
SAINTS MARY AND ELIZABETH MEDICAL CENTER
D/B/A SAINT ELIZABETH HOSPITAL
1431 NORTH CLAREMONT AVENUE
CHICAGO IL 60622

AFFIX ATTACHMENT

The face of this license has a colored background. Printed by Authority of the State of Illinois • 4/97 •

DISPLAY THIS PART IN A CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION



11/07/09

SAINTS MARY AND ELIZABETH MED C
D/B/A SAINT ELIZABETH HOSPITAL
1431 NORTH CLAREMONT AVENUE
CHICAGO IL 60622

FEE RECEIPT NO.

State of Illinois 1954461
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

DAMON T. ARNOLD, M.D.
DIRECTOR

Issued under the authority of
The State of Illinois
Department of Public Health

EXPIRATION DATE	CATEGORY	I.D. NUMBER
12/31/10	BGBD	0002584

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 01/01/10

BUSINESS ADDRESS

SAINTS MARY AND ELIZABETH MEDICAL CENTER
D/B/A SAINT MARY OF NAZARETH HOSPITAL
2233 WEST DIVISION STREET
CHICAGO IL 60622

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ATTACHMENT 1

← DISPLAY THIS PART IN A CONSPICUOUS PLACE

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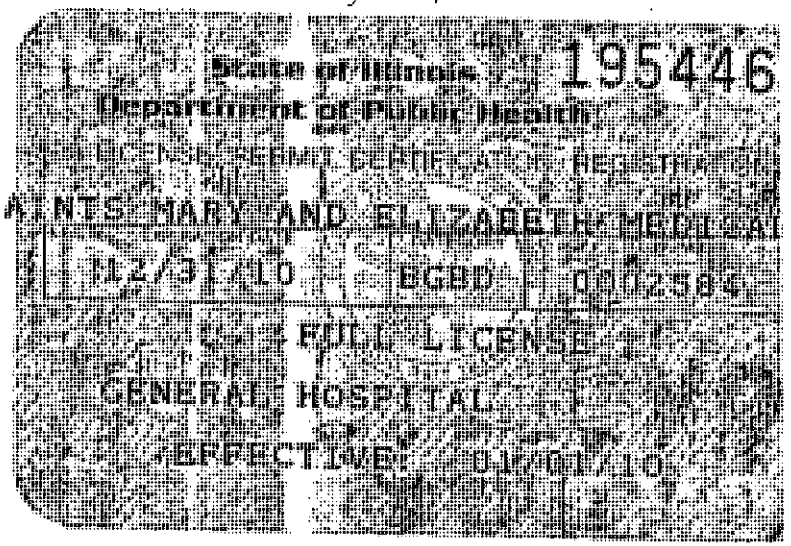
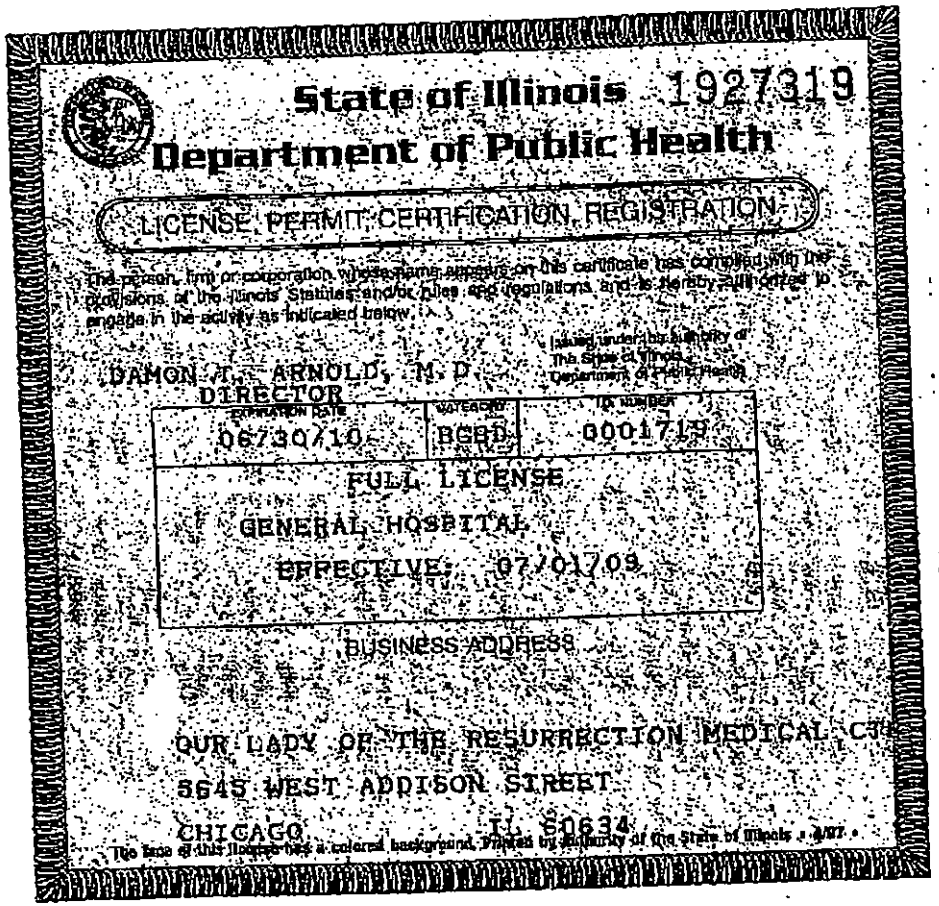


11/07/09

SAINTS MARY AND ELIZABETH MED C
D/B/A SAINT MARY OF NAZARETH HO
2233 WEST DIVISION STREET
CHICAGO IL 60622

FEE RECEIPT NO.

ATTACHMENT 10



State of Illinois 1927319
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

DAMON T. ARNOLD, M.D.
DIRECTOR

Issued under the authority of The State of Illinois Department of Public Health

EXPIRATION DATE	CATEGORY	ID NUMBER
06/30/10	BGBD	0001719

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 07/01/09

BUSINESS ADDRESS

OUR LADY OF THE RESURRECTION MEDICAL CTR
5645 WEST ADDISON STREET
CHICAGO IL 60634

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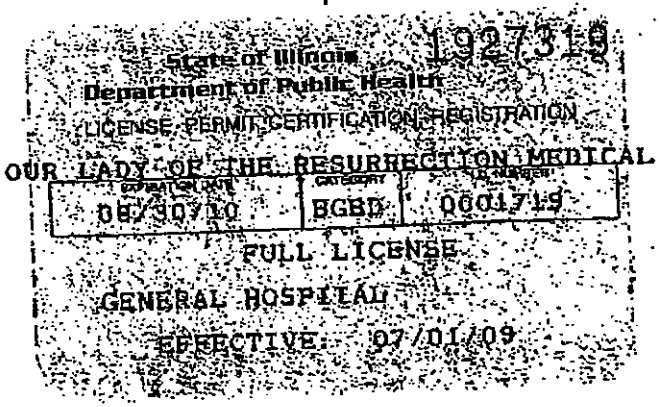
REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION



State of Illinois 1927319
Department of Public Health
LICENSE, PERMIT, CERTIFICATION, REGISTRATION

OUR LADY OF THE RESURRECTION MEDICAL

EXPIRATION DATE	CATEGORY	ID NUMBER
06/30/10	BGBD	0001719

FULL LICENSE

GENERAL HOSPITAL

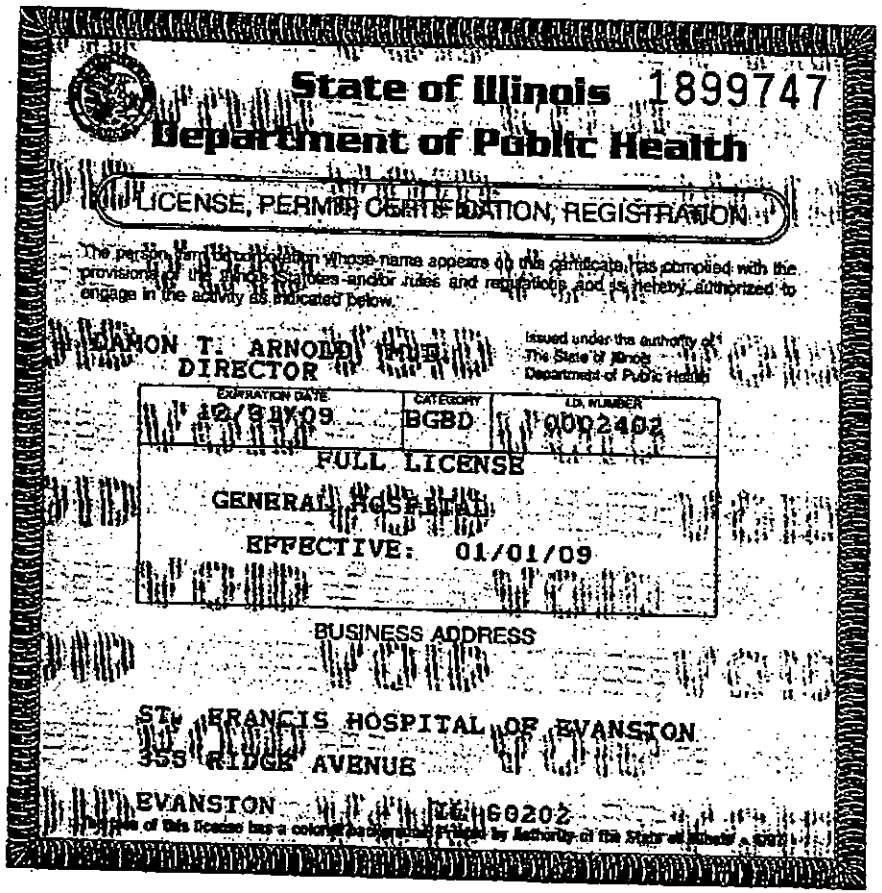
EFFECTIVE: 07/01/09

05/02/09

OUR LADY OF THE RESURRECTION MEDIC
5645 WEST ADDISON STREET

CHICAGO IL 60634

FEE RECEIPT NO.



State of Illinois 1899747
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The person named below whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

LAMON T. ARNOLD, MHE
DIRECTOR

Issued under the authority of The State of Illinois Department of Public Health

EXPIRATION DATE	CATEGORY	I.D. NUMBER
12/31/09	BGBD	0002402

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 01/01/09

BUSINESS ADDRESS

ST. FRANCIS HOSPITAL OF EVANSTON
355 RIDGE AVENUE
EVANSTON IL 60202

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State of Illinois 1899747
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

ST. FRANCIS HOSPITAL OF EVANSTON

EXPIRATION DATE	CATEGORY	I.D. NUMBER
12/31/09	BGBD	0002402

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 01/01/09

11/01/08

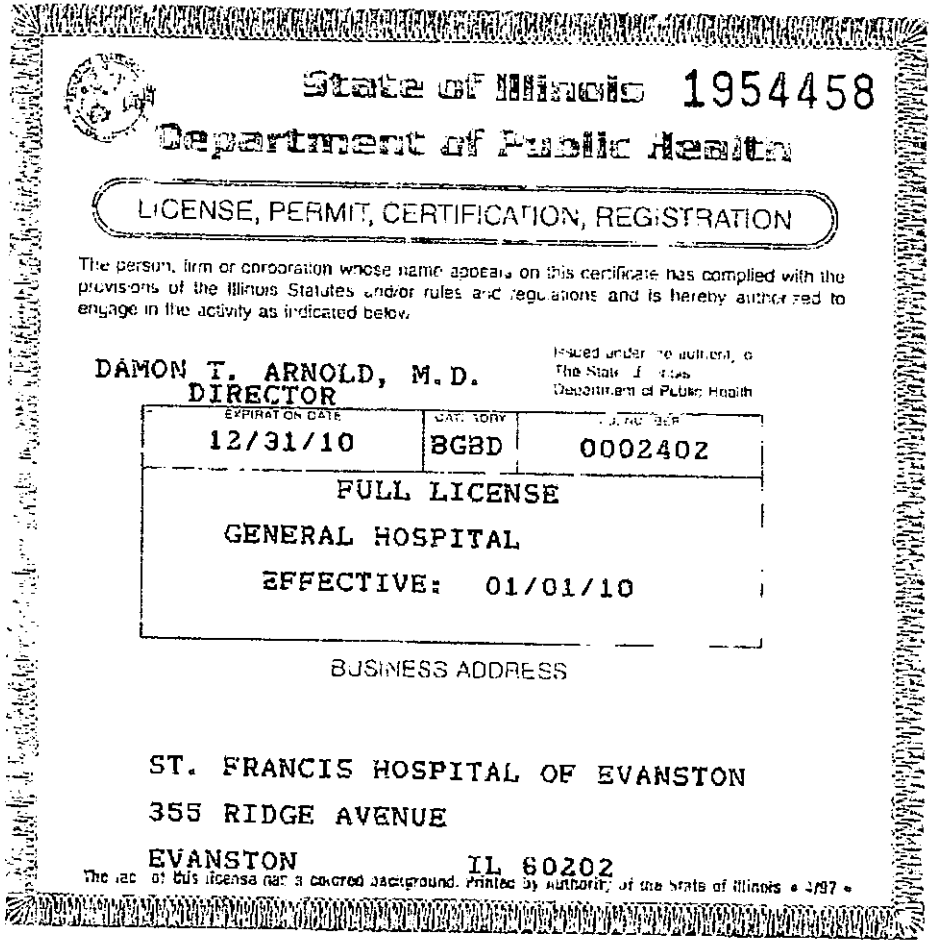
ST. FRANCIS HOSPITAL OF EVANSTON
355 RIDGE AVENUE

EVANSTON IL 60202

FEE RECEIPT NO.

ATTACHMENT 10

COPY



State of Illinois 1954458

Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

DAMON T. ARNOLD, M.D.
DIRECTOR

Issued under the authority of
The State of Illinois
Department of Public Health

EXPIRATION DATE	CATEGORY	ID NUMBER
12/31/10	BGBD	0002402

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 01/01/10

BUSINESS ADDRESS

ST. FRANCIS HOSPITAL OF EVANSTON
355 RIDGE AVENUE
EVANSTON IL 60202

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REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION

↓

State of Illinois 1954458

Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

ST. FRANCIS HOSPITAL OF EVANSTON

EXPIRATION DATE	CATEGORY	ID NUMBER
12/31/10	BGBD	0002402

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 01/01/10

11/07/09

ST. FRANCIS HOSPITAL OF EVANSTON
355 RIDGE AVENUE

EVANSTON IL 60202

FEE RECEIPT NO.

68

ATTACHMENT 10

ATTACHMENT 10

DISPLAY THIS PART IN A CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION

State of Illinois 1932360
Department of Public Health
LICENSE, PERMIT, CERTIFICATION, REGISTRATION
SAINT JOSEPH HOSPITAL

EXPIRATION DATE	DISCIPLINE	NUMBER
07/02/10	HOSP	0065184

FULL LICENSE
GENERAL HOSPITAL
EFFECTIVE: 07/03/09

06/06/09

SAINT JOSEPH HOSPITAL
2900 NORTH LAKE SHORE DRIVE
CHICAGO IL 60657

ATTACHMENT 10

State of Illinois 1927307
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

DAMON T. ARNOLD, M.D.
DIRECTOR

Issued under the authority of The State of Illinois Department of Public Health

EXPIRATION DATE	CATEGORY	I.D. NUMBER
06/30/10	BGBD	0001008

FULL LICENSE
GENERAL HOSPITAL
EFFECTIVE: 07/01/09

BUSINESS ADDRESS

HOLY FAMILY MEDICAL CENTER
100 NORTH RIVER ROAD
DES PLAINES IL 60016 1278

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REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION

State of Illinois 1927307
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

HOLY FAMILY MEDICAL CENTER

EXPIRATION DATE	CATEGORY	I.D. NUMBER
06/30/10	BGBD	0001008

FULL LICENSE
GENERAL HOSPITAL
EFFECTIVE: 07/01/09

05/02/09

HOLY FAMILY MEDICAL CENTER
100 NORTH RIVER ROAD
DES PLAINES IL 60016 1278

FEE RECEIPT NO.

AMERICAN OSTEOPATHIC ASSOCIATION
BUREAU OF HEALTHCARE FACILITIES ACCREDITATION
HEALTHCARE FACILITIES ACCREDITATION PROGRAM (HFAP)

CERTIFIED [illegible] 142 ph 312 202 8060 | 800 621 1773 | fax 312 202 8206

June 13, 2008

Margaret McDermott
Chief Executive Officer
St. Mary & Elizabeth Medical Center - St. Mary Campus
233 West Division
Chicago, IL 60622

Dear Ms. McDermott:

The American Osteopathic Association's Bureau of Healthcare Facilities Accreditation at its meeting May 31, 2008, reviewed the survey report for:

St. Mary & Elizabeth Medical Center – St. Mary Campus
Chicago, IL
Medicare Provider # 140180

and granted ACCREDITATION with resurvey within 3 years. The accreditation is effective as of the date of your survey December 5-7, 2007.

Sincerely,

George A. Reuther

George A. Reuther
Secretary

GAR/pmh

cc: President, Governing Body
Chief of Staff
Laura Weber, Health Insurance Specialist, CMS
Region V, CMS

RECEIVED
JUN 25 2008

AMERICAN OSTEOPATHIC ASSOCIATION
BUREAU OF HEALTHCARE FACILITIES ACCREDITATION
HEALTHCARE FACILITIES ACCREDITATION PROGRAM (HFAP)

142 East Ontario Street, Chicago, IL 60611-2864 ph 312 202 8060 | 800 621 1773 | fx 312 202 8206

CERTIFIED # 7004 2510 0000 2291 3280 REVISED

September 30, 2008

Margaret McDermott
Chief Executive Officer
Saint Mary & Elizabeth Medical Center - Saint Elizabeth Campus
1431 North Claremont
Chicago, IL 60622

Dear Ms. McDermott:

The American Osteopathic Association's Bureau of Healthcare Facilities Accreditation at its meeting May 31, 2008, reviewed the survey report for:

Saint Mary & Elizabeth Medical Center - Saint Elizabeth Campus
Chicago, IL
Medicare Provider # 140094

and granted ACCREDITATION with resurvey within 3 years. The accreditation is effective as of the date of your survey December 5-7, 2007.

Sincerely,

George A. Reuther

George A. Reuther
Secretary

GAR/pmh

cc: President, Governing Body
Chief of Staff
Laura Weber, Health Insurance Specialist, CMS
Region V, CMS

AMERICAN OSTEOPATHIC ASSOCIATION
BUREAU OF HEALTHCARE FACILITIES ACCREDITATION
HEALTHCARE FACILITIES ACCREDITATION PROGRAM (HFAP)

142 East Ontario Street, Chicago, IL 60611-2864 ph 312 202 8060 | 800 621 1773 | fx 312 202 8206

CERTIFIED # 7004 2510 0000 2291 2894

June 13, 2008

Jeffrey Murphy
President / CEO
St. Francis Hospital
355 Ridge Avenue
Evanston, IL 60202

Dear Mr. Murphy:

The American Osteopathic Association's Bureau of Healthcare Facilities Accreditation at its meeting May 31, 2008 reviewed the survey report for:

St. Francis Hospital
Evanston, IL
Medicare Provder # 140080

and granted ACCREDITATION with resurvey within 3 years. The accreditation is effective as of the date of your survey October 24-26, 2007.

In reviewing your report, the Bureau made the observations which are contained on the enclosed sheet and requires that an interim progress report by your facility, indicating progress made toward correction of cited deficiencies.

The next report is to be received in the AOA Division of Healthcare Facilities Accreditation by August 1, 2008.

Sincerely,

George A. Reuther

George A. Reuther
Secretary

GAR/pmh

Enclosure

cc: President, Governing Body
Chief of Staff
Laura Weber, Health Insurance Specialist, CMS
Region V, CMS

BUREAU OF HEALTHCARE FACILITIES ACCREDITATION
HEALTHCARE FACILITIES ACCREDITATION PROGRAM (HFAP)

142 East Ontario Street, Chicago, IL 60611-2864 ph: 312 202 8060 | 800 621 1773 | fx: 312 202 8206

CERTIFIED # 7004 2510 0000 2291 3419

September 19, 2008

Jeffrey Murphy
Chief Executive Officer
St. Francis Hospital
355 Ridge Avenue
Evanston, IL 60202

Dear Mr. Murphy:

The American Osteopathic Association's Bureau of Healthcare Facilities Accreditation at its meeting September 6, 2008, reviewed and accepted your Interim Progress Report and no further action is required.

Sincerely,

George A. Reuther

George A. Reuther
Secretary

GAR/pmh

CC President Governing Body
Chief-of-Staff
Laura Weber, Health Insurance Specialist, CMS
Region V, CMS

BUREAU OF HEALTHCARE FACILITIES ACCREDITATION
HEALTHCARE FACILITIES ACCREDITATION PROGRAM (HFAP)

CERTIFIED# 7004 2510 0000 6937 6291 ph: 312 202 8060 | 800 621 1773 | fx: 312 202 8206

June 13, 2008

Ronald Struxness
Chief Executive Officer
St. Joseph's Hospital
2900 N. Lake Shore Drive
Chicago, IL 60657

Dear Mr. Struxness:

The American Osteopathic Association's Bureau of Healthcare Facilities Accreditation at its meeting May 31, 2008, reviewed the survey report for:

St. Joseph's Hospital
Chicago, IL
Medicare Provider # 140224

and granted ACCREDITATION with resurvey within 3 years. The accreditation is effective as of the date of your survey October 17-19, 2007.

Sincerely,

George A. Reuther

George A. Reuther
Secretary

GAR/pmh

cc: President, Governing Body
Chief of Staff
Laura Weber, Health Insurance Specialist, CMS
Region V, CMS

Healthcare Facilities Accreditation Program

HFAP
Healthcare Facilities Accreditation Program
ACCREDITING HEALTHCARE FACILITIES FOR OVER 60 YEARS

grants this

CERTIFICATE OF ACCREDITATION

to

St. Francis Hospital

Evanston, IL

This Facility has met the applicable HFAP accreditation requirements and is therefore fully accredited by the Healthcare Facilities Accreditation Program

2007-2010

Executive Director
American Osteopathic Association

President
American Osteopathic Association

Chairman
Bureau Healthcare Facilities Accreditation

ATTACHMENT 10

DIVISION OF HEALTHCARE FACILITIES ACCREDITATION

HFAP Healthcare Facilities Accreditation Program

American Osteopathic Association

ACCREDITING HEALTHCARE FACILITIES FOR OVER 60 YEARS

142 East Ontario Street • Chicago, Illinois 60611-2864 • 800-621-1773 • 312-202-8000 • Fax 312-202-8206

May 1, 2008

Sister Donna Marie, C.R.
Chief Executive Officer
Resurrection Medical Center
7435 West Talcott Avenue
Chicago, Illinois 60631

Dear Sr. Donna Marie:

This letter is to verify that Resurrection Medical Center is accredited by the Healthcare Facilities Accreditation Program (HFAP) of the American Osteopathic Association (AOA). The facility was surveyed on December 10 - 12, 2007.

Your facility is currently accredited and will remain accredited until survey report findings are processed per HFAP protocol and an accreditation decision is rendered by the Bureau. You may use a copy of this letter with external organizations to indicate the accreditation status of your facility. Questions about the HFAP may be addressed to my attention at 312-202-8060.

Sincerely,

George A. Reuther

George A. Reuther
Director

C: Lawrence U. Haspel, D.O., Chair, Bureau of Healthcare Facilities Accreditation

J:Corr/2008/Resurrection MC

Healthcare Facilities Accreditation Program

HFAP
Healthcare Facilities Accreditation Program

grants this

CERTIFICATE OF ACCREDITATION

to

Resurrection Medical Center

Chicago, IL

This Facility has met the applicable HFAP accreditation requirements and is therefore fully accredited by the Healthcare Facilities Accreditation Program

2007-2010

Executive Director
American Osteopathic Association

President
American Osteopathic Association

Chairman
Bureau Healthcare Facilities Accreditation

ATTACHMENT 10

BUREAU OF HEALTHCARE FACILITIES ACCREDITATION
HEALTHCARE FACILITIES ACCREDITATION PROGRAM (HFAP)

142 East Ontario Street, Chicago, IL 60611-2864 ph 312 202 8060 | 800 621 1773 | fx 312 202 8208

June 13, 2008

Ivette Estrada
Chief Executive Officer
Our Lady of the Resurrection Medical Center
5654 West Addison Street
Chicago, IL 60634

Dear Ms. Estrada:

The American Osteopathic Association's Bureau of Healthcare Facilities Accreditation at its meeting May 31, 2008, reviewed the survey report for:

Our Lady of the Resurrection Medical Center
Chicago, IL
Medicare Provider # 140251

and granted ACCREDITATION with resurvey within 3 years. The accreditation is effective as of the date of your survey November 5-7, 2007.

Sincerely,

George A. Reuther

George A. Reuther
Secretary

GAR/pmh

cc: President, Governing Body
Chief of Staff
Laura Weber, Health Insurance Specialist, CMS
Region V, CMS

Healthcare Facilities Accreditation Program

HFAP
Healthcare Facilities Accreditation Program

grants this

CERTIFICATE OF ACCREDITATION

to

Our Lady of the Resurrection Medical Center

Chicago, IL

This Facility has met the applicable HFAP accreditation requirements and is therefore fully accredited by the Healthcare Facilities Accreditation Program

2007-2010

Executive Director
American Osteopathic Association

President
American Osteopathic Association

Chairman
Bureau Healthcare Facilities Accreditation

DIVISION OF HEALTHCARE FACILITIES ACCREDITATION

HFAP Healthcare Facilities Accreditation Program

American Osteopathic Association

ACCREDITING HEALTHCARE FACILITIES FOR OVER 60 YEARS

142 East Ontario Street • Chicago, Illinois 60611-2864 • 800-621-1773 • 312-202-8000 • Fax 312-202-8206

May 1, 2008

John Baird
Chief Executive Officer
Holy Family Medical Center
100 N. River Road
Des Plaines, IL 60016

Dear Mr. Baird:

This letter is to verify that Holy Family Medical Center is accredited by the Healthcare Facilities Accreditation Program (HFAP) of the American Osteopathic Association (AOA). The facility was surveyed on September 10 – 12, 2007.

Your facility is currently accredited and will remain accredited until survey report findings are processed per HFAP protocol and an accreditation decision is rendered by the Bureau. You may use a copy of this letter with external organizations to indicate the accreditation status of your facility. Questions about the HFAP may be addressed to my attention at 312-202-8060.

Sincerely,

George A. Reuther

George A. Reuther
Director

C: Lawrence U. Haspel, D.O., Chair, Bureau of Healthcare Facilities Accreditation

J:Corr/2008/Res_Holy Family Medical Center

Healthcare Facilities Accreditation Program

grants this

CERTIFICATE OF ACCREDITATION

to

Holy Family Medical Center

Des Plaines, IL

This Facility has met the applicable HFAP accreditation requirements and is therefore fully accredited by the Healthcare Facilities Accreditation Program

2007-2010

Executive Director
American Osteopathic Association

President
American Osteopathic Association

Chairman
Bureau Healthcare Facilities Accreditation

ATTACHMENT 10

AMERICAN OSTEOPATHIC ASSOCIATION
BUREAU OF HEALTHCARE FACILITIES ACCREDITATION
HEALTHCARE FACILITIES ACCREDITATION PROGRAM (HFAP)

142 East Ontario Street, Chicago, IL 60611-2864 ph 312 202 8060 | 800 621 1773 | fx 312 202 8206

CERTIFIED # 7004 2510 0000 2291 3280 REVISED

September 30, 2008

Margaret McDermott
Chief Executive Officer
Saint Mary & Elizabeth Medical Center – Saint Elizabeth Campus
1431 North Claremont
Chicago, IL 60622

Dear Ms. McDermott:

The American Osteopathic Association's Bureau of Healthcare Facilities Accreditation at its meeting May 31, 2008, reviewed the survey report for:

Saint Mary & Elizabeth Medical Center – Saint Elizabeth Campus
Chicago, IL
Medicare Provider # 140094

and granted ACCREDITATION with resurvey within 3 years. The accreditation is effective as of the date of your survey December 5-7, 2007.

Sincerely,

George A. Reuther

George A. Reuther
Secretary

GAR/pmh

cc: President, Governing Body
Chief of Staff
Laura Weber, Health Insurance Specialist, CMS
Region V, CMS

ATTACHMENT 10

HFAP
Healthcare Facilities Accreditation Program

American Osteopathic Association

ACCREDITING HEALTHCARE FACILITIES FOR OVER 60 YEARS

142 East Ontario Street • Chicago, Illinois 60611-2864 • 800-621-1773 • 312-202-8000 • Fax 312-202-8206

May 1, 2008

John Baird
Chief Executive Officer
Holy Family Medical Center
100 N. River Road
Des Plaines, IL 60016

Dear Mr. Baird:

This letter is to verify that Holy Family Medical Center is accredited by the Healthcare Facilities Accreditation Program (HFAP) of the American Osteopathic Association (AOA). The facility was surveyed on September 10 – 12, 2007.

Your facility is currently accredited and will remain accredited until survey report findings are processed per HFAP protocol and an accreditation decision is rendered by the Bureau. You may use a copy of this letter with external organizations to indicate the accreditation status of your facility. Questions about the HFAP may be addressed to my attention at 312-202-8060.

Sincerely,

George A. Reuther

George A. Reuther
Director

C: Lawrence U. Haspel, D.O., Chair, Bureau of Healthcare Facilities Accreditation

J:Corr/2008/Res_Holy Family Medical Center

BUREAU OF HEALTHCARE FACILITIES ACCREDITATION
HEALTHCARE FACILITIES ACCREDITATION PROGRAM (HFAP)

142 East Ontario Street, Chicago, IL 60611-2864 ph 312 202 8060 | 800 621 1773 | fx 312 202 8208

June 13, 2008

Ivette Estrada
Chief Executive Officer
Our Lady of the Resurrection Medical Center
5654 West Addison Street
Chicago, IL 60634

Dear Ms. Estrada:

The American Osteopathic Association's Bureau of Healthcare Facilities Accreditation at its meeting May 31, 2008, reviewed the survey report for:

Our Lady of the Resurrection Medical Center
Chicago, IL
Medicare Provider # 140251

and granted ACCREDITATION with resurvey within 3 years. The accreditation is effective as of the date of your survey November 5-7, 2007.

Sincerely,

George A. Reuther

George A. Reuther
Secretary

GAR/pmh

cc: President, Governing Body
Chief of Staff
Laura Weber, Health Insurance Specialist, CMS
Region V, CMS

DIVISION OF HEALTHCARE FACILITIES ACCREDITATION

HFAP Healthcare Facilities Accreditation Program

American Osteopathic Association

ACCREDITING HEALTHCARE FACILITIES FOR OVER 60 YEARS

142 East Ontario Street • Chicago, Illinois 60611-2864 • 800-621-1773 • 312-202-8000 • Fax 312-202-8206

May 1, 2008

Sister Donna Marie, C.R.
Chief Executive Officer
Resurrection Medical Center
7435 West Talcott Avenue
Chicago, Illinois 60631

Dear Sr. Donna Marie:

This letter is to verify that Resurrection Medical Center is accredited by the Healthcare Facilities Accreditation Program (HFAP) of the American Osteopathic Association (AOA). The facility was surveyed on December 10 - 12, 2007.

Your facility is currently accredited and will remain accredited until survey report findings are processed per HFAP protocol and an accreditation decision is rendered by the Bureau. You may use a copy of this letter with external organizations to indicate the accreditation status of your facility. Questions about the HFAP may be addressed to my attention at 312-202-8060.

Sincerely,

George A. Reuther

George A. Reuther
Director

C: Lawrence U. Haspel, D.O., Chair, Bureau of Healthcare Facilities Accreditation

J:Corr/2008/Resurrection MC

BUREAU OF HEALTHCARE FACILITIES ACCREDITATION
HEALTHCARE FACILITIES ACCREDITATION PROGRAM (HFAP)

CERTIFIED # 7004 2510 0000 1917 6201 ph 312 202 8060 | 800 621 1773 | fx: 312 202 8206

June 13, 2008

Ronald Struxness
Chief Executive Officer
St. Joseph's Hospital
2900 N. Lake Shore Drive
Chicago, IL 60657

Dear Mr. Struxness:

The American Osteopathic Association's Bureau of Healthcare Facilities Accreditation at its meeting May 31, 2008, reviewed the survey report for:

St. Joseph's Hospital
Chicago, IL
Medicare Provider # 140224

and granted ACCREDITATION with resurvey within 3 years. The accreditation is effective as of the date of your survey October 17-19, 2007.

Sincerely,

George A. Reuther

George A. Reuther
Secretary

GAR/pmh

cc: President, Governing Body
Chief of Staff
Laura Weber, Health Insurance Specialist, CMS
Region V, CMS

AMERICAN OSTEOPATHIC ASSOCIATION
BUREAU OF HEALTHCARE FACILITIES ACCREDITATION
HEALTHCARE FACILITIES ACCREDITATION PROGRAM (HFAP)

142 East Ontario Street, Chicago, IL 60611-2864 ph 312 202 8060 | 800 621 1773 | fx 312 202 8206

CERTIFIED # 7004 2510 0000 2291 2894

June 13, 2008

Jeffrey Murphy
President / CEO
St. Francis Hospital
355 Ridge Avenue
Evanston, IL 60202

Dear Mr. Murphy:

The American Osteopathic Association's Bureau of Healthcare Facilities Accreditation at its meeting May 31, 2008 reviewed the survey report for:

St. Francis Hospital
Evanston, IL
Medicare Provder # 140080

and granted ACCREDITATION with resurvey within 3 years. The accreditation is effective as of the date of your survey October 24-26, 2007.

In reviewing your report, the Bureau made the observations which are contained on the enclosed sheet and requires that an interim progress report by your facility, indicating progress made toward correction of cited deficiencies.

The next report is to be received in the AOA Division of Healthcare Facilities Accreditation by **August 1, 2008.**

Sincerely,

George A. Reuther

George A. Reuther
Secretary

GAR/pmh

Enclosure

cc: President, Governing Body
Chief of Staff
Laura Weber, Health Insurance Specialist, CMS
Region V, CMS

ATTACHMENT 10

Healthcare Facilities Accreditation Program

HFAP
Healthcare Facilities Accreditation Program

grants this

to

Belmont / Harlem Surgery Center, LLC

Chicago, IL

This Facility has met the applicable HFAP accreditation requirements and is therefore fully accredited by the Healthcare Facilities Accreditation Program

2008-2011

Executive Director
American Osteopathic Association

President
American Osteopathic Association

Chairman
Bureau Healthcare Facilities Accreditation

ATTACHMENT 10

The Joint Commission

July 2, 2009

Donna Marie Wolowicki, CR
Executive Vice President and Chief Executive Officer
Resurrection Medical Center
7435 West Talcott Avenue
Chicago, IL 60631-3746

Joint Commission ID #: 3836
Program: Disease-Specific Care Certification
Certification Activity: 45-day Evidence of Standards Compliance
Certification Activity Completed: 07/02/2009
Program: DSC-Advanced Primary Stroke Center

Dear Sister Wolowicki:

The Joint Commission would like to thank your organization for participating in the certification process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the certification process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization a Passed Certification decision for all services reviewed under the applicable manual noted below:

- Disease Specific Care Certification Manual

This certification cycle is effective beginning June 30, 2009. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 24 months.

Please visit Quality Check® on The Joint Commission web site for updated information related to your certification decision.

We encourage you to share this certification decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the Centers for Medicare and Medicaid Services (CMS), state or regional regulatory services, and the public you serve of your organization's certification decision.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Ann Scott Blouin RN, PhD

Ann Scott Blouin, RN, Ph.D.
Executive Vice President
Accreditation and Certification Operations

ATTACHMENT 10

Resurrection Medical Center
7435 West Talcott Avenue
Chicago, IL 60631-3746

Organization Identification Number: 3836

Evidence of Standards Compliance (45 Day) Submitted: 6/30/2009

DISEASE
Advanced Primary Stroke Center

Program
Disease-Specific Care Certification

Executive Summary

Disease-Specific Care Certification :	As a result of the certification review conducted on the above date(s), there are no Requirements for Improvement identified. You will have follow-up in the area(s) indicated below: • Measure of Success (MOS) – A follow-up Measure of Success will occur in four (4) months.

If you have any questions, please do not hesitate to contact your Account Representative.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

ATTACHMENT 10

41

The Joint Commission
Summary of Compliance

Program	Standard	Level of Compliance
DSC	DF.2@DSC	Compliant

1923420

DAMON T. ARNOLD, M.D.
DIRECTOR

04/30/10 | BGBD 7003131

FULL LICENSE

AMBUL SURGICAL TREAT CNTR

EFFECTIVE: 05/01/09

BELMONT/HARLEM SURGERY CENTER, LLC

3101 NORTH HARLEM AVENUE

CHICAGO IL 60634

1923420

BELMONT/HARLEM SURGERY CENTER, LLC

04/30/10 | BGBD 7003131

FULL LICENSE

AMBUL SURGICAL TREAT CNTR

EFFECTIVE: 05/01/09

04/04/09

BELMONT/HARLEM SURGERY CENTER, LLC
3101 NORTH HARLEM AVENUE
3101 NORTH HARLEM AVENUE
CHICAGO IL 60634

59678

93

ATTACHMENT 10

State of Illinois 1881619

Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

DAMON T. ARNOLD, M.D.
DIRECTOR

Issued under the authority of
The State of Illinois
Department of Public Health

EXPIRATION DATE	CATEGORY	I.D. NUMBER
04/09/2010	BGBE	0044792

LONG TERM CARE LICENSE
SKILLED 164
INTERMEDIATE 082
SHELTERED 007

UNRESTRICTED 253 TOTAL BEDS

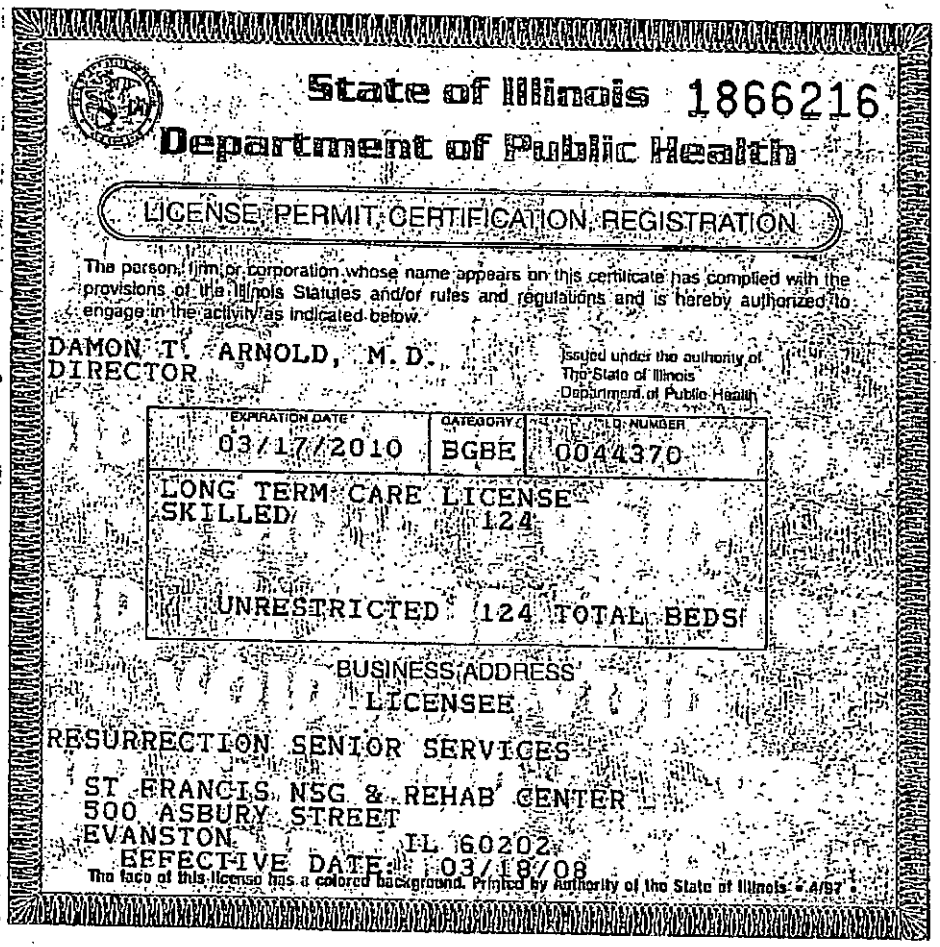
BUSINESS ADDRESS
LICENSEE

RESURRECTION SENIOR SERVICES

VILLA SCALABRINI NSG & REHAB
480 NORTH WOLF ROAD
NORTHLAKE IL 60164
EFFECTIVE DATE: 04/10/08

The face of this license has a colored background. Printed by Authority of the State of Illinois • 4/97 •

ATTACHMENT 10



State of Illinois 1866216

Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

DAMON T. ARNOLD, M.D.
DIRECTOR

Issued under the authority of The State of Illinois Department of Public Health

EXPIRATION DATE	CATEGORY	I.D. NUMBER
03/17/2010	BGBE	0044370

LONG TERM CARE LICENSE
SKILLED 124

UNRESTRICTED 124 TOTAL BEDS

BUSINESS ADDRESS
LICENSEE

RESURRECTION SENIOR SERVICES

ST FRANCIS NSG & REHAB CENTER
500 ASBURY STREET
EVANSTON IL 60202

EFFECTIVE DATE: 03/18/08

The face of this license has a colored background. Printed by Authority of the State of Illinois - 4/97

DISPLAY THIS PART IN A CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION

State of Illinois 1866216

Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

EXPIRATION DATE	CATEGORY	I.D. NUMBER
03/17/2010	BGBE	0044370

LONG TERM CARE LICENSE
SKILLED 124

UNRESTRICTED 124 TOTAL BEDS

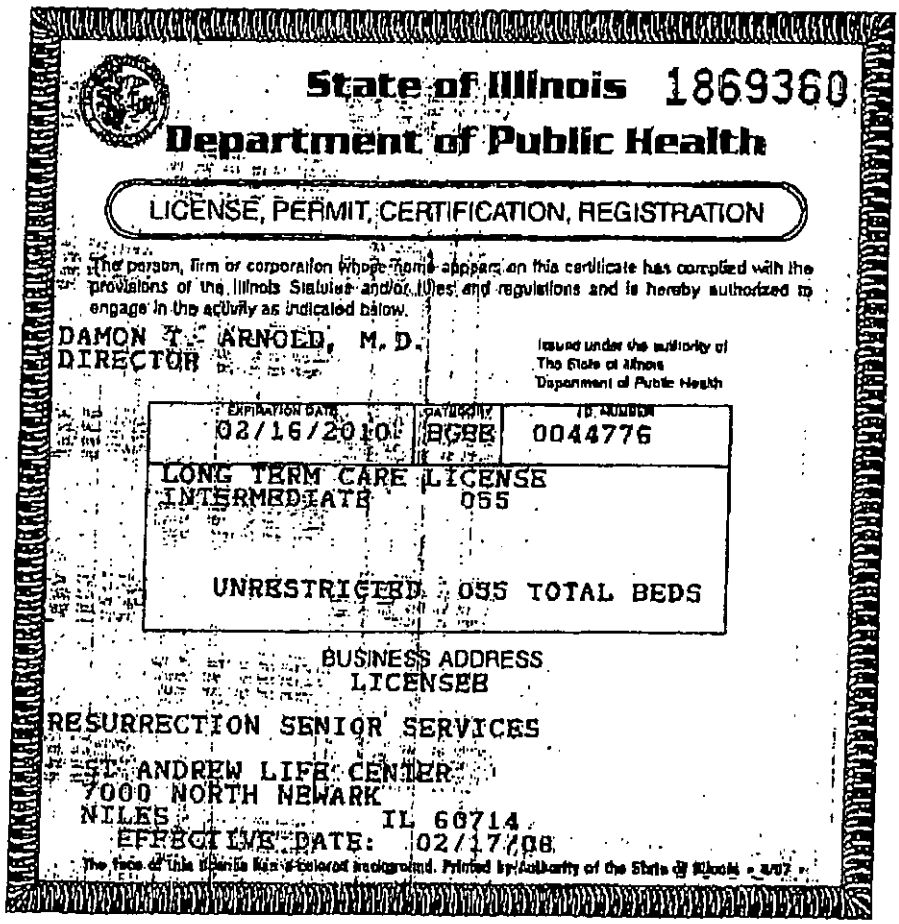
02/28/08

ST FRANCIS NSG & REHAB CENTER
500 ASBURY STREET
EVANSTON IL 60202

FEE RECEIPT NO.

95

ATTACHMENT 10



State of Illinois 1869360

Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

DAMON T. ARNOLD, M.D.
DIRECTOR

Issued under the authority of
The State of Illinois
Department of Public Health

EXPIRATION DATE	CATEGORY	I.D. NUMBER
02/16/2010	BCBB	0044776

LONG TERM CARE LICENSE
INTERMEDIATE 055

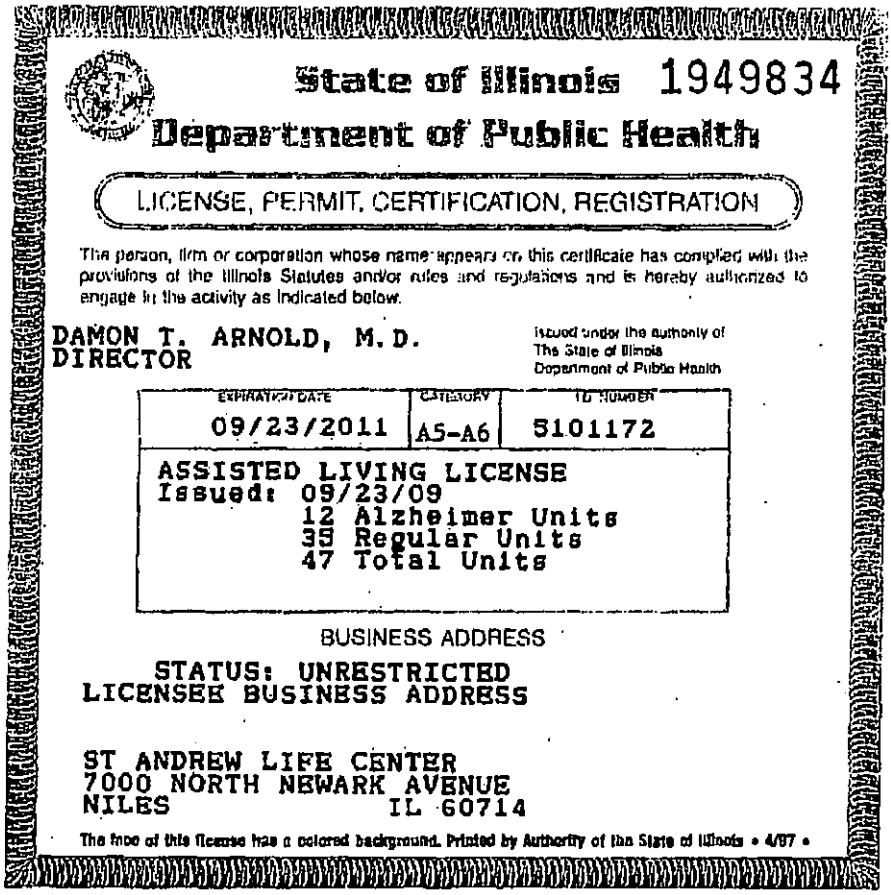
UNRESTRICTED 055 TOTAL BEDS

BUSINESS ADDRESS
LICENSEE

RESURRECTION SENIOR SERVICES
ST ANDREW LIFE CENTER
7000 NORTH NEWARK
NILES IL 60714
EFFECTIVE DATE: 02/17/08

The face of this diploma has a colored background. Printed by authority of the State of Illinois - 3/07 -

ATTACHMENT 10



State of Illinois 1949834

Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

DAMON T. ARNOLD, M.D.
DIRECTOR

Issued under the authority of
The State of Illinois
Department of Public Health

EXPIRATION DATE	CATEGORY	ID NUMBER
09/23/2011	A5-A6	5101172

ASSISTED LIVING LICENSE
Issued: 09/23/09
12 Alzheimer Units
35 Regular Units
47 Total Units

BUSINESS ADDRESS

STATUS: UNRESTRICTED
LICENSEE BUSINESS ADDRESS

ST ANDREW LIFE CENTER
7000 NORTH NEWARK AVENUE
NILES IL 60714

The face of this license has a colored background. Printed by Authority of the State of Illinois • 4/97 •

ATTACHMENT 10

98

ATTACHMENT 10

State of Illinois 1938827

Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below

RAMON T. ARNOLD, M.D.
DIRECTOR

Issued under the authority of the State of Illinois Department of Public Health

EXPIRATION DATE	CATEGORY	ID NUMBER
02/02/2011	BGBE	0044354

LONG TERM CARE LICENSE
SKILLED 112
INTERMEDIATE 035
SHELTERED 015

UNRESTRICTED 162 TOTAL BEDS

BUSINESS ADDRESS

LICENSEE

RESURRECTION SENIOR SERVICES

RESURRECTION LIFE CENTER
7370 WEST TALCOTT AVENUE
CHICAGO IL 60631

EFFECTIVE DATE: 07/15/09

The face of this license has a colored background. Printed by Authority of the State of Illinois • 4/97 •

← DISPLAY THIS PART IN A CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION

↓

State of Illinois 1938827

Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

EXPIRATION DATE	CATEGORY	ID NUMBER
02/02/2011	BGBE	0044354

LONG TERM CARE LICENSE
SKILLED 112
INTERMEDIATE 035
SHELTERED 015

UNRESTRICTED 162 TOTAL BEDS

07/15/09

RESURRECTION LIFE CENTER
7370 WEST TALCOTT AVENUE
CHICAGO IL 60631

FEE RECEIPT NO.

ATTACHMENT 10

State of Illinois 1920539
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

DAMON T. ARNOLD, M.D.
DIRECTOR

Issued under the authority of
The State of Illinois
Department of Public Health

EXPIRATION DATE	CATEGORY	I.D. NUMBER
02/14/2011	A2-A3	5101685

ASSISTED LIVING LICENSE
Issued: 02/14/09
37 Regular Units
37 Total Units

BUSINESS ADDRESS

STATUS: UNRESTRICTED
LICENSEE BUSINESS ADDRESS

RESURRECTION RETIREMENT COMM.
7262 WEST PETERSON AVENUE
CHICAGO IL 60631

The face of this license has a colored background. Printed by Authority of the State of Illinois • 4/97 •

← DISPLAY THIS PART IN A CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION

↓

State of Illinois 1920539
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

EXPIRATION DATE	CATEGORY	I.D. NUMBER
02/14/2011	A2-A3	5101685

ASSISTED LIVING LICENSE

37 Regular Units
37 Total Units

03/12/09

RESURRECTION RETIREMENT COMM.
7262 WEST PETERSON AVENUE
CHICAGO IL 60631

FEE RECEIPT NO.

ATTACHMENT 10

/ 20

State of Illinois 1892182

Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

DAMON T. ARNOLD, M.D.
DIRECTOR

Issued under the authority of
The State of Illinois
Department of Public Health

EXPIRATION DATE	CATEGORY	I.D. NUMBER
08/24/2010	A5-A6	5100216

ASSISTED LIVING LICENSE
Issued: 08/24/08
64 Regular Units
64 Total Units

BUSINESS ADDRESS
STATUS: UNRESTRICTED
LICENSEE BUSINESS ADDRESS

BETHLEHEM WOODS RET COMMUNITY
1571 W OGDEN AVE
LAGRANGE PARK IL 60526

The face of this license has a colored background. Printed by Authority of the State of Illinois - 4/97 -

← DISPLAY THIS PART IN A CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION

↓

State of Illinois 1892182
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

EXPIRATION DATE	CATEGORY	I.D. NUMBER
08/24/2010	A5-A6	5100216

ASSISTED LIVING LICENSE

64 Regular Units
64 Total Units

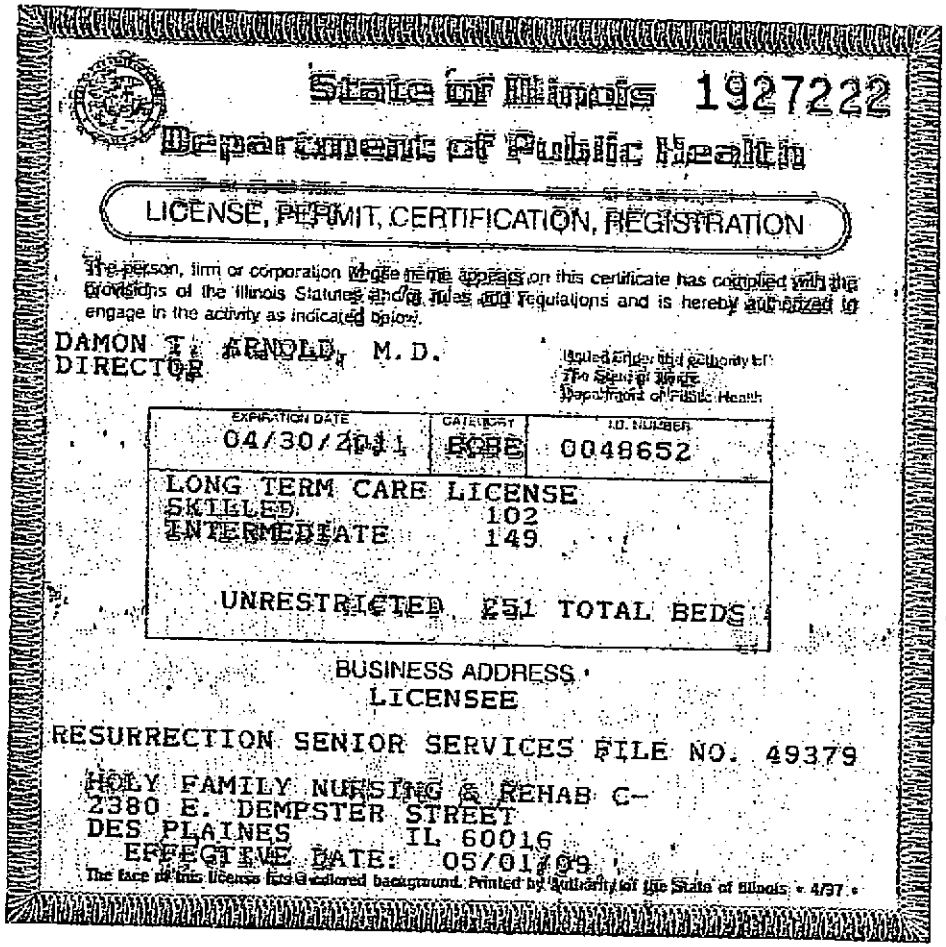
09/08/08

BETHLEHEM WOODS RET COMMUNITY
1571 W OGDEN AVE
LAGRANGE PARK IL 60526

FEE RECEIPT NO.

ATTACHMENT 10

101



State of Illinois 1927222

Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and Rules and Regulations and is hereby authorized to engage in the activity as indicated below.

DAMON T. ARNOLD, M.D.
DIRECTOR

Issued under the authority of
The State of Illinois
Department of Public Health

EXPIRATION DATE	CATEGORY	I.D. NUMBER
04/30/2011	RCBE	0048652

LONG TERM CARE LICENSE
SKILLED 102
INTERMEDIATE 149

UNRESTRICTED 251 TOTAL BEDS

BUSINESS ADDRESS
LICENSEE

RESURRECTION SENIOR SERVICES FILE NO. 49379

HOLY FAMILY NURSING & REHAB C-
2380 E. DEMPSTER STREET
DES PLAINES IL 60016
EFFECTIVE DATE: 05/01/09

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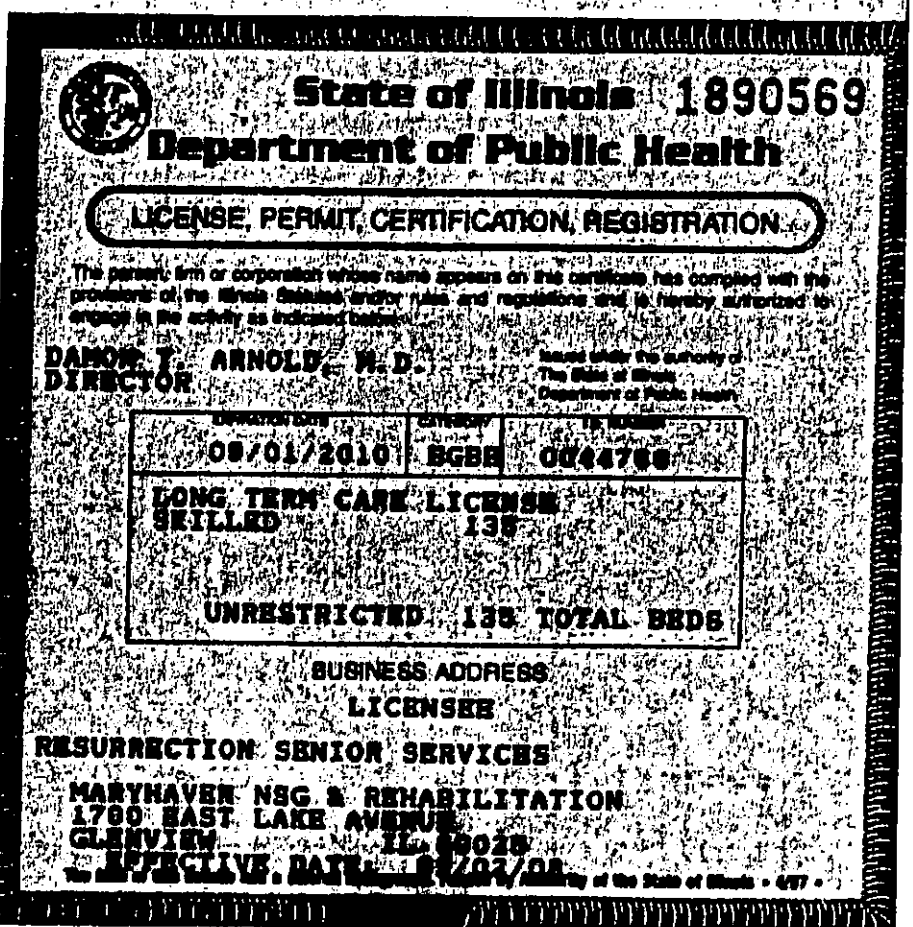


State of Illinois 1890569
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

DAMON T. ARNOLD, M.D.
DIRECTOR

Issued under the authority of The State of Illinois Department of Public Health

Expiration Date	Category	I.D. Number
08/01/2010	BGBE	0044788

LONG TERM CARE LICENSE
SKILLED 135

UNRESTRICTED 135 TOTAL BEDS

BUSINESS ADDRESS
LICENSEE
RESURRECTION SENIOR SERVICES
MARYHAVEN NSG & REHABILITATION
1700 EAST LAKE AVENUE
GLENVIEW IL 60025

EFFECTIVE DATE 8/02/08

State of Illinois 1890570
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

DAMON T. ARNOLD, M.D.
DIRECTOR

Issued under the authority of The State of Illinois Department of Public Health

EXPIRATION DATE	CATEGORY	I.D. NUMBER
09/07/2010	BGBE	0044784

LONG TERM CARE LICENSE
SKILLED 099

UNRESTRICTED 099 TOTAL BEDS

BUSINESS ADDRESS

LICENSEE

RESURRECTION SENIOR SERVICES

ST BENEDICT NURSING & REHAB
6930 WEST TOUHY AVENUE
NILES IL 60714

EFFECTIVE DATE: 09/08/08

The face of this license has a colored background. Printed by Authority of the State of Illinois • 4/87 •

ATTACHMENT 10

ATTACHMENT 10

State of Illinois 1937426
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

DAMON T. ARNOLD, M.D.
DIRECTOR

Issued under the authority of
The State of Illinois
Department of Public Health

EXPIRATION DATE	CATEGORY	ID NUMBER
06/30/10	073	1010210

HOME HEALTH AGENCY LICENSES
SKILLED NURSING**SPEECH THERAPY
PHYSICAL THERAPY **********
OCCUPATIONAL THERAPY **********
MEDICAL SOCIAL SERVICE *******
HOME HEALTH AIDE **********

BUSINESS ADDRESS

RESURRECTION COMPREHENSIVE CARE
5747 W. DEMPSTER
MORTON GROVE IL 60053

The face of this license has a colored background. Printed by Authority of the State of Illinois • 4/07 •

← DISPLAY THIS PART IN A CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION

↓

State of Illinois 1937426
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

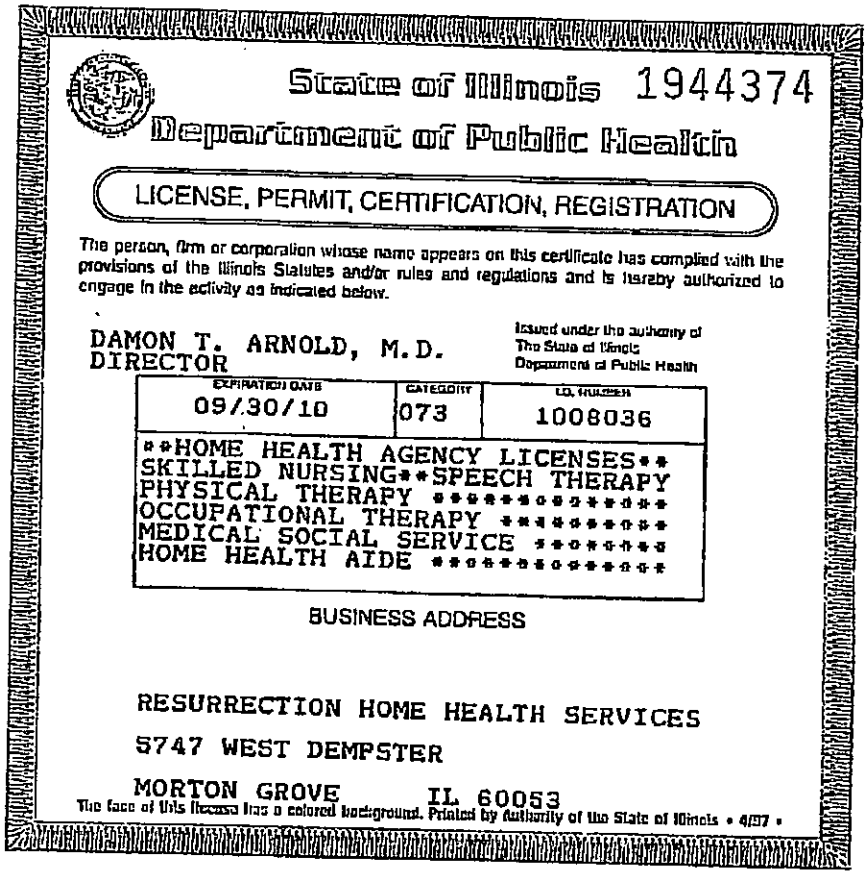
EXPIRATION DATE	CATEGORY	ID NUMBER
06/30/10	073	1010210

HOME HEALTH AGENCY LICENSES
SKILLED NURSING**SPEECH THERAPY
PHYSICAL THERAPY **********
OCCUPATIONAL THERAPY **********
MEDICAL SOCIAL SERVICES *******
HOME HEALTH AIDE **********

07/04/09

RESURRECTION COMPREHENSIVE CARE
5747 W. DEMPSTER
MORTON GROVE IL 60053

FEE RECEIPT NO. 073007



State of Illinois 1944374

Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

DAMON T. ARNOLD, M.D.
DIRECTOR

Issued under the authority of The State of Illinois Department of Public Health

EXPIRATION DATE	CATEGORY	ID NUMBER
09/30/10	073	1008036

HOME HEALTH AGENCY LICENSES
SKILLED NURSING**SPEECH THERAPY
PHYSICAL THERAPY **********
OCCUPATIONAL THERAPY **********
MEDICAL SOCIAL SERVICE ********
HOME HEALTH AIDE **********

BUSINESS ADDRESS

RESURRECTION HOME HEALTH SERVICES
5747 WEST DEMPSTER
MORTON GROVE IL 60053

The face of this license has a colored background. Printed by Authority of the State of Illinois • 4/97 •

← DISPLAY THIS PART IN A CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION

↓

State of Illinois 1944374
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

EXPIRATION DATE	CATEGORY	ID NUMBER
09/30/10	073	1008036

HOME HEALTH AGENCY LICENSES
SKILLED NURSING**SPEECH THERAPY
PHYSICAL THERAPY **********
OCCUPATIONAL THERAPY **********
MEDICAL SOCIAL SERVICES ********
HOME HEALTH AIDE **********

09/29/09

RESURRECTION HOME HEALTH SERVICES
5747 WEST DEMPSTER
MORTON GROVE IL 60053

FEE RECEIPT NO. 006750

105

ATTACHMENT 10

carf

enhancing PEOPLE'S LIVES

August 21, 2008

Linda L. Dean, PT, M.B.A.
Director, Rehabilitation Services
Resurrection Medical Center
7435 West Talcott Avenue
Chicago, IL 60631

Dear Mrs. Dean:

It is my pleasure to inform you that Resurrection Medical Center has been accredited by CARF for a period of three years for the following programs:

Inpatient Rehabilitation Programs - Hospital (Adults)
Outpatient Medical Rehabilitation Programs - Multiple Service (Adults)

This accreditation will extend through August 2011. This achievement is an indication of your organization's dedication and commitment to improving the quality of the lives of the persons served. Services, personnel, and documentation clearly indicate an established pattern of practice excellence.

Your organization should take pride in achieving this high level of accreditation. CARF will recognize this accomplishment in its listing of organizations with accreditation, and we encourage you to make this accomplishment known throughout your community. Communication of this award to your referral and funding sources, the media, and local and federal government officials will promote and distinguish your organization. Enclosed are some materials that will help you publicize this achievement.

The survey report is intended to support a continuation of the quality improvement of your programs. It contains comments on your organization's strengths as well as suggestions and recommendations. A quality improvement plan demonstrating your efforts to implement the survey recommendations must be submitted within the next 90 days to retain accreditation. Guidelines and the form for completing the plan are enclosed for your use. Please submit this report to the attention of the customer service unit Administrative Coordinator.

Your Certificate of Accreditation is being sent under separate cover. Please note that you may use the enclosed form to order additional copies of the certificate.

If you have any questions regarding your organization's accreditation, you are encouraged to seek support from a Resource Specialist in your customer service unit by calling extension 174.

CARF INTERNATIONAL
4891 East Grant Road
Tucson, AZ 85712 USA
Toll-free/TTY 888 281 6531 ■ Fax 520 318 1129
www.carf.org

CARF-CCAC
1730 Rhode Island Avenue, NW, Suite 209
Washington, DC 20036 USA
Toll-free 866 888 1122 ■ Fax 202 587 5009
www.carf.org/aging

CARF CANADA
10665 Jasper Avenue, Suite 1403A
Edmonton, Alberta T5J 3S9 Canada
Tel 780 429 2538 ■ Fax 780 426 7274
www.carfcanada.ca

ATTACHMENT 10

We encourage your organization to continue fully and productively using the CARF standards as part of your ongoing commitment to accreditation. We commend your commitment and consistent efforts to improve the quality of your programs. We look forward to working with your organization in the future.

Sincerely,

Brian J. Boon, Ph.D.
President/CEO

llp
Enclosures

CARF INTERNATIONAL
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10665 Jasper Avenue, Suite 1400A
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ATTACHMENT 10

PURPOSE

The proposed change of ownership for West Suburban Medical Center will assure that the hospital remains a viable provider of inpatient and outpatient services to the residents of west suburban Cook County and the far western Chicago neighborhoods that the hospital has traditionally served, providing services that improve the health care and well being of the area's residents.

The table below identifies the 2008 patient origin for the hospital. No changes of any substance in patient origin were experienced during 2009, and no changes of substance are anticipated following the proposed change of ownership.

As can be noted from the table below, 16 ZIP Code areas account for approximately 82% of the hospital's admissions, with each of those ZIP Code areas being located either on the far west side of Chicago, or in west suburban Cook County. Also of note is the fact that West Suburban is located on Austin Boulevard, which serves as the border between Oak Park and the City of Chicago.

West Suburban Medical Center
2008 Patient Origin

ZIP Code Area	Location	% of Adm.	Cumulative %
60644	Chicago	23.2%	23.2%
60651	Chicago	18.2%	41.4%
60639	Chicago	10.0%	51.4%
60302	Oak Park	7.1%	58.5%
60624	Chicago	4.5%	63.0%
60707	Elmwood Park	3.0%	66.1%
60304	Oak Park	2.6%	68.7%
60402	Berwyn	2.4%	71.1%
60804	Cicero	1.7%	72.8%
60130	Forest Park	1.7%	74.5%
60634	Chicago	1.5%	76.0%
60623	Chicago	1.5%	77.5%
60153	Maywood	1.4%	78.9%
60305	Rover Forest	1.0%	79.9%
60104	Bellwood	1.0%	80.9%
60641	Chicago	1.0%	81.9%
	271 ZIP Code areas with <1%	18.0%	100.0%

The primary issues that have led to this project, which addresses a change of ownership, exclusively, are the desire of Resurrection Health Care to ensure that the communities traditionally served by West Suburban Medical Center retain the access to health care services provided through West Suburban, and Resurrection Health Care's need to divest itself of selected assets in order assure the continued viability of the system. This need to divest was identified both through an internal strategic planning process as well as through independent outside analyses commissioned by Resurrection.

The proposed change of ownership will, in addition to allowing Resurrection to divest itself of the hospitals and improve its financial viability by doing so, assure that

services historically provided by the hospital will remain in the community, and that accessibility to those services will not be diminished as a result of the change of ownership. The acquiring co-applicants have certified that, consistent with IHFSRB requirements, they will neither eliminate programs nor reduce accessibility.

In addition to the improved financial viability of the divesting co-applicants, a goal for the acquiring co-applicants is the continued provision of services at or above West Suburban's current level, as identified through the utilization of those services. As is the case with many changes of ownership, an initial drop in utilization may occur as the result of physicians modifying their admitting practices. In terms of a quantifiable objective for the acquiring co-applicants, the goal will be to return to 2009 market shares for all services within twelve months of the change of ownership.

ALTERNATIVES

Resurrection Health Care studied a number of alternatives to the proposed project over the past two plus years. A summary of these and the reasons for rejecting these alternatives are given below:

Alternative 1: Convert Westlake Hospital from an acute care hospital into a specialty center

Several alternatives for a specialty center were explored including conversion to an LTACH, a women's hospital, a behavioral health center and a rehabilitation hospital. These alternatives were each ultimately rejected due to a lack of clear patient need in light of the presence of other area providers, as well as due to cost concerns.

Alternative 2: Consolidate the hospitals into a single campus

A plan was considered to develop Westlake Hospital into a mixed outpatient and non-health care related community services facility, and relocate the College of Nursing from West Suburban Medical Center to the Westlake campus. This plan was ultimately rejected due to capital and other costs. Even with a significant investment of such capital funds, profitability for either facility as a result of these changes could not be assured.

Alternative 3: Lease Westlake Hospital for non-acute care hospital use:

A plan was explored to lease Westlake Hospital to community organizations as a community health center. This plan was rejected because of the high risk that lease income would not be sufficient to allow Westlake to break even. This plan would also do nothing to mitigate the financial losses at West Suburban Medical Center.

Alternative 4: Close the hospitals and sell the properties for non-hospital usage:

This alternative was rejected as highly undesirable if a sale was possible, since closure would significantly reduce access to health care services to residents of the hospitals' communities, and result in significant job losses in the communities.

SUMMARY COMPARISION OF ALTERNATIVES TO PROJECT

Alternative	Cost	Financial Benefits	Quality	Accessibility
Convert Westlake to a specialty center	Pro formas not completed because this alternative was not considered viable.	This alternative would likely result in continued financial losses at Westlake and do little to mitigate losses at West Suburban	This alternative was considered because it would promote needed quality health care in both communities.	An acute care hospital would be lost to the Melrose Park community.
Consolidate the two hospitals into a single campus.	Intital capital costs - $22-25 M	Losses might be reduced, but not eliminated.	This alternative would help sustain quality health care in both communities.	An acute care hospital would be lost to the Melrose Park community.
Lease Westlake Hospital for non-acute care hospital use	Capital costs of conversion estimated at $12.7 million	Plan would likely not break even and WSMC losses would continue.	This alternative would also sustain quality health care in both communities.	An acute care hospital would be lost to the Melrose Park community.
Close the hospitals and sell the properties for non-hospital usage	Maintenance costs of the properties would continue until a buyer could be found.	RHC's financial losses from the two hospitals would end	Existing health care services in the community would be lost.	Both communities would lose access to their current hospital provider.
Current scenario. Transfer ownership of Westlake and West Sububan to Vanguard.	estimated $750,000 (for both hospitals) in costs to RHC for legal fees, community relations, etc.	RHC will realize the benefit of the purchase price to sustain its core markets and repay RHC for a portion of the over $166M in operational subsidies provided to the hospitals over the past 5 years.	Vanguard has a good reputation for quality. Quality services to both communities will be maintained.	Accessibility of current services would be maintained.

ATTACHMENT 12

IMPACT STATEMENT

The proposed change of ownership will have a significant positive community and health care delivery impact on Oak Park and the surrounding communities historically served by West Suburban Medical Center. Consistent with IHFSRB rules, this impact statement covers the two-year period following the proposed change of ownership.

The current owner of West Suburban Medical Center, Resurrection Health Care, and as described elsewhere in this application, has identified the need to divest itself of the hospital, and without the acquisition as being proposed, the scope of services to be provided at West Suburban Medical Center under new ownership could be reduced, or potentially, as has been the case with a number of other Chicago area hospitals, the hospital could be discontinued altogether. As a result of the proposed acquisition, a hospital that has been a primary provider of health care services to its community for decades, will continue to do so.

Anticipated Changes to the Number of Beds or Services Currently Offered

No changes are anticipated either to the number of beds (234) or to the scope of services currently provided at West Suburban Medical Center.

The current and proposed bed complement, consistent with West Suburban Medical Center's 2008 IDPH Hospital Profile are:

- 135 medical/surgical beds
- 5 pediatrics beds
- 24 intensive care beds
- 20 obstetrics/gynecology beds
- 50 long-term care beds

Among the other clinical services currently offered and proposed to be provided are: surgery (including cardiovascular surgery), nursery, clinical laboratory, pharmacy, diagnostic imaging, cardiac catheterization, GI lab, emergency department, outpatient clinics, and physical, occupational, and speech therapy.

Operating Entity

Upon the change of ownership, the operating entity/licensee will be VHS West Suburban Medical Center, Inc.

Reason for the Transaction

The proposed change of ownership is the result of the Resurrection Health Care system's identified need and desire to divest itself of the hospital for a variety of operational and financial reasons.

Additions or Reductions in Staff

The acquiring co-applicants fully intend to offer all current hospital employees their current position at their current wage or salary and seniority level, and all accrued vacation time will be honored by Vanguard. No changes in staffing, aside from those

routine changes typical to hospitals are anticipated during the first two years following the proposed change of ownership.

Cost/Benefit Analysis of the Transaction

1. Cost

The costs associated with the transaction are limited to those identified in Section I and discussed in ATTACHMENT 7, those being the cash being paid to the seller, and ancillary costs identified in ATTACHMENT 7 as "Consulting and Other Fees", which include the legal fees, public relations consulting fees, CON-development related costs, CON review fees, and miscellaneous costs associated with the transaction. No major capital costs for construction, modernization or equipment acquisition are anticipated during the first two years following the change of ownership.

2. Benefit

The community will benefit greatly from the change of ownership, and primarily from the continued availability of West Suburban Medical Center and its current programmatic complement. Last year, the hospital admitted approximately 10,600 patients, provided approximately 200,000 outpatient visits, and treated over 43,000 patients in its emergency department. As noted above, the acquiring co-applicants are committed to, at minimum, retaining the current programmatic complement consistent with IHFSRB requirements, and assessments related to program expansion will commence shortly after the change of ownership occurs.

The continued ability to access West Suburban Medical Center is particularly important to the more disadvantaged communities and neighborhoods traditionally served by West Suburban Medical Center. In 2008, 27.0% of all patients admitted to the hospital were Medicaid recipients, and another 2.5% were full charity care write-offs.

The commitment to the provision of care to Medicaid recipients and the provision of charity care will continue following the acquisition, and Vanguard has a strong history of doing so through its current Chicago area hospitals. According to IDPH data, during 2008 21.4% and 20.5% of the patients admitted to Louis A. Weiss Memorial Hospital and MacNeal Memorial Hospital were Medicaid recipients, respectively. In addition, 2.4% and 3.4% of the patients admitted to the two hospitals, respectively, were cared for without charge as full charity write-offs. Both Weiss and MacNeal were noted in an October 19, 2009 article appearing in *Crain's Chicago Business*, comparing the amount of Medicaid and charity care services provided by Chicago area for-profit hospitals to the amount provided by the area's largest not-for-profit hospitals. *Crain's* reported that Weiss and MacNeal ranked eighth and tenth, respectively, of the 26 hospitals included in the analysis in terms of charity care and Medicaid revenue as a percentage of patient revenue. A copy of that article is attached.

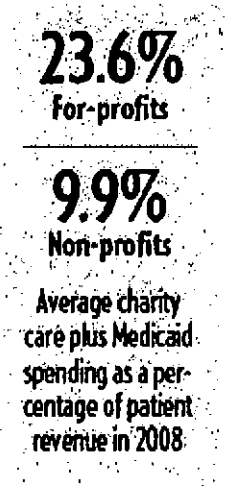
Finally, with 1,291 employees, West Suburban Medical Center is a major area employer, and, as noted above, the acquiring co-applicants have committed to retain all of the hospital's current employees, at their current positions and wages or salaries.

From this week's In Other News

Non-profits no better on charity care

By: Mike Colias October 19, 2009

With non-profit hospitals under pressure to justify their tax breaks by providing more charity care, a *Crain's* analysis shows that local for-profit hospitals provide as much — and often more — treatment to poor people as their non-profit, tax-exempt peers.



Six Chicago-area hospitals are for-profit and pay taxes. Yet all of them spent a bigger chunk of their revenue last year on a combination of charity care and treatment of public-aid patients compared to the majority of the area's 20 largest non-profit hospitals, according to a review of data from the Illinois Department of Public Health.

"There is some degree of an unlevel playing field in the relationship between charity and tax status," says Brian Lemon, CEO of MacNeal Hospital in Berwyn, which is owned by a for-profit, Tennessee-based hospital chain and provided $2.2 million in free care last year. "In terms of our mission, there's no difference."

Critics contend that non-profit hospitals aren't doing enough to earn their tax breaks, which shield them from property and income taxes and allow them to issue tax-free bonds and receive deductible donations. The blurred line between tax-exempt institutions and their for-profit competitors underscores the need for clearer criteria for determining tax exemptions, some experts say.

"I definitely think it argues for a finer point on what charity is, and I think we're grinding toward that," says Beaufort Longest, director of the Health Policy Institute at the University of Pittsburgh.

Illinois has been a flashpoint in a national debate over charity care ever since Champaign County officials stripped Provena Covenant Medical Center of its exemption in 2003,

determining its charity care of less than 1% of revenue wasn't enough. The case is now in the hands of the Illinois Supreme Court, which heard arguments last month and is expected to rule in coming months.

Federal law requires hospitals to provide a "community benefit" in exchange for tax exemptions. Among other things, hospitals point to the free or discounted care they provide to poor people, as well as the losses they absorb from treating patients on Medicaid, the health plan for the indigent that generally doesn't cover treatment costs.

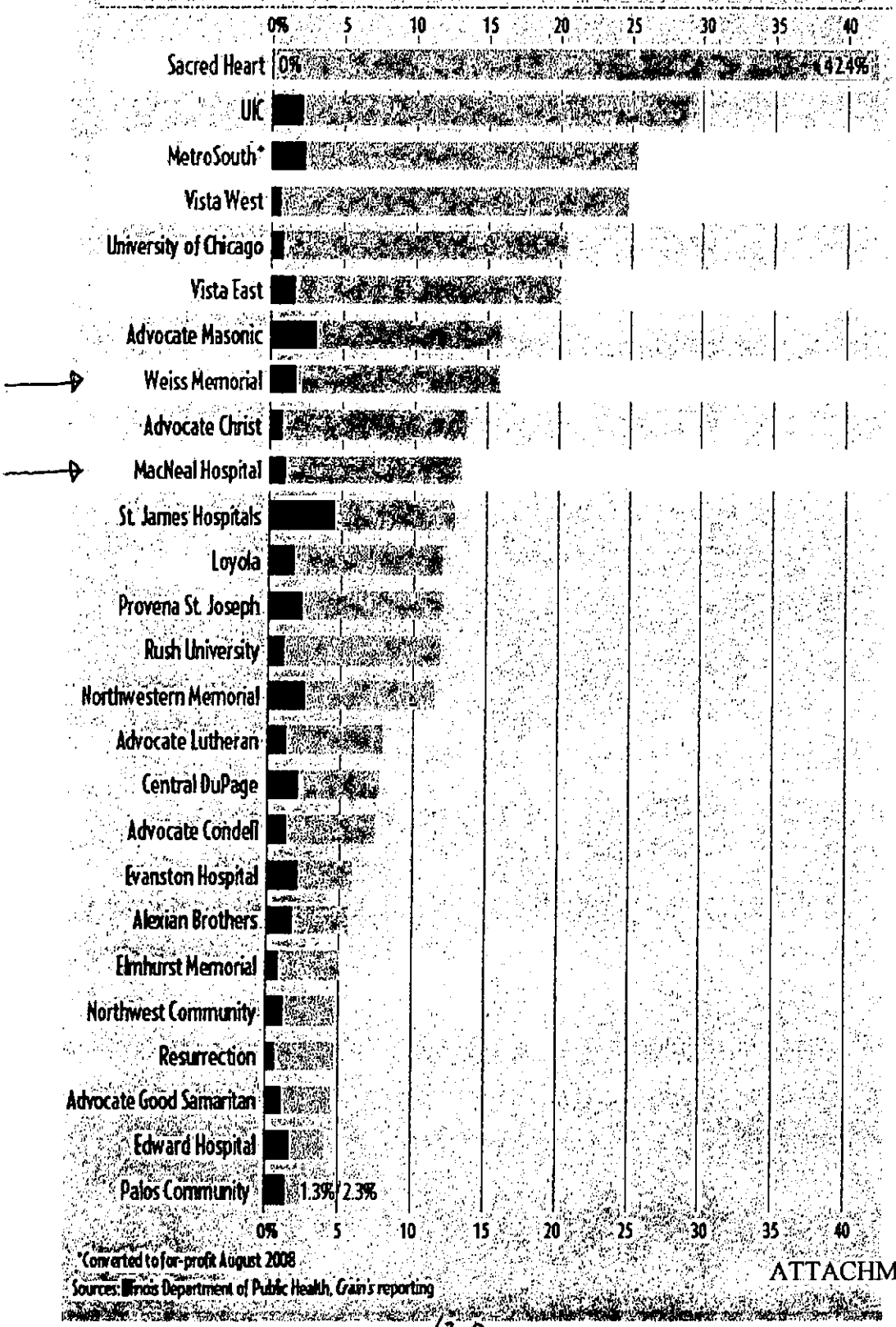
Experts say it's no surprise that for-profit hospitals offer free care. Like their non-profit brethren, they are required by law to treat patients who end up in their emergency rooms, regardless of ability to pay. And many Chicago-area non-profits have above-average Medicaid loads because they are in low-income areas.

Story continues below

CHARITY CHECK

Non-profit hospitals enjoy tax breaks in exchange for community benefits, including care for the poor. But local for-profit hospitals often do as much or more as their tax-exempt peers.

CHARITY AND MEDICAID REVENUE As a percent of patient revenue



*Converted to for-profit August 2008

Sources: Illinois Department of Public Health, *Crain's* reporting

ATTACHMENT 18A

MORE FREE CARE

In many cases, local for-profit hospitals dole out more free care and public aid than non-profits. Weiss Memorial Hospital in Uptown and Vista Medical Center East in Waukegan each spent 1.6% of patient revenue on charity last year. That's higher than half of the area's 20 largest hospitals, including Resurrection Medical Center (0.5%); Northwest Community Hospital (1.1%), and Palos Community Hospital (1.3%).

Yet Weiss paid about $2 million in property and sales taxes last year, while Northwest Community's tax exemption helped it avoid $11.2 million in taxes, according to the Chicago-based Center for Budget and Tax Accountability. Palos' exemption was worth $12.8 million, the group says.

Weiss also had a bigger Medicaid load relative to its size: 14% of its revenue came from the public-aid program, vs. 3.5% for Northwest Community's and less than 1% for Palos.

An April study from the Center for Budget and Tax Accountability said that 47 local hospitals earned $489.5 million in property and sales tax breaks while providing only $175.7 million in free or discounted care to the poor. The hospital industry calls the study flawed.

Howard Peters, senior vice-president of the Illinois Hospital Assn., says it's inappropriate to compare non-profit and for-profit hospitals, in part because they have different ownership structures. Investor-owned hospitals aim to return profits to shareholders, whereas at non-profits, "any excess revenues go back into the enterprise."

He calls charity care "the narrowest definition" of the benefits hospitals provide their communities. He says Medicaid as a percentage of revenue isn't a good benchmark of charity because hospitals' losses from the program vary depending on their cost structure. He says non-profit hospitals on average likely lose more money on Medicaid than for-profit institutions, although those figures aren't publicly available.

"Whether investor-owned or not-for-profit, hospitals across the board are doing a lot of good things in a tough environment to meet the needs of their communities," Mr. Peters says.

The only local hospital to report no charity care spending last year was Sacred Heart Hospital, a for-profit on the West Side with a heavy Medicaid load. CEO Edward Novak says the hospital provides plenty of free care, but it doesn't track or report it. He sees no difference between his hospital and tax-exempt competitors.

"If you look like a business and act like a business, how do you call yourself a charity?" he says.

ACCESS

Resurrection Health Care's acute care hospitals operate under common admissions policies, which are attached. Those policies address the provision of charity care services. Financial assistance and charity care provisions are made to patients having a household income equal to or less than 400% of the Federal Poverty Level, combined with a general lack of liquid assets. Full (100%) write-offs are provided to those having a household income of 100% or less of the Federal Poverty Level, with a sliding scale used for those with an income of more than 100% but less than 400% of the Federal Poverty Level.

Similarly, the two hospitals (MacNeal Memorial and Weiss Memorial) in the acquiring co-applicants' health care system operate under common admissions policies, and those policies (attached) will be adopted by West Suburban Medical Center following the change of ownership. The policies to be used provide for financial assistance and charity care provisions to be made to patients having a household income equal to or less than 500% of the Federal Poverty Level. Full (100%) write-offs are provided to those having a household income of 200% or less of the Federal Poverty Level, with a sliding scale used for those with an income of more than 200% but less than 500% of the Federal Poverty Level.

An excerpt from the policy is provided below, and the full policies pertaining to admissions are attached.

POLICY:

Charity Care or Financial Assistance. The Company's Hospitals shall provide charity care(free care) or financial assistance to uninsured patients for their emergency, non-elective care who qualify for classification as Financially Indigent or Medically Indigent in accordance with the Charity Care Financial Assistance Process set forth below. The Company's Hospitals shall adopt a written policy in conformity with the Company's Policy and Procedure set forth herein. Charity Care (100% discounts) under this Policy shall be available for uninsured patients with incomes below 200% of the Federal Poverty Level (the "Financially Indigent"). 40 to 80% discounts shall be available for uninsured patients either (1) with income below 500% FPL or (2) with balances due for hospital services in excess of 50% of their annual income (the "Medially Indigent").

West Suburban Medical Center will, as is the case now, operate without any restrictive admissions policies, related to race, ethnic background, religion, payment source, or any other factor. The hospital will continue to admit Medicare and Medicaid recipients, as well as patients in need of charity care. In addition, no agreements with private third party payors currently in place at West Suburban Medical Center are anticipated to be discontinued as a result of the proposed change of ownership.

Attached is a letter, consistent with the requirements of Section 1110.240(c), certifying that the admissions policies of West Suburban Medical Center will not become more restrictive than those now in place.

VANGUARD
HEALTH SYSTEMS

February 17, 2010

Illinois Health Facilities
and Services Review Board
Springfield, Illinois

RE: Acquisition of West Suburban Medical Center
Oak Park, Illinois

To Whom It May Concern:

Please be advised that upon the proposed acquisition of West Suburban Medical Center, there will be no policies adopted that will result in restrictions to admissions to the hospital.

It is the intent of VHS West Suburban Medical Center, Inc., which will be the licensee following the change of ownership, to adopt the admissions-related policies currently in effect at Louis A. Weiss Memorial Hospital and MacNeal Memorial Hospital. Those policies and procedures are included in ATTACHMENT 18B of the *Application for Permit* addressing the change of ownership, and it is anticipated that those policies will be adopted within sixty days of the change of ownership. Until such time that the proposed policies and procedure are adopted, the hospital will operate under the policies and procedures currently in place.

As a result, upon acquisition, the admissions policies will not become more restrictive.

Sincerely,

Charles N. Martin, Jr.

Notarized:

MCE: 11-07-12

NOTARY PUBLIC DAVIDSON COUNTY, TN

ATTACHMENT 18B

Resurrection Health Care

Admissions Policies

ATTACHMENT 18B

Resurrection Health Care

POLICY PROTOCOL		
CATEGORY: Patient Care Services		NUMBER: 1359.75
TITLE: Admission of the Patient		TITLE NUMBER: 004.04
		PAGE: 1 OF 2
EFFECTIVE DATE: February 2001	REVISION DATE: March 2009	SUPERSEDES: January 2006
REFER TO:		LOCATION:

PHILOSOPHY

Patient Services Policies are intended to describe the Resurrection Health Care commitment to a wholistic, customer-centered approach to care provided throughout continuum of clinical services.

PURPOSE

To provide for efficient admission of patients into the hospital and to establish an initial plan of care through communication with patient/family/significant other and members of the health care team.

PROCESS

1. Patients are admitted through the Admitting Department, Same Day Ambulatory Surgery, Heart Failure Clinic, Outpatient Department, and the Emergency Room.
2. Upon admission to the unit, nursing personnel are responsible for:
   2.1 Orienting patient/family to the unit.
   2.2 Verification and proper disposition of valuables.
   2.3 Completion of nursing admission history and assessment by an RN within timeframe based on area of service.
   WH Addendum: Refer to Policy 011.05
   2.4 Verifying status of Advance Directive.
   2.5 Initiating the development of a Plan of Care for inpatients.
   2.6 Contacting the appropriate Resident/Attending Physicians.
   2.7 Completion of "Family Representative and Documentation Form".
   WH addendum: Family Representative and Documentation Form is being completed with Patient Registration.
   WH addendum: Nursing personnel are responsible for initiating the Multidisciplinary Patient Education Record.

Resurrection Health Care

POLICY PROTOCOL		
CATEGORY: Patient Care Services		NUMBER: 1359.75
TITLE: Admission of the Patient		TITLE NUMBER: 004.04
		PAGE: 2 OF 2
EFFECTIVE DATE: February 2001	REVISION DATE: March 2009	SUPERSEDES: January 2006
REFER TO:		LOCATION:

This standard of care/policy is a guideline only. Each patient has his or her own unique set of circumstances, which may require that these procedures/standards of care not be followed. The needs of the patient supercede these, or any standards of care. Changes from these guidelines should be addressed in the medical record.

This policy has been approved the Executive Nursing Council and may not be altered or removed from this manual without the approval of the System Nursing Policy and Procedure Committee. Organizational specific information may be added to the end of the policy and altered, as the organization deems appropriate.

Watson, J. (1988). *Nursing: Human science and human care. A theory of nursing.* New York: National League for Nursing.

Watson, J. (1985). *Nursing: The philosophy and science of caring.* Niwot, CO: University Press of Colorado.

Nightingale, F. (1969). *Notes on nursing.* Toronto, Ontario: General Publishing Company, Ltd.

Resurrection Health Care

POLICY PROTOCOL		
CATEGORY: Finance		NUMBER: 100.15
TITLE: Financial Assistance/Charity Care and Uninsured Patient Discount Programs (This policy applies to hospitals only)		TITLE NUMBER: 122.05 PAGE: 1 OF 17
EFFECTIVE DATE: February 2002	REVISION DATE: January 2009	SUPERSEDES: September 2004
REFER TO:		LOCATION:

PHILOSOPHY

Finance Policies are intended to provide guidelines to promote responsible stewardship and allocation of resources.

PURPOSE

This policy establishes guidelines for the development and application of financial assistance and uninsured patient discount programs, by Resurrection Health Care system (RHC) hospitals. Such programs will be designed to assist individuals in financial need and other medically underserved individuals or groups to obtain appropriate medical care and advice, and thereby improve the health of those in the communities served by RHC hospitals.

PROCESS

1. Definitions

1.1 Federal Poverty Level means the level of household income at or below which individuals within a household are determined to be living in poverty, based on the Federal Poverty Guidelines as annually determined by the U.S. Department of Health and Human Services.

1.2 Financial Assistance/Charity Care means providing a discount of up to 100% of the charges associated with a patient's hospital care, or a discounted fee schedule, based on financial need.

Resurrection Health Care

POLICY PROTOCOL		
CATEGORY: Finance		NUMBER: 100.15
TITLE: Financial Assistance/Charity Care and Uninsured Patient Discount Programs (This policy applies to hospitals only)		TITLE NUMBER: 122.05 PAGE: 2 OF 17
EFFECTIVE DATE: February 2002	REVISION DATE: January 2009	SUPERSEDES: September 2004
REFER TO:		LOCATION:

1.3 Financial Assistance Programs means all programs set forth herein to provide assistance to those in financial need including financial assistance/charity care, uninsured patient discounts, and medical indigence discounts and payment caps.

1.4 Financial need means documented lack of sufficient financial resources to pay the applicable charge for medical care. Financial need may be evidenced by low household income and asset levels, or high levels of medical debt in relation to household income (medical indigence). Financial need determinations also take into consideration other relevant circumstances, such as employment status or health status of patient or other household members, which may affect a patient's ability to pay. The existence of financial need must be demonstrated by information provided by or on behalf of the patient, and/or other objective data available to the hospital. RHC hospitals may use asset or debt information to assist in making a determination regarding financial need, when income data is unavailable or inconclusive, or reported income is not supported by objective data.

1.5 Illinois Resident or Cook County Resident means a person who lives in Illinois (or Cook County as applicable) and intends to remain living in Illinois (or Cook County) indefinitely. Relocation to Illinois or Cook County for the sole purposes of receiving health care benefits does not satisfy the residency requirement.

1.6 Illinois Uninsured Patient Discount Act means the hospital uninsured patient discount act, as passed by the Illinois General Assembly in 2008, effective as of April 1, 2009, and as amended from time to time.

Resurrection Health Care

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1.7 Medically Necessary Hospital Services means:

1.7.1 Except to the extent necessary to determine services subject to the Illinois Underinsured Patient Discount, for purposes of this policy "Medically Necessary Hospital Services" means those hospital services required for the treatment or management of a medical injury, illness, disease or symptom that, if otherwise left untreated, as determined by an independent treating physician or other physician consulted by an RHC Hospital would pose a threat to the patient's ongoing health status, and that would be (a) covered by guidelines for Medicare coverage if the patient were a Medicare beneficiary with the same clinical presentation as the Uninsured Patient; or (b) a discretionary, limited resource program for which the potential for unlimited free care would threaten the hospital's ability to provide such program at all (such as substance and chemical abuse treatment, continuing care for certain chronic diseases, chemotherapy and HIV drugs, other than when provided in connection with other Medically Necessary Hospital Services).

1.7.2 Examples of services that are not Medically Necessary Hospital Services include, but are not limited to: (1) cosmetic health services; including elective cosmetic surgery (exclusive of plastic surgery designed to correct disfigurement caused by injury, illness, or congenital defect or deformity); (2) services that are experimental or part of a clinical research program; (3) elective goods or services that are not necessary to treat an illness or injury; (4) private and/or non-RHC medical or physician professional fees; and (5) services and/or treatments not provided at an RHC Hospital; (6) pharmaceuticals or medical equipment, except to the extent required in connection with other medically necessary inpatient or outpatient care being received by a hospital patient; and (7) procedures or services for which the hospital provides a discounted "flat rate" pricing package.

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1.8 Non-Retirement Household Liquid Assets includes cash, or non-cash assets that can readily be converted to cash, owned by a member of a household, including savings accounts, investment accounts, stocks, bonds, treasury bills, certificates of deposit and money market accounts, and cash value of life insurance policies. Non-retirement household liquid assets will not include a patient's equity in his or her primary residence or assets held in qualified retirement plan or other similar retirement savings account for which there would be a tax penalty for early withdrawal of savings.

1.9 RHC Hospital means a hospital that is part of the not-for-profit, Catholic-sponsored health care system known as "Resurrection Health Care".

1.10 RHC Hospital Service Area means, for all hospitals, Cook County and with respect to each individual RHC hospital those portions of any adjacent counties that are within such hospital's defined service area or core community, based on the zip code of a predominant portion of the hospital's patient population.

1.11 Uninsured Patient means an individual who is or was a patient of an RHC hospital and at the time of service is or was not (a) covered under a policy of health insurance or (b) not a beneficiary under a public or private health insurance, health benefit, or other health coverage program, including Medicare, Medicaid, TriCare, SCHIP and All-Kids, high deductible health insurance plans, workers' compensation, accident liability insurance, or other third party liability plan.

2. Patient Treatment Standards. All patients of RHC hospitals shall be treated with respect and dignity regardless of their ability to pay for medical care, or their need for charitable assistance.

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3. Financial Assistance/Charity Care and other Financial Assistance Programs

3.1 Discount for Low-Income Uninsured Patients. Financial Assistance/Charity Care discounts or discounted fee schedules will be available for Medically Necessary Hospital Services provided to Uninsured Patients who are unable to pay all or part of the otherwise applicable charge for their care due to financial need, as documented in accordance with this Policy. Patients demonstrating financial need based on household income at or below one hundred percent (100%) of the Federal Poverty Level, combined with a general lack of liquid assets, will receive a one hundred percent (100%) discount on Medically Necessary Hospital Services. Patients generally lacking liquid assets who have household income between one hundred percent (100%) and up to four hundred percent (400%) of the Federal Poverty Level will receive a sliding-scale discount for such hospital care, at levels approved by the RHC Executive Leadership Team.

3.2 Payment Caps Under Illinois Uninsured Patient Discount Act. To the extent required by the Illinois Uninsured Patient Discount Act, and subject to other eligibility standards and exclusions as set forth by such law including standards based on asset level, Uninsured Patients who are Illinois residents having household income of up to six hundred percent (600%) of the Federal Poverty Level shall not be required to pay to an RHC hospital more than twenty five percent (25%) of such patient's family gross income within a twelve (12) month period.

3.3 Other Payment Caps. An Uninsured Patient who is eligible for Financial Assistance/Charity Care at an RHC Hospital pursuant to the criteria set forth in Section 5.1 or 5.3 below shall be eligible for a payment cap based on RHC's

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charitable commitment to catastrophic medical expenses assistance based on medical indigence, as follows:

3.3.1 For an eligible Uninsured Patient who demonstrates that s/he has a household income of four hundred percent (400%) or less of the Federal Poverty Level, such patient's payment obligation within any 12-month period will be limited to the higher of: (a) ten percent (10%) of the patient's annual gross household income; or (b) ten percent (10%) of the patient's Non-Retirement Household Liquid Assets.

3.3.2 For an eligible Uninsured Patient who demonstrates that s/he has a household income over four hundred percent (400%) of the Federal Poverty Level, or less, such patient's payment obligation within any 12-month period will be limited to the higher of: (a) fifteen percent (15%) of annual gross household income; or (b) fifteen percent (15%) of the patient's Non-Retirement Household Liquid Assets.

3.4 Financial Assistance/Charity Care for Insured Patients. Subject to insurance and governmental program restrictions (which may limit the ability to grant a discount on co-pays or deductibles, versus discounts on co-insurance), insured individuals, federal program beneficiaries and other individuals who are not automatically eligible for Financial Assistance/Charity Care hereunder but who demonstrate medical indigence or other financial need, may receive a Financial Assistance/Charity Care discount in similar or different amounts as are available to Uninsured Patients under this policy, as determined appropriate under the circumstances by RHC Patient Financial Services.

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4. Discounts for Uninsured, Medically Indigent Patients. Uninsured Patients whose household income is greater than four hundred percent (400%) of the Federal Poverty Level or who do not meet the automatic eligibility criteria set forth in Section 5 below, will nevertheless be eligible to receive a financial assistance/charity care discount based on a determination of medical indigence, by virtue of having medical bills from an RHC hospital in an amount equal to or greater than fifteen percent (15%) of their household income and available assets. Such Financial Assistance/Charity Care discount for uninsured higher income but medically indigent patients shall be one that is reasonable in relation to the individual patient's household financial circumstances and the health status of the patient and other family members.

5. Eligibility for Financial Assistance Programs

5.1 Automatic Eligibility: Cook County and Adjacent County Residents and Patients Needing Emergency Medical Care. In order to best serve the needs of the low-income and medically underserved members of their respective communities, RHC hospitals' Financial Assistance/Charity Care and other Financial Assistance Programs (other than the RHC uninsured discount, which will be available to all patients irrespective of residence) will be automatically available to all residents (regardless of citizenship or immigration status) of Cook County and those portions of any adjacent counties that are within a hospital's service area, subject to a determination of financial need or other eligibility requirements. In addition, all RHC hospitals will provide financial assistance/charity care discounts to eligible patients in connection with hospital emergency department and other medical services necessary to diagnose, treat or stabilize an emergency medical condition.

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5.2 Patient Responsibilities. RHC hospitals may condition receipt of charitable assistance under any Financial Assistance Program on a patient acting reasonably and in good faith, by providing the hospital, within 30 days after the hospital's request, with all reasonably-requested financial and other relevant information and documentation needed to determine the patient's eligibility for assistance, including cooperating with the hospital's financial counselors in applying for coverage under governmental programs, such as Medicaid, accident coverage, crime victims funds, and other public programs that may be available to pay for health care services provided to the patient. In addition, an RHC hospital may, in its discretion, choose not to provide Financial Assistance/Charity Care discounts to voluntarily uninsured individuals who with other household members are at least 50% owners of the business in which they work, if such business had gross receipts in the prior tax year of an amount that is greater than $200,000.

5.3 Discretionary Extension of Financial Assistance. Each RHC hospital is authorized to extend the availability of its Financial Assistance Programs to residents of other Illinois counties, other U.S. states or foreign countries, including travelers or out-of-town visitors, based on reasonable, standardized criteria applicable to all patients of such hospital.

5.4 Conditions of Discretionary Financial Assistance Program Participation. For individuals other than those who are automatically eligible to participate in an RHC Financial Assistance Program as set forth in Section 5.1 above, RHC hospitals may, as they determine appropriate, condition the receipt of such financial assistance on disclosure by the patient's immediate relatives, host family or sponsoring organization of their financial information, sufficient to demonstrate ability or inability to pay or contribute to the costs of care for their relative or hosted guest. The hospital may further condition any discretionary grant of financial assistance on a contribution toward the costs of the patient's

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care and/or a guarantee of payment by such relatives, hosts or others (as applicable), in the event the patient fails to qualify for coverage through governmental or private insurance and the patient fails to pay the amounts for which s/he is responsible. The hospital may also take into consideration the availability of other options for the proposed patient to receive medical care.

6. Uninsured Patient Discounts

6.1 Charitable Need for Uninsured Patient Discount. RHC believes that a substantial portion of uninsured individuals who seek hospital care are uninsured involuntarily, due to financial need, and further, that because of their uninsured status and inability to pay, many uninsured individuals delay or refrain from seeking needed medical care. RHC also believes, based on the experience of its hospitals in asking patients to apply for Financial Assistance/Charity Care discounts, that due to privacy and other concerns many uninsured individuals with financial need will not provide sufficient information to enable RHC hospitals to verify the existence of financial need.

6.2 RHC Charitable Uninsured Patient Discount. Therefore, as part of their charitable commitment to the poor and underserved, RHC hospitals will provide a discount on hospital charges to all Uninsured Patients, irrespective of residency, location or any other criteria, equal to 25% of the hospital charge for which the Uninsured Patient is responsible. If an Uninsured Patient also qualifies for a discount under the hospital's Financial Assistance/Charity Care standards, the amount of such discount will be applied to the patient's charge after application of the uninsured discount. Such RHC uninsured patient discount will not apply to any patient who qualifies for a discount under the Illinois Uninsured Patient Discount Act.

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6.3 Discount Under Illinois Uninsured Patient Discount Act. To the extent required by law, RHC hospitals shall provide an alternative form of discount to uninsured Illinois residents with gross family income of up to 600% of the Federal Poverty Level, and the 25% uninsured discount methodology set forth above shall not apply to any portion of such patients' bill.

6.4 Eligibility for Additional Financial Assistance. Patients receiving a discount based on uninsured status, whether under the RHC Charitable Uninsured Discount or pursuant to the Illinois Uninsured Patient Act, shall be eligible for an additional financial assistance described in this policy, pursuant to the eligibility standards set forth herein.

7. Hospital Responsibilities for Communicating Availability of Financial Assistance/Charity Care and Other Charitable Assistance Programs

7.1 Communicating Availability of Financial Assistance/Charity Care Discounts. Each RHC hospital will maintain effective methods of communicating the availability of Financial Assistance/Charity Care discounts to all patients, in multiple appropriate media and in multiple appropriate languages. The mechanisms that the Hospital will use to communicate the availability of Financial Assistance/Charity Care will include, but are not limited to the following:

7.1.1 Signage. Signs shall be conspicuously posted in the admission, registration and other appropriate areas of the hospital stating that patients may be eligible for Financial Assistance/Charity Care discounts, and describing how to obtain more information, including identification of appropriate hospital representatives by title. Such signs shall be prepared

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in English, Spanish, and any other language that is the primary language of at least 5% of the patients served by the hospital annually.

7.1.2 Provision of Financial Assistance Materials to Uninsured Patients. RHC hospitals will provide a summary of its Financial Assistance Programs and a Financial Assistance application to all persons receiving hospital care that it identifies as Uninsured Patients at the time of in-person registration, admission, or such later time at which the patient is first identified as an Uninsured Patient. For patients presenting in the Emergency Department, all RHC hospitals will provide such Financial Assistance materials at such time and in such manner as is consistent with their obligations under EMTALA to assess and stabilize the patient before making inquiry of the patient's ability to pay.

7.1.3 Brochures. Brochures, information sheets and/or similar forms of written communication regarding the hospital's Financial Assistance/Charity Care policy shall be maintained in appropriate areas of the hospital (e.g., the Emergency Department, organized registration areas, and the Business Office) stating in at least English, Spanish and Polish, that the hospital offers Financial Assistance/Charity Care discounts, and describing how to obtain more information.

7.1.4 Website. Each RHC's section of the Resurrection Heath Care website must include: a notice in a prominent place that financial assistance is available at the hospital; a description of the financial assistance application process; and a copy of the RHC hospital financial assistance application form.

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7.1.5 Billing Notices. Each RHC hospital shall include a note on or with the Hospital bill and/or statement regarding the hospital's Financial Assistance/Charity Care program, and how the patient may apply for consideration under this program.

7.1.6 Financial Counselors. Each RHC hospital shall have one or more financial counselors whose contact information is listed or provided with other information concerning the hospital's Financial Assistance/Charity Care discount program, who are available to discuss eligibility and other questions concerning the program, and to provide assistance with applications.

8. Communication with Patients Regarding Eligibility Determination for Financial Assistance/Charity Care.

8.1 Notification of Determination. When an RHC hospital has made a determination that a patient's bill will be discounted or adjusted in whole or in part based on a determination of financial need, the hospital will notify the patient of such eligibility determination, and that there will be no further collection action taken on the discounted portion of the patient's bill.

8.2 Changes in Patient Financials Circumstances. Adverse changes on the patient's financial circumstances may result in an increase in any Financial Assistance/Charity Care discount provided by the hospital. Under no condition, however, would adverse or other changes in a patient's financial circumstances affect the hospital's continuation of any ongoing treatment during an episode of care.

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9. Application of Financial Assistance/Charity Care Determination to Past-Due Bills. When a patient has been granted a discount on his or her bill under the hospital's Financial Assistance/Charity Care program, the hospital will automatically apply a similar discount or adjustment to all other outstanding patient bills. The hospital will advise the patient of such adjustment of prior accounts, and that the hospital will forego any further attempted to collect the amounts written off on such accounts.

10. Updating Prior Financial Need Determinations

10.1 Effective Time of Financial Assistance Qualification Determination. A determination of a patient's household income in connection with the patient's qualification for any form of Financial Assistance under this Policy will remain in effect the patient's entire episode of care, provided that if an episode of care continues for more than thirty (30) days, the hospital may request the patient to re-verify or supplement household income information or other eligibility information as the hospital reasonably deems appropriate, including cooperating with the hospital financial counselor to re-evaluate the patient's potential eligibility for coverage under Medicaid or other governmental programs and for the hospital's Financial Assistance/Charity Care program.

10.2 Re-Verification Within Six Months. When a patient (or the member of the household of a patient) who has received a determination of financial need under an RHC hospital's Financial Assistance/Charity Care program subsequently receives or applies for care from the same or any other RHC hospital more than 30 days but less than 6 months later, the hospital shall request appropriate information necessary to update the patient's or prospective patient's Financial Assistance/Charity Care application and re-verify the prior financial need determination. Hospital Financial Counselors will work with the patient to make the updating process as convenient as possible while assuring accuracy of

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information. The hospital shall consider the patient's (or prospective patient's) eligibility for Financial Assistance/Charity Care based on current income and assets, and other objective information obtained by the hospital relating to financial need, such as credit reports, new W-2s, tax returns or other data.

10.3 New Application Requirements. If more than six (6) months has expired since a patient's Financial Assistance eligibility determination, the patient must submit a new Financial Assistance application.

11. Financial Assistance/Charity Care Determinations Required Prior to Non-Emergency Services. RHC hospitals will make all reasonable efforts to expedite the evaluation of patients for eligibility for coverage under governmental programs and otherwise for Financial Assistance/Charity Care. Such evaluations must generally be made by an RHC hospital prior to provision of non-emergency hospital services. Persons who have come to a RHC hospital emergency department seeking care for a potential emergency medical condition will first receive a medical screening exam conducted in compliance with the Emergency Medical Treatment and Active Labor Act, as amended (EMTALA) and all care needed to stabilize any emergency medical condition, prior to an evaluation for coverage eligibility under governmental programs or Financial Assistance/Charity Care.

12. Staff Training and Understanding of Hospital Financial Assistance/Charity Care Program

12.1 General Program Knowledge. Employed staff of each RHC hospitals shall be trained, at the levels appropriate to their job function, with respect to the availability of the Financial Assistance/Charity Care discount program offered by such hospital for the benefit of poor and underserved members of such hospital's community.

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12.2 Specific Program Knowledge. Hospital staff who regularly interact with patients, including all staff in each hospital's Patient Financial Services, Patient Access and Registration departments will understand the hospital's Financial Assistance/Charity Care discount program, and be able to either accurately answer questions or direct questions regarding such programs to financial counselors or other contact persons.

12.3 Annual Training. All Patient Financial Services and Access department staff, and other applicable staff shall attend an annual in-service on the RHC hospital Financial Assistance/Charity Care discount program for RHC hospitals, which will be prepared and supervised by the RHC Finance Division, in consultation with the RHC Office of Legal Affairs, the System Compliance Officer and hospital senior management.

13. Collection Activity

13.1 General. All RHC hospitals shall engage in reasonable collection activities for collection of the portions of bills for which patients are responsible after application of any Financial Assistance/Charity Care discount, uninsured patient discount, insurance allowances and payment and other applicable adjustments.

13.2 Cessation of Collection Efforts on Discounted Amounts. No RHC hospital will engage in or direct collections activity with respect to any discounts on health care charges provided as a result of a determination of eligibility under the hospital's Financial Assistance/Charity Care program, unless it is later determined that the patient omitted relevant information relating to actual income or available assets, or provided false information regarding financial need or other eligibility

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criteria. Balances remaining after financial assistance discounts are applied will be subject to reasonable collection activity, consistent with this Policy.

13.3 Use of Reasonable Legal Processes to Enforce Patient Debt. Reasonable legal process, including the garnishment of wages, may be taken by any RHC Hospital to collect any patient debt remaining after any adjustment or discount for Financial Assistance/Charity Care, uninsured status or other reason, under the following circumstances:

13.3.1 For Uninsured Patients:

- The hospital has given the patient the opportunity to assess the accuracy of the hospital's bill;
- The hospital has given the Uninsured Patient the opportunity to apply for Financial Assistance/Charity Care and/or (a) a reasonable payment plan, or (b) a discount for which the patient is eligible pursuant to the Illinois Patient Uninsured Discount Act;
- The hospital has given the Uninsured Patient at least 60 days after discharge or receipt of services to apply for Financial Assistance/Charity Care;
- If the patient has indicated, and the hospital is able to verify, that the patient is unable to pay the full amount due in one payment, the hospital has offered the patient a reasonable payment plan;
- If the hospital and patient have entered into a reasonable payment plan, the patient has failed to make payments when due; and
- There is objective evidence that the patient's household income and/or assets are sufficient to meet his or her financial obligation to the hospital.

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13.3.2 For Insured Patients:

- The hospital has provided the patient the opportunity, for at least 30 days after the date of the initial bill, to request a reasonable payment plan for the portion of the bill for which the patient is responsible;
- If the patient requests a reasonable payment plan, and fails to agree to a plan within 30 days after such request; and
- If the hospital and patient have entered into a reasonable payment plan, the patient has failed to make payments when due.

13.4 Residential Liens. No RHC hospital will place a lien on the primary residence of a patient who has been determined to be eligible for Financial Assistance/Charity Care, for payment of the patient's undiscounted balance due. Further, consistent with long-standing RHC policy, in no case will any RHC provider execute a lien by forcing the sale or foreclosure of the primary residence of any patient to pay for any outstanding medical bill.

13.5 No Use of Body Attachments. In accordance with long-standing practice, no RHC hospital will use body attachment to require any person, whether receiving Financial Assistance/Charity Care discounts or not, to appear in court.

13.6 Collection Agency Referrals. RHC hospitals will ensure that all collection agencies used to collect patient bills promptly refer any patient who indicates financial need, or otherwise appears to qualify for Financial Assistance/Charity Care discounts, to a financial counselor to determine if the patient is eligible for such a charitable discount.

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Charity Care Policy

ATTACHMENT 18B

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PHILOSOPHY

Finance Policies are intended to provide guidelines to promote responsible stewardship and allocation of resources.

PURPOSE

This policy establishes guidelines for the development and application of financial assistance and uninsured patient discount programs, by Resurrection Health Care system (RHC) hospitals. Such programs will be designed to assist individuals in financial need and other medically underserved individuals or groups to obtain appropriate medical care and advice, and thereby improve the health of those in the communities served by RHC hospitals.

PROCESS

1. Definitions

1.1 Federal Poverty Level means the level of household income at or below which individuals within a household are determined to be living in poverty, based on the Federal Poverty Guidelines as annually determined by the U.S. Department of Health and Human Services.

1.2 Financial Assistance/Charity Care means providing a discount of up to 100% of the charges associated with a patient's hospital care, or a discounted fee schedule, based on financial need.

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1.3 Financial Assistance Programs means all programs set forth herein to provide assistance to those in financial need including financial assistance/charity care, uninsured patient discounts, and medical indigence discounts and payment caps.

1.4 Financial need means documented lack of sufficient financial resources to pay the applicable charge for medical care. Financial need may be evidenced by low household income and asset levels, or high levels of medical debt in relation to household income (medical indigence). Financial need determinations also take into consideration other relevant circumstances, such as employment status or health status of patient or other household members, which may affect a patient's ability to pay. The existence of financial need must be demonstrated by information provided by or on behalf of the patient, and/or other objective data available to the hospital. RHC hospitals may use asset or debt information to assist in making a determination regarding financial need, when income data is unavailable or inconclusive, or reported income is not supported by objective data.

1.5 Illinois Resident or Cook County Resident means a person who lives in Illinois (or Cook County as applicable) and intends to remain living in Illinois (or Cook County) indefinitely. Relocation to Illinois or Cook County for the sole purposes of receiving health care benefits does not satisfy the residency requirement.

1.6 Illinois Uninsured Patient Discount Act means the hospital uninsured patient discount act, as passed by the Illinois General Assembly in 2008, effective as of April 1, 2009, and as amended from time to time.

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1.7 Medically Necessary Hospital Services means:

1.7.1 Except to the extent necessary to determine services subject to the Illinois Underinsured Patient Discount, for purposes of this policy "Medically Necessary Hospital Services" means those hospital services required for the treatment or management of a medical injury, illness, disease or symptom that, if otherwise left untreated, as determined by an independent treating physician or other physician consulted by an RHC Hospital would pose a threat to the patient's ongoing health status, and that would be (a) covered by guidelines for Medicare coverage if the patient were a Medicare beneficiary with the same clinical presentation as the Uninsured Patient; or (b) a discretionary, limited resource program for which the potential for unlimited free care would threaten the hospital's ability to provide such program at all (such as substance and chemical abuse treatment, continuing care for certain chronic diseases, chemotherapy and HIV drugs, other than when provided in connection with other Medically Necessary Hospital Services).

1.7.2 Examples of services that are not Medically Necessary Hospital Services include, but are not limited to: (1) cosmetic health services; including elective cosmetic surgery (exclusive of plastic surgery designed to correct disfigurement caused by injury, illness, or congenital defect or deformity); (2) services that are experimental or part of a clinical research program; (3) elective goods or services that are not necessary to treat an illness or injury; (4) private and/or non-RHC medical or physician professional fees; and (5) services and/or treatments not provided at an RHC Hospital; (6) pharmaceuticals or medical equipment, except to the extent required in connection with other medically necessary inpatient or outpatient care being received by a hospital patient; and (7) procedures or services for which the hospital provides a discounted "flat rate" pricing package.

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1.8 Non-Retirement Household Liquid Assets includes cash, or non-cash assets that can readily be converted to cash, owned by a member of a household, including savings accounts, investment accounts, stocks, bonds, treasury bills, certificates of deposit and money market accounts, and cash value of life insurance policies. Non-retirement household liquid assets will not include a patient's equity in his or her primary residence or assets held in qualified retirement plan or other similar retirement savings account for which there would be a tax penalty for early withdrawal of savings.

1.9 RHC Hospital means a hospital that is part of the not-for-profit, Catholic-sponsored health care system known as "Resurrection Health Care".

1.10 RHC Hospital Service Area means, for all hospitals, Cook County and with respect to each individual RHC hospital those portions of any adjacent counties that are within such hospital's defined service area or core community, based on the zip code of a predominant portion of the hospital's patient population.

1.11 Uninsured Patient means an individual who is or was a patient of an RHC hospital and at the time of service is or was not (a) covered under a policy of health insurance or (b) not a beneficiary under a public or private health insurance, health benefit, or other health coverage program, including Medicare, Medicaid, TriCare, SCHIP and All-Kids, high deductible health insurance plans, workers' compensation, accident liability insurance, or other third party liability plan.

2. Patient Treatment Standards. All patients of RHC hospitals shall be treated with respect and dignity regardless of their ability to pay for medical care, or their need for charitable assistance.

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3. Financial Assistance/Charity Care and other Financial Assistance Programs

3.1 Discount for Low-Income Uninsured Patients. Financial Assistance/Charity Care discounts or discounted fee schedules will be available for Medically Necessary Hospital Services provided to Uninsured Patients who are unable to pay all or part of the otherwise applicable charge for their care due to financial need, as documented in accordance with this Policy. Patients demonstrating financial need based on household income at or below one hundred percent (100%) of the Federal Poverty Level, combined with a general lack of liquid assets, will receive a one hundred percent (100%) discount on Medically Necessary Hospital Services. Patients generally lacking liquid assets who have household income between one hundred percent (100%) and up to four hundred percent (400%) of the Federal Poverty Level will receive a sliding-scale discount for such hospital care, at levels approved by the RHC Executive Leadership Team.

3.2 Payment Caps Under Illinois Uninsured Patient Discount Act. To the extent required by the Illinois Uninsured Patient Discount Act, and subject to other eligibility standards and exclusions as set forth by such law including standards based on asset level, Uninsured Patients who are Illinois residents having household income of up to six hundred percent (600%) of the Federal Poverty Level shall not be required to pay to an RHC hospital more than twenty five percent (25%) of such patient's family gross income within a twelve (12) month period.

3.3 Other Payment Caps. An Uninsured Patient who is eligible for Financial Assistance/Charity Care at an RHC Hospital pursuant to the criteria set forth in Section 5.1 or 5.3 below shall be eligible for a payment cap based on RHC's

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charitable commitment to catastrophic medical expenses assistance based on medical indigence, as follows:

3.3.1 For an eligible Uninsured Patient who demonstrates that s/he has a household income of four hundred percent (400%) or less of the Federal Poverty Level, such patient's payment obligation within any 12-month period will be limited to the higher of: (a) ten percent (10%) of the patient's annual gross household income; or (b) ten percent (10%) of the patient's Non-Retirement Household Liquid Assets.

3.3.2 For an eligible Uninsured Patient who demonstrates that s/he has a household income over four hundred percent (400%) of the Federal Poverty Level, or less, such patient's payment obligation within any 12-month period will be limited to the higher of: (a) fifteen percent (15%) of annual gross household income; or (b) fifteen percent (15%) of the patient's Non-Retirement Household Liquid Assets.

3.4 Financial Assistance/Charity Care for Insured Patients. Subject to insurance and governmental program restrictions (which may limit the ability to grant a discount on co-pays or deductibles, versus discounts on co-insurance), insured individuals, federal program beneficiaries and other individuals who are not automatically eligible for Financial Assistance/Charity Care hereunder but who demonstrate medical indigence or other financial need, may receive a Financial Assistance/Charity Care discount in similar or different amounts as are available to Uninsured Patients under this policy, as determined appropriate under the circumstances by RHC Patient Financial Services.

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4. Discounts for Uninsured, Medically Indigent Patients. Uninsured Patients whose household income is greater than four hundred percent (400%) of the Federal Poverty Level or who do not meet the automatic eligibility criteria set forth in Section 5 below, will nevertheless be eligible to receive a financial assistance/charity care discount based on a determination of medical indigence, by virtue of having medical bills from an RHC hospital in an amount equal to or greater than fifteen percent (15%) of their household income and available assets. Such Financial Assistance/Charity Care discount for uninsured higher income but medically indigent patients shall be one that is reasonable in relation to the individual patient's household financial circumstances and the health status of the patient and other family members.

5. Eligibility for Financial Assistance Programs

5.1 Automatic Eligibility: Cook County and Adjacent County Residents and Patients Needing Emergency Medical Care. In order to best serve the needs of the low-income and medically underserved members of their respective communities, RHC hospitals' Financial Assistance/Charity Care and other Financial Assistance Programs (other than the RHC uninsured discount, which will be available to all patients irrespective of residence) will be automatically available to all residents (regardless of citizenship or immigration status) of Cook County and those portions of any adjacent counties that are within a hospital's service area, subject to a determination of financial need or other eligibility requirements. In addition, all RHC hospitals will provide financial assistance/charity care discounts to eligible patients in connection with hospital emergency department and other medical services necessary to diagnose, treat or stabilize an emergency medical condition.

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5.2 Patient Responsibilities. RHC hospitals may condition receipt of charitable assistance under any Financial Assistance Program on a patient acting reasonably and in good faith, by providing the hospital, within 30 days after the hospital's request, with all reasonably-requested financial and other relevant information and documentation needed to determine the patient's eligibility for assistance, including cooperating with the hospital's financial counselors in applying for coverage under governmental programs, such as Medicaid, accident coverage, crime victims funds, and other public programs that may be available to pay for health care services provided to the patient. In addition, an RHC hospital may, in its discretion, choose not to provide Financial Assistance/Charity Care discounts to voluntarily uninsured individuals who with other household members are at least 50% owners of the business in which they work, if such business had gross receipts in the prior tax year of an amount that is greater than $200,000.

5.3 Discretionary Extension of Financial Assistance. Each RHC hospital is authorized to extend the availability of its Financial Assistance Programs to residents of other Illinois counties, other U.S. states or foreign countries, including travelers or out-of-town visitors, based on reasonable, standardized criteria applicable to all patients of such hospital.

5.4 Conditions of Discretionary Financial Assistance Program Participation. For individuals other than those who are automatically eligible to participate in an RHC Financial Assistance Program as set forth in Section 5.1 above, RHC hospitals may, as they determine appropriate, condition the receipt of such financial assistance on disclosure by the patient's immediate relatives, host family or sponsoring organization of their financial information, sufficient to demonstrate ability or inability to pay or contribute to the costs of care for their relative or hosted guest. The hospital may further condition any discretionary grant of financial assistance on a contribution toward the costs of the patient's

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care and/or a guarantee of payment by such relatives, hosts or others (as applicable), in the event the patient fails to qualify for coverage through governmental or private insurance and the patient fails to pay the amounts for which s/he is responsible. The hospital may also take into consideration the availability of other options for the proposed patient to receive medical care.

6. Uninsured Patient Discounts

6.1 Charitable Need for Uninsured Patient Discount. RHC believes that a substantial portion of uninsured individuals who seek hospital care are uninsured involuntarily, due to financial need, and further, that because of their uninsured status and inability to pay, many uninsured individuals delay or refrain from seeking needed medical care. RHC also believes, based on the experience of its hospitals in asking patients to apply for Financial Assistance/Charity Care discounts, that due to privacy and other concerns many uninsured individuals with financial need will not provide sufficient information to enable RHC hospitals to verify the existence of financial need.

6.2 RHC Charitable Uninsured Patient Discount. Therefore, as part of their charitable commitment to the poor and underserved, RHC hospitals will provide a discount on hospital charges to all Uninsured Patients, irrespective of residency, location or any other criteria, equal to 25% of the hospital charge for which the Uninsured Patient is responsible. If an Uninsured Patient also qualifies for a discount under the hospital's Financial Assistance/Charity Care standards, the amount of such discount will be applied to the patient's charge after application of the uninsured discount. Such RHC uninsured patient discount will not apply to any patient who qualifies for a discount under the Illinois Uninsured Patient Discount Act.

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6.3 Discount Under Illinois Uninsured Patient Discount Act. To the extent required by law, RHC hospitals shall provide an alternative form of discount to uninsured Illinois residents with gross family income of up to 600% of the Federal Poverty Level, and the 25% uninsured discount methodology set forth above shall not apply to any portion of such patients' bill.

6.4 Eligibility for Additional Financial Assistance. Patients receiving a discount based on uninsured status, whether under the RHC Charitable Uninsured Discount or pursuant to the Illinois Uninsured Patient Act, shall be eligible for an additional financial assistance described in this policy, pursuant to the eligibility standards set forth herein.

7. Hospital Responsibilities for Communicating Availability of Financial Assistance/Charity Care and Other Charitable Assistance Programs

7.1 Communicating Availability of Financial Assistance/Charity Care Discounts. Each RHC hospital will maintain effective methods of communicating the availability of Financial Assistance/Charity Care discounts to all patients, in multiple appropriate media and in multiple appropriate languages. The mechanisms that the Hospital will use to communicate the availability of Financial Assistance/Charity Care will include, but are not limited to the following:

7.1.1 Signage. Signs shall be conspicuously posted in the admission, registration and other appropriate areas of the hospital stating that patients may be eligible for Financial Assistance/Charity Care discounts, and describing how to obtain more information, including identification of appropriate hospital representatives by title. Such signs shall be prepared

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in English, Spanish, and any other language that is the primary language of at least 5% of the patients served by the hospital annually.

7.1.2 Provision of Financial Assistance Materials to Uninsured Patients. RHC hospitals will provide a summary of its Financial Assistance Programs and a Financial Assistance application to all persons receiving hospital care that it identifies as Uninsured Patients at the time of in-person registration, admission, or such later time at which the patient is first identified as an Uninsured Patient. For patients presenting in the Emergency Department, all RHC hospitals will provide such Financial Assistance materials at such time and in such manner as is consistent with their obligations under EMTALA to assess and stabilize the patient before making inquiry of the patient's ability to pay.

7.1.3 Brochures. Brochures, information sheets and/or similar forms of written communication regarding the hospital's Financial Assistance/Charity Care policy shall be maintained in appropriate areas of the hospital (e.g., the Emergency Department, organized registration areas, and the Business Office) stating in at least English, Spanish and Polish, that the hospital offers Financial Assistance/Charity Care discounts, and describing how to obtain more information.

7.1.4 Website. Each RHC's section of the Resurrection Heath Care website must include: a notice in a prominent place that financial assistance is available at the hospital; a description of the financial assistance application process; and a copy of the RHC hospital financial assistance application form.

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7.1.5 Billing Notices. Each RHC hospital shall include a note on or with the Hospital bill and/or statement regarding the hospital's Financial Assistance/Charity Care program, and how the patient may apply for consideration under this program.

7.1.6 Financial Counselors. Each RHC hospital shall have one or more financial counselors whose contact information is listed or provided with other information concerning the hospital's Financial Assistance/Charity Care discount program, who are available to discuss eligibility and other questions concerning the program, and to provide assistance with applications.

8. Communication with Patients Regarding Eligibility Determination for Financial Assistance/Charity Care.

8.1 Notification of Determination. When an RHC hospital has made a determination that a patient's bill will be discounted or adjusted in whole or in part based on a determination of financial need, the hospital will notify the patient of such eligibility determination, and that there will be no further collection action taken on the discounted portion of the patient's bill.

8.2 Changes in Patient Financials Circumstances. Adverse changes on the patient's financial circumstances may result in an increase in any Financial Assistance/Charity Care discount provided by the hospital. Under no condition, however, would adverse or other changes in a patient's financial circumstances affect the hospital's continuation of any ongoing treatment during an episode of care.

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9. Application of Financial Assistance/Charity Care Determination to Past-Due Bills. When a patient has been granted a discount on his or her bill under the hospital's Financial Assistance/Charity Care program, the hospital will automatically apply a similar discount or adjustment to all other outstanding patient bills. The hospital will advise the patient of such adjustment of prior accounts, and that the hospital will forego any further attempted to collect the amounts written off on such accounts.

10. Updating Prior Financial Need Determinations

10.1 Effective Time of Financial Assistance Qualification Determination. A determination of a patient's household income in connection with the patient's qualification for any form of Financial Assistance under this Policy will remain in effect the patient's entire episode of care, provided that if an episode of care continues for more than thirty (30) days, the hospital may request the patient to re-verify or supplement household income information or other eligibility information as the hospital reasonably deems appropriate, including cooperating with the hospital financial counselor to re-evaluate the patient's potential eligibility for coverage under Medicaid or other governmental programs and for the hospital's Financial Assistance/Charity Care program.

10.2 Re-Verification Within Six Months. When a patient (or the member of the household of a patient) who has received a determination of financial need under an RHC hospital's Financial Assistance/Charity Care program subsequently receives or applies for care from the same or any other RHC hospital more than 30 days but less than 6 months later, the hospital shall request appropriate information necessary to update the patient's or prospective patient's Financial Assistance/Charity Care application and re-verify the prior financial need determination. Hospital Financial Counselors will work with the patient to make the updating process as convenient as possible while assuring accuracy of

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information. The hospital shall consider the patient's (or prospective patient's) eligibility for Financial Assistance/Charity Care based on current income and assets, and other objective information obtained by the hospital relating to financial need, such as credit reports, new W-2s, tax returns or other data.

10.3 New Application Requirements. If more than six (6) months has expired since a patient's Financial Assistance eligibility determination, the patient must submit a new Financial Assistance application.

11. Financial Assistance/Charity Care Determinations Required Prior to Non-Emergency Services. RHC hospitals will make all reasonable efforts to expedite the evaluation of patients for eligibility for coverage under governmental programs and otherwise for Financial Assistance/Charity Care. Such evaluations must generally be made by an RHC hospital prior to provision of non-emergency hospital services. Persons who have come to a RHC hospital emergency department seeking care for a potential emergency medical condition will first receive a medical screening exam conducted in compliance with the Emergency Medical Treatment and Active Labor Act, as amended (EMTALA) and all care needed to stabilize any emergency medical condition, prior to an evaluation for coverage eligibility under governmental programs or Financial Assistance/Charity Care.

12. Staff Training and Understanding of Hospital Financial Assistance/Charity Care Program

12.1 General Program Knowledge. Employed staff of each RHC hospitals shall be trained, at the levels appropriate to their job function, with respect to the availability of the Financial Assistance/Charity Care discount program offered by such hospital for the benefit of poor and underserved members of such hospital's community.

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12.2 Specific Program Knowledge. Hospital staff who regularly interact with patients, including all staff in each hospital's Patient Financial Services, Patient Access and Registration departments will understand the hospital's Financial Assistance/Charity Care discount program, and be able to either accurately answer questions or direct questions regarding such programs to financial counselors or other contact persons.

12.3 Annual Training. All Patient Financial Services and Access department staff, and other applicable staff shall attend an annual in-service on the RHC hospital Financial Assistance/Charity Care discount program for RHC hospitals, which will be prepared and supervised by the RHC Finance Division, in consultation with the RHC Office of Legal Affairs, the System Compliance Officer and hospital senior management.

13. Collection Activity

13.1 General. All RHC hospitals shall engage in reasonable collection activities for collection of the portions of bills for which patients are responsible after application of any Financial Assistance/Charity Care discount, uninsured patient discount, insurance allowances and payment and other applicable adjustments.

13.2 Cessation of Collection Efforts on Discounted Amounts. No RHC hospital will engage in or direct collections activity with respect to any discounts on health care charges provided as a result of a determination of eligibility under the hospital's Financial Assistance/Charity Care program, unless it is later determined that the patient omitted relevant information relating to actual income or available assets, or provided false information regarding financial need or other eligibility

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criteria. Balances remaining after financial assistance discounts are applied will be subject to reasonable collection activity, consistent with this Policy.

13.3 Use of Reasonable Legal Processes to Enforce Patient Debt. Reasonable legal process, including the garnishment of wages, may be taken by any RHC Hospital to collect any patient debt remaining after any adjustment or discount for Financial Assistance/Charity Care, uninsured status or other reason, under the following circumstances:

13.3.1 For Uninsured Patients:

- The hospital has given the patient the opportunity to assess the accuracy of the hospital's bill;
- The hospital has given the Uninsured Patient the opportunity to apply for Financial Assistance/Charity Care and/or (a) a reasonable payment plan, or (b) a discount for which the patient is eligible pursuant to the Illinois Patient Uninsured Discount Act;
- The hospital has given the Uninsured Patient at least 60 days after discharge or receipt of services to apply for Financial Assistance/Charity Care;
- If the patient has indicated, and the hospital is able to verify, that the patient is unable to pay the full amount due in one payment, the hospital has offered the patient a reasonable payment plan;
- If the hospital and patient have entered into a reasonable payment plan, the patient has failed to make payments when due; and
- There is objective evidence that the patient's household income and/or assets are sufficient to meet his or her financial obligation to the hospital.

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13.3.2 For Insured Patients:

- The hospital has provided the patient the opportunity, for at least 30 days after the date of the initial bill, to request a reasonable payment plan for the portion of the bill for which the patient is responsible;
- If the patient requests a reasonable payment plan, and fails to agree to a plan within 30 days after such request; and
- If the hospital and patient have entered into a reasonable payment plan, the patient has failed to make payments when due.

13.4 Residential Liens. No RHC hospital will place a lien on the primary residence of a patient who has been determined to be eligible for Financial Assistance/Charity Care, for payment of the patient's undiscounted balance due. Further, consistent with long-standing RHC policy, in no case will any RHC provider execute a lien by forcing the sale or foreclosure of the primary residence of any patient to pay for any outstanding medical bill.

13.5 No Use of Body Attachments. In accordance with long-standing practice, no RHC hospital will use body attachment to require any person, whether receiving Financial Assistance/Charity Care discounts or not, to appear in court.

13.6 Collection Agency Referrals. RHC hospitals will ensure that all collection agencies used to collect patient bills promptly refer any patient who indicates financial need, or otherwise appears to qualify for Financial Assistance/Charity Care discounts, to a financial counselor to determine if the patient is eligible for such a charitable discount.

Westlake Hospital & West Suburban Medical Center

Proposed Admissions Policies

ATTACHMENT 18B

VANGUARD HEALTH SYSTEMS

ADMISSIONS

POLICIES & PROCEDURES
Program for Pre-Admission .....

Date October 2004	Approved By
Section **BUSINESS OFFICE**	
Subsection Admissions – Program for Pre-Admission	
Policy Procedure No. **11-0300**	
Effective Date October 2004	Previous Date April 15, 1998

PRE-ADMISSION

Purpose

To encourage the Medical Staff to utilize the pre-admission program which will benefit the patient, physician, physician staff and the facility.

To expedite the processing of patients by obtaining and verifying demographic and financial information in advance of the patient's arrival.

To minimize the facility's and patient's financial risk by satisfying insurance coverage requirements prior to the incurring of charges.

Program Benefits

Patient Benefits

1. Pre-registered patients will have priority over patients who have not been pre-registered at time of actual admission.

   Exception: In the case of a medical emergency.

   a. The ability to schedule pre-registered patients for admission at a specific time will reduce the waiting time for the patient upon arrival at the facility.

2. The length of time required for the actual admission process will be greatly reduced due to prior preparation of all materials.

3. The patient may be informed in advance of his/her insurance coverage and of their financial responsibility due at time of admission. This eliminates the possibility of the patient being embarrassed and/or unprepared for the required deposit at time of admission.

4. Through the verification process patients are notified in advance of any benefit limitations, prior to service, thus avoiding an unexpected patient hardship.

Physician and Physician Staff Benefits

1. Verification of insurance coverage:

   a. Physicians and their staff should realize that the hospital makes every effort to obtain accurate and complete information. This information is provided to the physician as a courtesy. The hospital will not be responsible for its accuracy.

b. The facility will alert the physician of potential bad debt patients.

2. Updates of patient demographic information, e.g., address corrections:

   a. Eliminates duplication of physician staff time in obtaining information.

   b. May result in reduction of bad debt accounts receivable.

3. When available, the facility will provide a copy of the insurance claim form.

4. Facilities will schedule workshops for physician staff to present updates for current regulations and new services being offered by the facility:

   a. A questionnaire will be sent to determine a convenient day and time, as well as topics of interest.

   b. Facilities will schedule guest speakers for meetings. An agenda will be sent to the physician's office a minimum of two weeks prior to a scheduled meeting.

5. Recognition of physician's staff utilizing pre-admission program:

   a. Birthday acknowledgement.
   b. Holiday acknowledgment.

Facility Benefits

1. Stabilization of admission staffing pattern.
2. Reduction of bad debts.
3. Reduction of patient and physician complaints.
4. Reduction of telephone time from physician's office requesting information.
5. Improve relations with physicians and their staffs.
6. Open communications when concerns arise.
7. Improve community relations through presentation of information.
8. Increased productivity and a more organized work flow.
9. Increased up-front cash collection.

Program Implementation

1. Patient Accounts Manager will form a committee to include, but not be limited to, the following:

   a. Chief Executive Officer or designee.
   b. Admission Supervisor.
   c. Marketing Representative.
   d. Obstetrical Nursing Supervisor.
   e. Director of Nursing, Surgical and Operating Room Supervisors.

2. The Committee will solicit input from physician office managers.

3. The Committee will organize a presentation to introduce the pre-admission program as follows:

a. Prepare all handouts and obtain administrative approval.
b. Place on agenda an area for the physician staff to R.S.V.P.

    1) Review the R.S.V.P. responses. A telephone call, a week prior to a meeting, will be placed to the physician offices where no response has been received.

Related Policies

1. Insurance Verification.
2. Deposit Requirements.
3. Admission Policies.

Policies

1. Facilities will implement a complete pre-admission program for all types of elective patients. All elective patients should be pre-admitted/pre-registered whenever possible.

2. All ancillary departments will notify the admission office immediately upon making an appointment for service. When reservations are taken after admitting office hours, the scheduling department must inform the admission office in writing or upon opening of department the following day.

3. The Admission department will maintain a pre-admission scheduling log to include surgery, ancillary, and medical patients. A separate pre-admission log for obstetric patients, in expected date order, will be maintained.

4. Scheduling logs will be reviewed monthly by the Patient Accounts Manager to evaluate physician participation in the pre-admission program.

5. The Patient Accounts Manager will utilize pre-admission logs to evaluate the pre-admission program and report the results to the Chief Executive Officer on a monthly basis. This information will be utilized by the facility to develop a plan that will focus on those physicians not participating in the program.

6. Reservations for service will initiate the pre-admission procedure.

7. All patients seen and/or treated will have a patient financial folder prepared prior to or at the time of service. Patients determined to be a "no charges" service will still have a financial folder prepared documenting the reason for waiving fees. Charges are to be processed for these patients without exception. An administrative write-off must be authorized to adjust the balance to zero.

8. Patients will be contacted to obtain financial and demographic information:

    a. Patients will be contacted a minimum of forty-eight (48) hours prior to scheduled services. Obstetric patients will be pre-registered by the seventh month.

    b. Pre-registered accounts will be by process, working from the most current scheduled date of service to latest.

    c. Interviews will be conducted via telephone or in person, as necessary.

d. The facility will supply physician offices with a pre-registration form, which may be retum mailed or faxed to the facility. Upon receipt of the mailed registration form the admission clerk will telephone the patient for confirmation of information.

e. Pre-registration information will be entered into the hospital information system. Each screen will have all fields completed. The appropriate financial class and/or plan code will be assigned on all registrations.

9. Patients will be scheduled for pre-admission testing prior to the date of the scheduled service (SEE: Facility By-Laws).

   a. Physician's orders for diagnostic testing will be in accordance with facility By-Laws.

   b. Testing will be performed within seventy-two (72) hours prior to scheduled surgeries (SEE: Medical Staff By-Laws).

   c. An outpatient number will be assigned to each patient scheduled for pre-admission testing:

      1) The account will be processed as an outpatient if the patient's admission is canceled or rescheduled.
      2) Obstetric patients receiving services prior to delivery will be processed as an outpatient and services billed.

10. Insurance coverage and employment will be verified in advance of providing scheduled services.

    a. Medicare benefits are to be verified for both parts A & B coverage:

       1) The patient is eligible for both A & B if the card indicates "Hospital", as well as "Medical" coverage.
       2) The patient is eligible for part B only if the card only indicates "Medical" coverage.

    b. If the card indicates "Medical" coverage only, the patient must be registered with a financial class designated for inpatient Part B only if this is an inpatient stay.

11. Series/Recurring patients will have insurance coverage verified prior to time of service.

12. The Patient Accounts Manager will be notified of any patient refusing to satisfy deposit requirements or insurance coverage has been denied.

13. Elective admissions will be postponed in cases of private pay if monies cannot be collected prior to service.

    a. The Chief Executive Officer and the Physician will be notified of the patient's financial status. The Physician will notify the patient of postponement.

14. The Admission department will notify the patient and/or guarantor of the disposition of their insurance coverage as well as their estimated balance to be paid by time of admission.

15. The Admission clerk will verify and update the pre-admission log and the surgical unit log, twice each day.

Procedures

1. Inpatient Medical Admission

   a. The call is reviewed from the physician's office.

   b. The Admissions staff will obtain required patient information and update the system.

   c. The Admissions staff will schedule a time for the patient to arrive at the facility.

      1) Utilization Review must review all scheduled Medicare and Medicaid admissions to ensure these patients satisfy acuity criteria.
      2) This will allow for a more orderly flow in the admission office and prevent the patient from waiting upon arrival.
      3) Advance scheduling of admissions can improve the facility staffing patterns.

   d. The Admissions staff will contact the patient to obtain all information required for admissions:

      1) The staff will complete all pre-admission screens as each serves a specific purpose. This process can be accomplished while on telephone or by utilizing a pre-admission form.
      2) The staff will inform the patient that insurance benefits will be verified and a return call will be made to advise the patient of any balance due at time of admission.
      3) Insurance coverage will be verified. Additionally, the hospital information system will be searched for other outstanding liabilities.

   e. The staff will make a final telephone call to the patient informing them of the following:

      1) The required deposit required in addition to balances from prior services are due at time of admission.
      2) Advise the patient of required claim forms to be completed and signed by the insured.
      3) Inform the patient to provide the facility with copies of insurance cards or other proof of insurance.
      4) Notify the patient of the expected time of arrival at facility for admission.

   f. All paperwork will be completed prior to patient's arrival.

   g. A patient financial folder will be prepared to include:

      1) All advance testing results
      2) Physician orders
      3) Special permits
      4) Consents
      5) Identification bracelet and identification plate will be added upon bed assignment

   h. Reservations/patient financial folders will be maintained by expected date order.

2. Inpatient Surgical Admission

   a. Surgical admissions are slightly different in that the physician's office calls the surgical unit to schedule the procedure.

b. The notification to the admission office will be handled in the following manner:

1) After scheduling with the surgical unit, the call will be transferred to the Admissions Office. In some cases a reservation slip may be used.
2) The afternoon and evening Nursing Supervisor will assist the Admissions Department by notifying the emergency room registration clerk of all additions to the surgical schedule. Private pay patients will require 24 hour verification period, and will not be added without CFO approval.

c. All remaining procedures will be followed as set forth in Section: Actual Admissions.

3. Obstetric Admissions

a. A separate obstetrical file will be established to contain all obstetrical financial folders of pre-admitted patients.

1) The obstetrical file will be filed by expected date of confinement.

2) The obstetrical file will be monitored continuously for verification of insurance, deposit requirements, and to determine if the date of confinement has lapsed as follows:

a) Call the physician's office and inquire about the status of the patient's expected date of confinement.
b) If the patient miscarried or has delivered elsewhere, pull the financial folder and check for any charges or deposits.
c) If no charges have been incurred, the financial folder may be purged, and the patient removed from the pre-admission system.

3) The Admissions staff will verify and update the obstetrical pre-registration log with the prenatal records in the delivery room weekly.

b. All remaining procedures will be followed as set forth in Section: Inpatient Medical Admission.

4. Outpatient Services Admissions

a. After the physician office staff schedules testing or treatments with the ancillary department, the call will be transferred to the Admissions Office:

1) Until the ancillary department's scheduling log is able to be formatted to meet the registration requirements, the department may utilize a form with the required information.
2) All ancillary department schedules will be printed daily and sent to the Admissions Department. If a patient is scheduled late for a procedure the following day, the ancillary department scheduler or manager will call admissions to enable pre-admission procedures to be performed.

b. All remaining procedures will be followed as set forth in Section: Actual Admissions.

VANGUARD HEALTH SYSTEMS

POLICIES & PROCEDURES

Actual Admissions .....

Date October 2004	Approved By
Section **BUSINESS OFFICE**	
Subsection Admissions – Actual Admissions	
Policy Procedure No. **11-0301**	
Effective Date October 2004	Previous Date April 15, 1998

Purpose

To establish and define the admission policy of the facility.

To expedite the processing of patients by gathering demographic and financial information in advance of the patient's arrival.

To minimize the financial risk of the patient and the hospital by establishing the requirements and coverage of the third-party payer prior to incurring charges.

Related Procedures

1. Insurance verification.
2. Deposit requirements.
3. Admission of pre-admitted patients.

Policies

1. Treatment of all patients will be based upon a signed order from a physician as specified in the Medical Staff By-Laws of the facility.

2. The Admitting Department is responsible for the monitoring of privilege suspension list provided by the Medical Records Department, to ensure that all physicians have active admitting privileges:

   a. Each request for services will be verified against the current Suspension of Privileges list.

   b. Physicians whose names appear on said list will be referred to the department supervisor if an order for service is received.

   c. The Department Supervisor will notify the CEO or designee for approval.

3. All patients will be treated without distinction as to race, creed, color, sex or financial status.

4. The Admitting Department is responsible for creating a positive first impression to the patient, the patient's family and physicians:

   a. All admitting personnel will address the patient and/or family members using their proper names, e.g., Mr./Mrs. _____. (never as dearie, sweetie, etc.)

5. The Admitting Department will collect, record and verify demographic and financial information on all patients receiving services in the facility.

6. Treatment of patients, visitors and staff is to be respectful, accommodating and supportive as related to their respective needs.

7. The patient's condition will dictate the speed and order in which registration functions are completed:

   a. No registration procedure should ever jeopardize the safety of the patient.

   b. When circumstances dictate that the patient be under treatment without delay, registration procedures will follow as soon as possible.

   c. Questioning of patients regarding valuables will be performed prior to the patient departing the Admission Department, including all emergency room admissions.

   d. Admitting personnel will notify the proper nursing station of patient arrival prior to the patient leaving the Admission Department.

   e. Transportation personnel will never leave a patient unattended.

   f. The registrar will complete all fields in the registration system. Special note of prior stay information is imperative. The assignment of the correct financial classification according to type of coverage is required.

8. All registered patients will have a financial folder prepared.

9. The facility will establish a system for identification and tracking of Medicare patients, to be utilized for "prior stay" information.

10. Champus/Champva is always considered the secondary payer when any other coverage is involved, including Medicaid:

    NOTE: Patients can no longer be enrolled in both the Federal Programs of Medicare and Champus

    a. Champus (active duty) patients will present a non-availability (1251) form prior to services, in a non-emergency situation, if required, due to the forty (40) mile radius requirement.

    b. If a non-emergency admission, verify patient eligibility through the D.E.E.R. system. Request family member go to the nearest base and place in the system, if the patient is not shown in the system prior to service.

11. Active Duty Military patients will provide the facility with the necessary information for the physician to obtain treatment authorization from the Officer-of-the-Day located at the patients' duty station.

12. The Admission areas will maintain a list of all H.M.O./P.P.O. contracts. It is necessary to pre-certify all non-emergent H.M.O./P.P.O. admissions. The Admission Department will monitor and control the pre-certification, pre-authorization and extension confirmation forms:

    a. A complete listing of all authorization telephone numbers must be maintained. The Utilization Review (UR) Coordinator may perform the precertification/authorization function as well.

    b. Non-emergency patients will pay their deductibles prior to service. Emergency patients should pay at discharge.

13. An internal control system will be maintained to insure all patient files are properly transferred from admission areas to the patient accounting office.

Patient Types

1. Inpatient

   a. The primary care physician must be a member of the medical staff with admission privileges, as set forth in the facility By-Laws.

   b. The patient's condition must be documented in the medical record in such a manner as to meet criteria for acute inpatient care.

   c. The patient's condition is such that acute care is expected to be required for more than twenty-four (24) hours.

      1) The UR Coordinator will maintain systems to evaluate and monitor individual patient acuity, as related to established criteria, prior to or at the time of admission.

   d. The patient's bill will reflect a standard room and board charge.

2. Observation Patient

   a. Patients who do not meet inpatient criteria may be held for up to 23 hours and 59 minutes:

      1) Special circumstances may result in patients being held longer who do not satisfy acuity criteria.
      2) Special billing procedures are given in the Billing Section.
      3) Outpatient registration policies and procedures will apply to this type of patient.

3. Outpatient

   a. The primary care physician must be a member of the medical staff with privileges.

   b. The patient's condition does not require inpatient acute care. (See Observation Procedure).

   c. The patient's bill will not reflect a standard room and board charge.

   d. Patients may be registered for outpatient surgery, outpatient testing or treatment:

      1) Patient receiving outpatient services who then require care for longer than 23 hours and 59 minutes will be reviewed by utilization review personnel for appropriateness of continued observation and/or admission.

4. Emergency Room Patient

   a. Emergency room patients are presented in the following fashion:

      1) Ambulatory (walking)
      2) Ambulance
      3) Mobile Intensive Care Units
      4) Helicopter
      5) Automobile
      6) Fire Department
      7) Law Enforcement Officers

   b. Patients may or may not be under the direction of their private physician.

   c. Some patients may be determined by the treating physician to require inpatient admission.

Procedures

1. Inpatient Admission

   a. The registrar will check the hospital information system to determine if the patient has been pre-registered:

      1) Verify the accuracy of all information to include the financial class designation.

      2) Upon review of the pre-registration, the registrar will obtain any missing information.

      3) Check the open accounts receivable and bad debt file for any outstanding balance due:

         a) Any outstanding balances will be collected prior to patient departing from the registration area.
         b) If the patient is unable to pay outstanding account balances, request a financial counselor meet with the patient prior to admission.

         Exception: Patients requiring immediate care will be seen by the counselor when the patient's condition is stable.

      4) Collect estimated deductible and co-insurance amount due. If the patient is unable to pay, see "b" above.

      5) Self Pay patients will meet the deposit requirements as set forth in the deposit requirements section:

         a) If the patient is unable to meet the deposit requirements, see "b" above.

      6) Copy all identification cards, including front and back of insurance cards.

      7) Obtain a copy of the patient's/guarantor's drivers license.

      8) Copy transfer sheets from nursing home patients.

      9) Copy all insurance forms.

10) Complete HIPPA patient required forms:

a) Review hospital notice of privacy process with patient and give a copy to patient and obtain the patient or patient's representative signature acknowledging a receipt of the notice. The privacy notice is valid for six years.
b) If the patient refuses to sign the acknowledgement, the registrar will select the correct reason as indicated on the privacy form indicating the patient has refused to sign.
c) Review the facility directory "Opt Out" form with the patient. This form must be completed on EVERY visit. All HIPAA forms are sent with the chart to the nursing unit and will remain part of the patient's permanent medical record.

b. Admission clerks will follow the procedures set forth in numbers one through ten above when admitting direct and/or emergency patients.

c. Admission clerks will complete the Medicare Secondary Payer Questionnaire form to include the patient's signature and date.

d. Obtain all necessary signatures from the patient and/or family member. If a family member is signing on behalf of the patient, the relationship must be stated and recorded.

1) Witnessing: The admission clerk will date and sign all documents.

e. Process as follows:

1) Prepare a patient identification card.
2) Prepare a patient identification bracelet and place on the patient.
3) Transport the patient and documents to the assigned nursing station.
4) Check for any prior documents, such as lab results, physicians orders, etc.:
   a) When the patient is transported to the nursing floor, personnel will meet the nurse at the patient's room.
   b) If a nurse is not at the patient's room upon arrival, the person transporting the patient may call the nursing station to inform the nurse of the patient's arrival.
   c) The patient will never be left alone.
5) When a patient is transported directly to the nursing unit by the Emergency Room or ambulance personnel, admitting personnel will perform the admission process bed side, unless a family member is available in the admission area.
6) Notify the telecommunication operator of the admission immediately after the admission process, unless patient has chosen to 'opt out', prior to distribution of the patient chart.
7) Proceed in breaking down the remainder of the patient admission chart for distribution.
8) Review and forward the patient financial folder for insurance verification.

f. Upon receipt of pre-certification, pre-authorization and extension confirmation forms, a copy will be placed in the financial folder, whether the account is a pre-admission, in-house or in accounts receivable:

1) Document on the hospital information system regarding the number of days authorized and the date and time the authorization expires.
2) Deliver a copy of the authorized form to the appropriate staff members, e.g., U.R./D.R.G. Coordinator, etc.
3) The admissions supervisor will be responsible for maintaining a continual system to monitor in-house admissions, which may exceed the authorized length of stay.

4) The admission supervisor will meet daily with the U.R./D.R.G. Coordinator to discuss the patient's anticipated discharge date. This review will focus on insuring the patient's stay does not exceed authorized dates.
5) All discussions and or decisions will be documented in the system and/or financial folder for future reference.

2. Outpatient Admission

a. All outpatient services will be processed through the hospital medical necessity ABN software (see policy 11-304).

b. Outpatient admission will follow the same procedures as set forth under Inpatient Admission, above.

c. The admission clerk will proceed with breaking-down the patient admission chart for distribution.

d. The admission clerk will review and forward the patient financial folder for insurance verification.

3. Day Surgery

a. All outpatient surgical patients will be processed through the hospital medical necessity ABN software (see policy 11-304)

b. Surgery patients will follow the same procedures as set forth under Inpatient Admission, above

c. Admission clerks will proceed with breaking-down the patient admission chart for distribution.

d. Admission clerks will review and forward the patient financial folder for insurance verification, as per facility protocol.

4. Emergency Room Admissions

a. In accordance with COBRA regulations, a medical screening exam shall be provided to all patients presenting themselves for treatment. No inquiries regarding ability to pay shall be conducted prior to examination.

b. Emergency room admissions will follow the same procedures as set forth under Inpatient Admission, above.

c. Admission clerks will proceed with breaking-down the patient admission chart for distribution.

d. Admission clerks will review and forward financial folders for insurance verification, as per facility protocol.

5. Internal Control System

a. An internal system for controlling patient financial information and enhancing the accuracy of medical records statistical reporting will be maintained. Hospital information system generated discharge reports for inpatient, outpatient and emergency room patients will be used as follows:

1) Admission clerks will verify that all patients listed on the discharge report have a financial folder. If a patient does not have a folder/file, one will be made.
2) After review, the Admission clerk will sign the discharge report and place a check mark beside each patient name, indicating the folder is present.
3) Patient folders will be rubber banded together with the corresponding discharge report on top.
4) No folders or reports will be forwarded until complete.

6. Active Duty Military Patients

   a. For Active Duty Military patients the following steps are required upon admission and/or stay:

      1) The emergency room physician will obtain an authorization for treatment from the Officer-of-the-Day at the patients' military base. The patient will be transferred -- usually the following morning.

      2) Required billing information:

         a) Copy, front and back, of the military identification card.
         b) Obtain the name of the Commanding Officer.
         c) Obtain the name and address of military base.
         d) If the military patient is in transit to a new duty station, a copy of the orders must be obtained.
         e) The billing will be sent to the previous Commanding Officer.

7. Worker's Compensation Patients:

      1) All Worker's Compensation services must be authorized.

      2) Worker's Compensation will be listed as the primary payer.

      3) The patients/guarantors demographic information (address, telephone number, spouse, next of kin, etc.) must be obtained. This information will be critical in the event the worker's compensation claim is denied.

      4) Group insurance information will be obtained and listed as secondary payer.

         a) Group insurance will be verified, certified/authorized and listed as secondary

      5) All treatment reports must be filed timely as per specific state regulation.

8. Facility Employee/Dependent

   a. Facility employee/dependent insured under Vanguard Health System, Inc. group benefits will be admitted as all other insurance patients:

      1) Should the patient have two or more insurance carriers, the admitting clerk will determine primary, secondary, etc., as per standing protocols.

      2) A completed claim form must be presented at time of admission.

      3) Patients will be registered by using the Vanguard Health System, Inc. Employee Plan code.

9. Medicaid Pending

   a. To identify self pay patients who have applied and should quality for Medicaid. A Medicaid pending classification was established and will be utilized for those patients that have applied for Medicaid and may be approved for Medicaid, but are awaiting final determination from their home state.

      1) All self pay registrations will be screened for Medicaid eligibility.

      2) Medicaid applications should be processed on all hospital inpatients.

      3) Upon completion of the Medicaid application and the initial review of qualifications, the patient insurance plan will be changed from self pay to Medicaid pending (mapped to the Medicaid general ledger revenue account).

         a) The Medicaid pending insurance plan will reflect the expected Medicaid reimbursement at the time of billing.

         b) Upon determination of the patient's eligibility, the Business Office will update the insurance plan to reflect the designated Medicaid plan OR if denied for Medicaid, the insurance plan will be updated to self pay.

         c) At no time will the Medicaid contra be reversed for patients deemed ineligible for Medicaid.

10. Emergency Room Self Pay Patient Financial Application

   a. It is the policy that Vanguard facilities provide patients with quality patient care regardless of ability to pay for emergent treatment and in accordance with Hospital policies and procedures, and all applicable Federal, State and Local laws and regulations. Patient's not meeting emergent criteria, as determined by a medical screening examination, will be given the opportunity for treatment when financial obligations are met:

      1) Upon initial contact with an uninsured patient, review triage worksheet to determine medical assessment (non-emergent, urgent, or emergent).

      2) Emergent patients will be directed to the treatment area for immediate care. Registrars will conduct interviews in the treatment area after the patient has reviewed a medical screening exam and is stable.

      3) Urgent and non-emergent patients will be required to satisfy ER deposit requirements. Deposits may be made by check, cash or credit card.

      4) Patients not able to pay the full deposit amount will be asked to complete a Financial Disclosure Form (attachment I):

         a) All self pay patients will be given information regarding the hospital financial assistance program.

         b) Financial Disclosure Forms must be completed in its entirety and signed by the patient and/or their representative.

         c) The registrar will request a credit bureau report and review the report for pertinent information: current address, current employer, salary, available credit lines, etc.

d) The credit report will be attached to the Financial Disclosure Form and attached to the Business Office file.

e) The complete document will require the review of a Financial Counselor, Team Leader, or Supervisor for approval.

f) Once approved, the patient will be registered and made aware of their financial obligations.

* See attached applications.

EXHIBIT

ATTACHMENT 14

This facility provides Emergency Medical Care to all persons. The facility does have programs to assist you in satisfying your financial obligations if you are eligible.

I understand the questions on this application and that withholding or giving false information may result in prosecution for fraud. My answers are correct and complete to the best of my knowledge. I understand that I will have to provide documents to prove what I have said and I agree to do this. I authorize the facility to verify and obtain written copies of any of the information provided in the application and to make inquiry of my past employers to check my earnings or financial records.

ELIGIBILITY REQUIREMENTS FOR PAYMENT ARRANGEMENTS

PART 1

Guarantor Name _____
Address _____
City State Zip County Phone _____
How long at this address? _____

Method of Verification _____
_____
Example: Power bill, water bill, drivers license, etc.

Previous Address _____
Social Security Number _____
Date of Birth _____

Place of Employment _____
If not employed, what is your source of income? _____

Gross income per Month Number of Dependents _____

Spouse's name _____
Spouse's Place of Employment How Long? _____
Gross income per Month _____

What is your total gross income per month? _____

Total for 199____: _____
(Verified by tax return)

Do you have health insurance? If so, what type and with whom? _____
_____
Effective date: Is a copy of the card available? _____

EXHIBIT

ATTACHMENT 14

PART 2 - PERSONAL RESOURCE

REAL ESTATE

1. Do you or your spouse own (buying) any real estate (including a home, mobile home)?

   Yes_____ No_____

2. Give the following information about each property (real estate) that you own (buying).

   Owner (s) _____
   _____
   Address _____
   Tax Assessed Value $ _____
   Current Market Value $ _____
   Is there a mortgage or lien on any of the above property? _____
   If yes, give the balance owed: _____

VEHICLES

Do you own (buying) any of the following:

Automobile o Truck o Van o
Boat o Trailer o

	Make	Model	Year	Balance Owed
A.				
B.				

* Value of vehicle will be based on Vanguard guidelines.

LIFE INSURANCE

Do you and your spouse have any life insurance?_____

If yes, please complete the following:

Owner of Policy _____
Name of Insurance Company _____
Address of Insurance Company _____

Date of issue _____

Policy Type (whole life)_____

Face Value _____

Cash Value _____

EXHIBIT

ATTACHMENT 14

PART 2 - PERSONAL RESOURCE (cont.)

BANK ACCOUNTS

Do you and/or your spouse have any bank accounts? Yes _____ No _____
Name of Bank _____
Address _____

List accounts:

	ACCOUNT NUMBERS	BALANCE
CHECKING		
SAVINGS		
SAVINGS BONDS		
IRA/401 K		
CD'S		

SUMMARY (to be completed by hospital)

REAL ESTATE		
AUTOMOBILE		
LIFE INSURANCE		
CASH,SAVINGS,ETC.		

Will applicant liquidate any assets to cover hospital cost? _____

PART 3

Have you applied for Medicaid? If so, when? _____
Why were you denied assistance? _____

EXHIBIT

ATTACHMENT 14

PART 4 – PERSONAL RESOURCE (cont.)

1. Has your doctor made financial arrangements with you regarding his fee? _____

   If so, what are they? _____

2. Do you feel that this hospitalization is absolutely necessary? _____

   Explain. _____

PART 5

SIGNATURES

APPLICANT'S SIGNATURE _____

DATE _____

SPOUSE'S SIGNATURE _____

DATE _____

ELIGIBILITY APPROVED BY _____

DENIED _____

REASON FOR DENIAL _____

CHIEF FINANCIAL OFFICER'S APPROVAL _____

CHIEF EXECUTIVE OFFICER'S APPROVAL _____

EXHIBIT

INCOME VERIFICATION

I, _____, certify that my family income for the past 12 months has been $_____ and there are _____ people in my family. The income information can be verified by calling the following employer(s).

Company	Phone #	Company	Phone #

I certify the above to be true:

Guarantor: _____

Date: _____

Witness: _____

Date: _____

EXHIBIT

PLEASE READ CAREFULLY

BANK STATEMENTS

Copies of your latest bank statement (include checking and savings) on bank letterhead and a copy of your savings account passbook showing all transactions over the past 60 days and showing an up to date interest amount. If a recent bank statement is not available, have a bank employee write a letter on bank letterhead stating the account number, current balance, and the names on the account. Have the employee sign, date and put his/her position title on the bottom of the letter.

SAVINGS BONDS

If U.S. Savings Bonds are owned, we need to see them and need a written statement from a bank telling us what the current value is on each bond.

STOCKS OR BONDS

If stocks or bonds are owned, we need to see them and need a written statement from the company or broker as to the current value, the amount of dividends most recently received and the frequency that dividends are received.

TRUSTS

If a trust has been set up, we need to see a copy of the trust agreement, which will be submitted for clearance by our attorneys.

INSURANCE

All life, burial and health insurance policies must be disclosed. If a life or burial policy is owned by the applicant and the face value of all policies combined are $1,500.00 we need a written statement from the insurance company telling us the face value, cash surrender value and the amount of interest/dividends paid on the last anniversary date of the policy. If dividend/interest are not payable directly to the individual upon request, this should be documented as well.

VERIFICATION OF INCOME

All income you receive is considered in our determination. You must provide us with copies of all pension checks or any income you receive. Copies of current award letters should also be provided. If the above is not available, a written statement from the pension company disclosing the frequency and amount of your pension payment is required.

PROPERTY

If property is owned, a copy of the latest tax notice and deed must be presented.

VEHICLE REGISTRATION

If a vehicle is owned, a copy of the current registration must be provided.

If a mobile home is owned, a copy of the current registration and a written estimate from a licensed dealer disclosing the current fair market value of the home must be provided.

MEDICARE AND SOCIAL SECURITY

A copy of your Medicare and/or Social Security card must be provided.

VANGUARD HEALTH SYSTEMS

POLICIES & PROCEDURES

Date April 15, 1998	Approved By
Section **BUSINESS OFFICE**	
Subsection Admissions - Medicare Questionnaire/Secondary Payer Screening Form	
Policy Procedure No. **11-0303**	
Effective Date April 15, 1998	Previous Date

Medicare Questionnaire/Second

Purpose

To establish Medicare as the primary or secondary payer.

Related Policy

Medicare policies. Section 1862(b) of the Social Security Act. Title A2 of the CFR, Section 411.

Policies

1. A Medicare questionnaire must be completed for every **potential** Medicare patient registered for service:
   a. Admitting/registration personnel are responsible for the completion of the form (not the patient). The registrar should explain the need for this information when interviewing the patient.
2. The patient or his representative is to sign the completed form.
3. The completed form is to be placed in the patient's financial folder.
4. The patient's financial designation is to be determined based upon the information gathered on the Medicare Questionnaire:
   a. Financial designation assignment should be based on the primary insurance carrier.
   b. Medicare, with or without supplemental insurance, is primary if all questions on the Medicare Questionnaire are answered no.
   c. Medicare, with or without supplemental insurance will be secondary payer if any question is answered yes. At this point obtain primary payer information.
   d. Note, financial designation assignments for MSP cases are dependent upon specific facility policies. Some facilities may use specific MSP financial designation.

VANGUARD
HEALTH SYSTEMS

POLICIES & PROCEDURES

Medicare Mandated Forms .....

Date September 1, 2004	Approved By
Section **BUSINESS OFFICE**	
Subsection Admissions – Medicare Mandated Forms	
Policy Procedure No. **11-0304**	
Effective Date Sept. 1, 2004	Previous Date April 15, 1998

Purpose

To outline the use of the Medicare Advance Beneficiary Notice (ABN) for outpatient hospital services.

Policies

ABNs must be obtained in accordance with Medicare requirements. Hospitals must bill Medicare for all medically necessary services and obtain an ABN for outpatient services that are not medically necessary according to Local Coverage Determinations (LCD) and/or National Coverage Determinations (NCD), except as otherwise noted in this policy.

DEFINITIONS:

Ancillary Services: Hospital or other health care organization services other than room and board and professional services. Examples of ancillary services include diagnostic imaging, pharmacy, laboratory and rehabilitative therapy services.

Local Coverage Determination:: A decision made by Fiscal Intermediaries and Part B Carriers whether to cover a particular service on an intermediary-wide or carrier-wide basis in accordance with Section 1862(a)(1)(A) of the Social Security Act (*i.e.*, a determination whether the service is reasonable and necessary.) Hospitals are required to use only those LCD that have been issued by their specific Fiscal Intermediary.

Medical Necessity/Medically Necessary: For purposes of this policy, medical necessity or medically necessary refers to guidelines included in LCD and /or NCD in accordance with the Medical Necessity policy (GOS.GEN.002).
National Coverage Determination: A medical review policy as issued by CMS which identifies specific medical items, services, treatment procedures or technologies that may be covered and paid for by the Medicare program. NCD apply to services paid by both Fiscal Intermediaries and Part B Carriers.

Outpatient Services: Outpatient services are those services rendered to a person who has not been admitted by the hospital as an inpatient but is registered on the hospital records as an outpatient and who receives services (rather than supplies alone) from the hospital. Outpatient services include, but are not limited to, observation, emergency room, ambulatory surgery, laboratory, radiology and other ancillary department services.

Procedures

The statements listed below outline the Medicare requirements regarding outpatient ABNs.

ABN USE

1. Individuals involved in the ordering of services and/or registering of outpatients must review the patient's diagnosis, sign, symptom, disease or ICD-9-CM code for medical necessity to determine if an ABN is necessary.

2. An ABN **must** be obtained if one of the following conditions is met **and** the hospital intends to bill the beneficiary should Medicare deny payment. **If one of the conditions below is met and an ABN was not obtained prior to rendering the service, neither Medicare nor the beneficiary may be billed for the service.**
   - The test/service provided does not meet definitive medical necessity guidelines.
   - The test/service may only be paid for a limited number of times within a specified time period and this visit may exceed that limit.
   - The test/service is for investigative or research use only. For example, the service or drug/biological has not been approved by the Food and Drug Administration.

3. If the LCD and/or NCD is not definitive with regard to specific diagnoses, signs, symptoms or ICD-9-CM codes that will be covered or non-covered (*e.g.*, conditions that are generally not covered, but there are limited exceptions when additional documentation is submitted; or a policy that is not exclusive and claims not supported by the diagnoses listed may be reimbursable when supporting documentation is submitted; or when the Fiscal Intermediary considers factors other than those listed in the LCD) an ABN **should** be obtained. **However, if an ABN was not obtained, but additional documentation is present to support medical necessity, Medicare should be billed.**

4. A single ABN covering an extended course of treatment may be obtained provided the ABN identifies all items and services that may not be covered and does not extend more than one year. Examples of extended courses of treatment include physical therapy and repeat laboratory tests. If additional services are added to the extended course of treatment that is not medically necessary, an additional ABN must be obtained.

5. When a service has a technical component and a professional component, one ABN may be obtained provided the description of the service clearly indicates both components. For example, if a hospital bills on behalf of a radiologist for radiology interpretations performed at the hospital, one ABN may be obtained from the beneficiary that includes both the performance of the radiology procedure (technical component) and the radiologist's interpretation (professional component).

6. When a hospital laboratory receives a specimen only and the test to be performed does not meet medical necessity guidelines, the laboratory **must** obtain an ABN prior to performing the test **if the hospital intends to bill the beneficiary in the event Medicare denies payment**. If the integrity of the specimen is at risk and the test is not medically necessary, laboratory personnel may perform the test(s). **However, if an ABN is not obtained prior to performing the test(s), neither Medicare nor the beneficiary may be billed for the test(s).**

7. ABNs must be obtained **prior** to rendering non-medically necessary services. It is not appropriate to obtain an ABN after services have been rendered.

8. ABNs must not be obtained from a beneficiary nor the beneficiary held financially liable when payment for an item or service is bundled or packaged into another payment under the Medicare Outpatient Prospective Payment System (OPPS) even when those items or services do not meet medical necessity guidelines.

9. Routinely providing ABNs to beneficiaries is not an acceptable practice. Providing generic, blanket and blank ABNs is also not an acceptable practice. There must be a specific reason to believe Medicare may deny the test/service in order to request a beneficiary sign an ABN.

10. It is not appropriate to obtain an ABN when the beneficiary is unable to comprehend the ABN (*e.g.*, if the patient is comatose, confused or legally incompetent, he/she is unable to understand the implications of signing the ABN) and his/her authorized representative is not available.

11. An ABN must never be obtained from a beneficiary under great duress, in a medical emergency, or in any case where the Emergency Medical Treatment and Active Labor Act (EMTALA) applies, until a medical screening examination has been completed and the patient has been stabilized. This applies to treatment in any hospital outpatient department that is considered provider-based, located either on or off the campus of the hospital.

12. If the beneficiary refuses to sign the ABN and be financially responsible in the event Medicare denies payment, the ordering physician should be contacted to determine if non-performance of the services will compromise patient care.

13. If the beneficiary refuses to sign the ABN and be financially responsible in the event Medicare denies payment and demands that the services be performed, a second person should witness the provision of the ABN and the beneficiary's refusal to sign. The witness should sign an annotation on the ABN stating that he/she witnessed the provision of the ABN and the beneficiary's refusal to sign. The claim will be filed as if an ABN was obtained. In the case of a denial by Medicare, the beneficiary will be held liable per Section 1879(c) of the Social Security Act.

14. Once the ABN is signed it may not be altered in any way. If additional services will be provided for which an ABN will be needed, a new ABN must be obtained.

15. ABNs must not be used to notify a beneficiary of statutorily excluded services or items (*e.g.*, personal comfort items, routine physicals, outpatient prescription drugs).

ABN FORM

1. VHS facilities must use the CMS-approved form (CMS-R-131-G), which is available from either Standard Register or from Company-approved medical necessity vendors, and may not be altered (see Attachment A). All fields on the ABN form must be completed in sufficient detail to specify the potentially non-covered service. All entries must be in Arial or Arial Narrow font in the size range of 10 – 12 point font or legibly handwritten.

2. The signed ABN form should be distributed as follows: give one copy to the patient, retain one copy in the patient's hospital Business Office record.

BILLING

1. If the services are not medically necessary and an ABN was obtained prior to rendering the services, the services must be reported in FL 47 (Total Charges) on the UB-92. Occurrence code 32 must be entered in FL 32-35 indicating the date that the ABN was provided to the beneficiary. The GA modifier must be appended to the CPT/HCPCS code representing the service(s) for which an ABN was obtained.
   - The Fiscal Intermediary (FI) will make a determination whether or not the services will be paid by Medicare. If the FI determines that the services are non-covered, the facility must bill the beneficiary for the services for which an ABN was obtained.
   - If the FI pays for the services then the beneficiary must not be billed for the services for which an ABN was obtained.

2. If the services are supported by additional documentation indicating medical necessity and the LCD and/or NCD is not definitive with regard to specific diagnoses, signs, symptoms or ICD-9-CM codes which will be covered or non-covered, the services should be reported in FL 47 (Total Charges) on the UB-92. If an ABN was obtained, the GA modifier must be appended to the CPT/HCPCS code representing the service(s) for which the ABN was obtained. The additional documentation should be submitted with the claim to Medicare. The FI will make a determination whether or not the services will be paid by Medicare.
   - If the FI pays for the services, then the beneficiary must not be billed for the services.
   - If the FI determines that the services are non-covered and an ABN was obtained, the facility must bill the beneficiary for the services for which an ABN was obtained.
   - If the FI determines that the services are non-covered and an ABN was not obtained, the facility must not bill the beneficiary.
3. If multiple ABNs are obtained for services included on one claim, occurrence code 32 and the date the ABN was provided must be reported for each ABN, even if the date is the same for each ABN.

4. If the services are not medically necessary (according to definitive LCD and/or NCD) and an ABN was not obtained prior to rendering the non-covered services, the services must be removed from the UB-92. The charges should be written off as non-covered/non-allowable and must **not** be claimed as Medicare Bad Debt Expense.

OTHER

Ancillary Department and Business Office personnel must educate all staff associates and medical staff members responsible for ordering, referring, registering, performing, charging, coding and billing ancillary services regarding the contents of this policy.

REFERENCES:

Fiscal Intermediary Local Coverage Determinations s
CMS National Coverage Determinations
CMS Pub. 60AB, Transmittal No. AB-02-114, July 31, 2002 – ABNs and DMEPOS Refund Requirements
CMS Pub. 60AB, Transmittal No. A-02-117, November 1, 2002
Medicare Claims Processing Manual (Pub 100-4), Chapter 30 – Financial Liability Protections, Sections 40 – 50.7.8

Medicare Claims Processing Manual (Pub 100-4), Chapter 1, Section 60
Medicare Program Integrity Manual (Pub 100-8), Chapter 13, Sections 1.1 and 1.3

Patient's Name: _____ Medicare # (HICN): _____

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services.
We expect that Medicare will not pay for the item(s) or service(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, **Medicare probably will not pay for –**

Items or Services:

Because:

- ☐ Medicare does not pay for the item(s) or service(s) for your condition.
- ☐ Medicare does not pay for the item(s) or service(s) more often than _____.
- ☐ Medicare does not pay for experimental or research use items or services.

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully.**

- Ask us to explain, if you don't understand why Medicare probably won't pay.
- Ask us how much these items or services will cost you (**Estimated Cost: $**_____), in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN & DATE** YOUR CHOICE.

☐ **Option 1. YES. I want to receive these items or services.**
I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items or services and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare's decision.

☐ **Option 2. NO. I have decided not to receive these items or services.**
I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.

_____ _____
Date **Signature of patient or person acting on patient's behalf**

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information, which Medicare sees, will be kept confidential by Medicare.

OMB Approval No. 0938-0566 Form No. CMS-R-131-G (June 2002)

VANGUARD HEALTH SYSTEMS

POLICIES & PROCEDURES

Consents .....

Date October 2004	Approved By
Section **BUSINESS OFFICE**	
Subsection Admissions – Consents	
Policy Procedure No. **11-0305**	
Effective Date October 2004	Previous Date April 15, 1998

Purpose

To establish the policy and procedures for obtaining consents subject to federal, state and local laws, rules and regulations.

To establish responsibility for obtaining consents.

Related Policies

1. State consent manual.
2. Medical Staff By-Laws conceming the obtaining of consent for special procedures.

Policies

1. All patients, or the patient's legal representative, will sign a Conditions of Admissions/Treatment form prior to services being rendered:

2. Exceptions:

   a. If the patient is unable to sign the Conditions of Admissions/Treatment form and a family member is present and willing to sign, they may do so. The patient's signature must be obtained when the patient's medical condition improves and is legally able.

   b. Patients that are unaccompanied and unable to sign or "Minors" will require telephone consent in accordance with state laws.

   c. All exceptions must be documented and witnessed.

3. A copy of the Conditions of Admission and the Assignment of Benefits will go into the patient's financial folder:

   a. The Admitting Department is responsible for:

      1) Obtaining the signature of the correct person on the Conditions of Admission at the time of registration.

      2) Explaining the Conditions of Admissions/Treatment to the patients.

      3) Obtaining the subscribers signature for Assignment of Benefits unless payment in full for services is obtained.

      4) Delivery of any special consent forms (which may be sent to them for safekeeping) to the charge nurse for placement in the chart:

a) The original copy of the Conditions of Admissions/Treatment is sent to the nursing station to be retained in the patient's medical chart.

4. Signature:

   a. The patient's signature must be their complete legal name, (no nicknames).

   b. Signatures other than the patient's must be complete and accompanied with an explanation of the relationship to the patient.

   c. The witnessing representative will sign the form in the designated place.

   d. All signatures will be dated and timed by the hospital's representative.

   e. All signatures must be in ink.

   f. For facilities that have specialty units, the Admitting Department will obtain all specific signatures and forms as required.

VANGUARD HEALTH SYSTEMS

POLICIES & PROCEDURES

Date April 15, 1998	Approved By
Section **BUSINESS OFFICE**	
Subsection Admissions – Chief Executive Officer's Admission Letter	
Policy Procedure No. **11-0306**	
Effective Date April 15, 1998	Previous Date

Chief Executive Officer's Admi

Purpose

To thank patients for selecting our facility when needing health care services.

To inform patients of the facility's policy and procedures regarding insurance payer's responsibilities and the contractual relationship with the facility.

Policies

1. All patients receiving services will receive the administrator's admission letter at time of registration:

   Exceptions: Patient's covered by Medicaid, Worker's Compensation, and Special State Programs.

   a. The administrator's admission letter must be produced on facility letter head.

Procedures

1. All admitting areas, including emergency room and outpatient registration are responsible for the distribution of the administrator's letter.

   a. The administrator's letter is to be given to all patients regardless of patient type with the exception of patients described above.

   b. The administrator's letter will be given to the patient or the patient's representative at the time of registration.

EXHIBIT

SAMPLE CHIEF EXECUTIVE OFFICER'S LETTER

Date

Name
Address

Dear Patient:

With complex new healthcare regulations, tightened reimbursements and cost-cutting measures, virtually all insurance carriers require pre-authorization or second opinions. Most carriers have additional restrictions and/or exclusions on some services within their plans. We want to provide you with information that will assist you in obtaining maximum insurance benefits for the services we are providing. Our admissions office can help you determine the requirements of your insurance policy and in some cases help you satisfy these requirements.

Another way we help you is to bill your insurance company directly. While we usually do this within 4 days of your discharge, we often do not receive payment from your insurance carrier within the expected 30 days. This is an area where you can be of help to us and preclude your receiving a hospital bill for services that the insurance company should pay.

If you have not received notification of payment from your insurance carrier within 30 days following discharge, please call your insurance representative or employer to determine why they have delayed payment to the hospital. You will be held responsible for the amount due if your insurance company fails to respond to the hospital.

While we understand that most people do not want to be in the hospital, we are pleased that you have chosen this hospital. We appreciate the opportunity to provide you with the best of care and to make your stay as comfortable as possible.

Sincerely,

Chief Executive Officer

VANGUARD
HEALTH SYSTEMS

POLICIES & PROCEDURES

Insurance Verification .....

Date October 2004	Approved By
Section **BUSINESS OFFICE**	
Subsection Admissions – Insurance Verification	
Policy Procedure No. **11-0310**	
Effective Date October 2004	Previous Date April 15, 1998

Purpose

To establish an organized method for confirmation of third-party payer coverage and benefits.

To establish responsibility for the verification of third-party coverage and requirements.

Related Policies

1. Contract agreements with all insurance carriers and employer groups
2. Pre-Admission Certification System procedures
3. Deposit policy

Policies

1. All insurance coverage will be verified in a timely manner.

   a. Pre-registered patients will be verified prior to admission.

   b. Direct or emergency room admissions will be verified at time of service or admission, or within twenty-four (24) hours.

   c. Obstetrical admissions will have insurance verified at time of pre-registration and again in the eighth (8th) month of pregnancy.

   d. Week-end and holiday admissions will be verified the first working day:

      Exception: Payers that have twenty-four (24) hour access for verification and authorization.

   e. Series/recurring patients will be re-verified each month as services continue.

   f. The Admission Department will verify insurance benefits on all C.A.T. scan, M.R.I. and Nuclear Medicine patients prior to the procedure. Any exception requires approval of the Chief Financial Officer.

2. Employment status will be verified on all group insurance:

   a. Obtain date of hire from employer.
   b. Verify current employment.

3. Insurance benefits will be verified on the following:

   a. Inpatients (all types)
   b. Day Surgery (short stay)

c. Outpatient Services
d. Specific Outpatient Procedures
e. Emergency Room Services

4. Pre-Certification will be done immediately on all payers requiring authorization prior to services.

5. The hospital information system insurance master file will be updated on an ongoing basis.

Procedures

1. The verification clerk will obtain the following information and document the patient financial folder in the appropriate location.

   a. Is the group covered?

   b. Is the insured covered?

   c. Verify correctness of the insured group and subscriber numbers.

   d. If the patient is a dependent of the insured, is the patient covered?

   e. If the dependent is over the age of eighteen (18) and a full-time student, does insurance require a statement from the school attended?

      Note: A full time student status normally continues through the age of twenty-three (23) years.

   f. If the dependent is married, is he/she covered under the parent's insurance coverage?

      Note: Special care when verifying. A request for written verification of coverage should be made.

   g. Is the admitting diagnosis covered?

   h. Is the surgical procedure covered?

   i. Is there a waiting period?

   j. Is the coverage dependent on the level of care (inpatient versus outpatient)?

   k. Does the admitting diagnosis require pre-authorization?

      1) Has the pre-authorization been received?

      2) If yes, obtain authorization number.

   l. Does the admitting diagnosis require a second opinion?

      1) If yes, has the requirement been satisfied?

      2) If requirements have not been satisfied:

a) Call the patient for information needed.

b) Call the admitting physician to advise him of the missing requirements and probable re-scheduling.

m. Obtain effective date of coverage.

n. Does coverage contain a pre-existing clause?

o. Determine the amount of the deductible and if any portion has been satisfied?

p. Determine if benefits are restricted by length of stay or dollar amount limitations.

q. Is an individual claim form required for billing? Does the employer require the claim to be submitted through the place of employment?

r. Obtain correct billing address for claim submission. Does the claim need to be submitted to the employee first?

s. Obtain the correct telephone number for claim follow-up procedure.

t. Obtain the full name of the person confirming coverage.

u. Document the date verification was obtained.

v. Any high-priced procedures, such as CAT scan, MRI, and Nuclear Medicine procedures will require insurance verification prior to the procedure being performed.

Exception: The Patient Accounts Manager may approve a procedure without verification due to time of day, holiday, weekend, or any other reason deemed appropriate. Approval must be documented in the patient financial folder.

2. Review the insurance benefits and requirements.

   a. Determine the necessity for authorization prior to treatment.

   b. Take necessary actions to obtain required authorizations.

3. Determine the necessity for second opinions and required levels of care.

4. Advise the physician and patient of requirements.

5. Record appropriate documentation to ensure maximum reimbursement.

6. Determine patient liability amount:

   a. Determination will be based on insurance verification and facility anticipated total charges.

      See: Deposit Requirements.

b. Discuss insurance benefits with the patient.

c. Upon verification the patient will be informed of their liability and the facility collection policy. Any outstanding exhausted balances should be collected at this time.

VANGUARD
HEALTH SYSTEMS

POLICIES & PROCEDURES

Date April 15, 1998	Approved By
Section **BUSINESS OFFICE**	
Subsection Admissions – Verification of Medicare Health Insurance Claim Number (H.I.C.)	
Policy Procedure No. **11-0311**	
Effective Date April 15, 1998	Previous Date

Verification of Medicare Health

Purpose

To establish a procedure for verifying the Health Insurance Claim (HIC) number for Medicare patients requesting service.

Policies

1. Patients requesting service will be asked to provide their Medicare number:

   a. A copy of the Medicare identification card should be obtained whenever possible.

   b. A copy of a Medicaid card may also be used to obtain the Medicare number, in most cases.

   c. A Medicare explanation of benefits from a prior claim may be utilized to obtain the Medicare number, if available.

   d. A previous paid patient account record may be utilized to obtain a Medicare number.

2. When informed that the patient has Medicare, but is unable to provide a Medicare number, a telephone call will be placed to the local Social Security Administration (SSA) Office to obtain the Medicare number if possible:

   a. Facilities that are unable to verify Medicare benefits electronically will utilize the Social Security Administration Form 1600.

   b. The Admitting Department is responsible for submission of the Form 1600.

   c. The SSA Form 1600 will be completed and mailed at the time of registration.

   d. The completion and mailing of the SSA Form 1600 will be documented on the hospital information system by the employee completing the form.

   e. The patient's account number will be placed on the SSA Form 1600 following the hospital address to facilitate the matching of the retumed SSA Form 1600 with the patient's account.

   f. A copy of the SSA Form 1600 will be placed in the patient's financial folder at the time of the completion.

   g. A duplicate form will be sent as a second request if the reply has not been received within ten (10) working days of the original request:

      1) The Admitting Department is responsible for the second request if the patient is still in-house.

2) The Medicare Biller is responsible for the second request if the patient has been discharged.

3) Close monitoring of responses is necessary due to time delays at Social Security offices.

h. Medicare cannot be billed without a correct Medicare number.

VANGUARD
HEALTH SYSTEMS

POLICIES & PROCEDURES

Admission Checklist .....

Date April 15, 1998	Approved By
Section **BUSINESS OFFICE**	
Subsection Admissions – Admission Checklist	
Policy Procedure No. **11-0314**	
Effective Date April 15, 1998	Previous Date

Purpose

To establish a quality assurance process which confirms completion of critical registration tasks.

Related Procedures

1. Admission and registration policies and procedures.

Policies

1. An admission checklist can be completed at the time of registration:
   a. The admission checklist can be printed on the inside front of the financial folder or a separate form.
   b. Documentation will be clear and concise.
   c. The admission checklist will be signed by the admitting representative processing the patient.
   d. The Admitting Supervisor will sign the patient financial folder after reviewing the registration for accuracy and completeness:
      1) Any missing information will be obtained by the admitting department within twenty-four (24) hours.
      2) The Admitting Supervisor will be responsible for insuring critical registration information is accurate and complete.

VANGUARD
HEALTH SYSTEMS

POLICIES & PROCEDURES

Physician Definitions .....

Date April 15, 1998	Approved By
Section **BUSINESS OFFICE**	
Subsection Admissions – Physician Definitions	
Policy Procedure No. **11-0317**	
Effective Date April 15, 1998	Previous Date

Purpose

To ensure each physician definition is interpreted in the same method within Vanguard Health System, Inc..

Policies

1. For the purpose of identifying physician types as a function of Admission, the following definitions will be used:

Description	Definition
Admitting Physician	Physician who actually admits the patient to the hospital.
Attending Physician	Physician who actually treats and visits the patient while the patient is in house and who overall monitors and manages the care of the patient during the inpatient stay.
Consulting Phys.	Physician specialist, called in by the attending physician to review, treat, monitor, and/or manage a certain portion of a patient care.
Family Physician	The Physician the patient and the patient's family normally sees for care on routine matters.
Referring Physician	Physician who refers the patient to the hospital.

VANGUARD HEALTH SYSTEMS

POLICIES & PROCEDURES

Date: September 14, 2009	Approved By: Neal Somaney
Section: **Business Office Policy and Procedure**	
Subsection: Admitting - Address and/ or Social Security Number Verification	
Policy Procedure No. **11-0320**	
Effective Date October 1, 2009	Previous Date

1. **Purpose**
   To provide guidelines for registrations requiring Address Verification.

2. **Scope**
   Registration process for patients that are known to have a bad address on file or are unable to provide consistent or complete information at the time of registration.

3. **Policy**

   3.1. Verification of the guarantor's address using Verification software should be completed in each of the following scenarios:

      3.1.1. Regardless of insurance, when the registrar is aware the patient's prior account has had mail returned to the facility.

      3.1.2. When the patient presents inconsistent information without any valid identification.

      3.1.3. If the patient is not a minor and has not provided their Social Security number.

      3.1.4. All Red Flag Event scenarios.

   3.2. If the information returned from the address verification system does not match the information provided by the patient, complete the following steps:

      3.2.1. Ask the patient to verify all current demographic information, i.e. their address

      3.2.2. If the patient then provides information that is consistent with the Address Verification transaction, update the demographic information in the patient registration and guarantor fields.

      3.2.3. If the patient does not provide information that is consistent with the Address Verification transaction, indicate the inconsistency in the hospital patient accounts system notes. Keep the address provided by the patient in the demographics, but list the address returned from the Address Verification in the patient account notes.

      3.2.4. Determine if the inconsistency leads to a potential Red Flag Event, if the registrar determines a Red Flag event has occurred, follow Red Flag reporting policy and procedure.

Westlake Hospital & West Suburban Medical Center

Proposed Charity Care Policy

ATTACHMENT 18B

I declare under penalty of perjury that the answers I have given are true and correct to the best of my knowledge. I agree to tell the provider of service within ten (10) days if there are any changes in my (or the persons on whose behalf I am acting) income, property, expenses or in the persons household or any change of address. I understand that I may be asked to prove my statements and my eligibility statements will be subject to verification by contact with my employer, bank credit verification and property searches. I understand the county is required by law to keep any information I provide confidential. I further agree, that in consideration for receiving health care services as a result of an accident or injury, to reimburse the county from the proceeds of litigation or settlement resulting from such an act.	Declaro bajo pena de perjuria que las respuestas que he dado son verdaderas y correctas al mejor de mi conocimiento. Acuerdo decirle al abastecedor del servicio en el plazo de diez dias si hay algunos cambios en mi (o personas en el favor que yo este actuando) renta, propiedad, gastos o en la casa de las personas o cualquier cambio de direccion. Entiendo que puedo ser pedido probar mis declaraciones de la elegibilidad estaran conforme a la verificacion al lado de contacto con mi patron, verification del credito de banco y busquedas de propiedad. Entiendo que el condado es requerido por ley de protejer cualquier informacion que yo proporcione confidencial. Tambien convengo, en la consideracion de recibir servicios del cuidado medico como resultado de un accidente o lesion, de tener que reembolsarle al condado de los ingresos de la demanda o cualquier resultado de tal acto.

202

Signature/Firma

Date/Fecha

For Hospital Use Only/Uso Solamente Para el Hospital

Facility/Facilidad: _____ **Accepted/Aceptar:** _____ **Denied/Negacion:** _____

COMMENTS/COMETARIOS:

ATTACHMENT 18B

Signature Approval

Date

[Hospital Logo]

Date:

Re:
Admission #
Balance Due:

Dear ,

Thank you for choosing _____ Hospital. We appreciate you taking the time to complete and return the Application for Assistance. _____ Hospital uses this information to determine your eligibility for a reduced fee under the _____ Hospitals Charity Care Financial Assistance program.

In reviewing your Application for Financial Assistance, we have determined that you are not eligible for charity care or financial assistance under our policy. Our determination was based upon your income, household size and Federal Poverty Guidelines.

If you have any questions about our decision, please call Customer Service at (XXX)___-____.

Sincerely,

Customer Service Representative

VANGUARD
HEALTH SYSTEMS

POLICIES & PROCEDURES

Date: -April 1, 2009	Approved By: Neal Somaney
Section: Business Office	
Subsection: Uninsured Patients Discount Policy	
Policy Procedure No. – **11-0806**	
Effective Date: July 1, 2009	Previous Date: N/A
Chicago Hospitals April 1. 2009	

SCOPE:
All Company-affiliated hospitals.

PURPOSE:

This Policy and Procedure is established to provide the operational guidelines for Company's hospitals to apply a consistent approach to extending discounts to "Uninsured Patients".

This Policy is intended to work in tandem with applicable charity care policies that provide for discounts or full write-off of charges to qualified patients.

POLICY:

1. Uninsured Hospital Discount- The Company's Hospitals shall provide a discount to uninsured patients for all medically necessary inpatient or outpatient hospital service, including pharmaceuticals or supplies provided by the hospital to the patient who qualify for classification as Uninsured in accordance with the Uninsured Discount Process set forth below. The Company's Hospitals shall adopt a written policy in conformity with the Company's Policy and Procedure set forth herein. An Uninsured Discount up to 65% of charges will be provided under this Policy. This shall be available for all uninsured patients that are provided medically necessary services as defined as covered under Title XVIII of the federal Social Security Act (CMS) for beneficiaries with the same clinical presentation. A "medically necessary" service does not include any of the following:

- Non-medical services such as social or vocational services.
- Elective cosmetic surgery

2. Billing and Collection Processes for Uninsured Patients. All uninsured patients receiving care at the Company's Hospitals will be treated with respect and in a professional manner before, during and after receiving care. Each of the Company's Hospitals should adopt a written policy in conformity with the Company's Policy and Procedure set forth herein for its billing and collection practices in respect of all uninsured patients.

VANGUARD
HEALTH SYSTEMS

POLICIES & PROCEDURES

Date: -April 1, 2009	Approved By: Neal Somaney
Section: Business Office	
Subsection: Uninsured Patients Discount Policy	
Policy Procedure No. – **11-0806**	
Effective Date: July 1, 2009	Previous Date: N/A
Chicago Hospitals April 1. 2009	

PROCEDURE:

A. UNINSURED DISCOUNT PROCESS

1. **Eligibility:** Each Company Hospital will determine that each patient designated as uninsured is eligible for the discount.

    a. Determination of Eligibility for Uninsured Discount:
        i. Each Hospital will request that patients qualifying for the uninsured discount verify the following information:

            1. The patient is not currently a beneficiary under a public or private health insurance, health benefit, or other health coverage program, including high deductible health insurance plans.

            2. The patient is not covered under any policy of health insurance or entitled to COBRA benefits.

            3. The patient is not covered under workers' compensation, accident liability insurance, or any other third party liability

            4. The patient is not eligible for coverage under any public program such as Medicare, Medicaid, or any other State, County of Federal program

The hospital will determine if the patient is eligible for the uninsured discount and register the patient using the appropriate self- pay plan code.

1. **Information Falsification.** Falsification of information may result in denial of the Uninsured Discount. If, after a patient is granted an uninsured discount and Hospital finds material provision(s) of the uninsured discount policy to be untrue, the uninsured discount may be withdrawn and the patient will be billed for full charges..

2. **Medicaid Eligibility.** .If it is determined the patient will qualify for Medicaid as well as the uninsured discount the patient will be registered into a self pay plan indicating the patient has a Medicaid application pending. The account will remain in self-pay until such time the Medicaid application is either approved or denied. If the patient is approved for Medicaid the self-pay insurance plan will be updated to a Medicaid plan and the uninsured discount will be replaced with the Medicaid contractual.

VANGUARD
HEALTH SYSTEMS

POLICIES & PROCEDURES

Date: -April 1, 2009	Approved By: Neal Somaney
Section: Business Office	
Subsection: Uninsured Patients Discount Policy	
Policy Procedure No. – **11-0806**	
Effective Date: July 1, 2009	Previous Date: N/A
Chicago Hospitals April 1, 2009	

3. **Insurance Coverage cannot be determined.** If the hospital is unable to determine the patient has health insurance the account will be classified as self- pay until such time insurance coverage can be verified.

4. **Third Party Liability.** If is determined the patients injury or illness could be billed to a third party payer including auto liability the account will be classified as self pay – TPL. These accounts will be discounted but the TPL vendor will send and pursue the full charges.

5. **Insurance Cash received for Uninsured Patient.** If the hospital receives, a payment from a health insurance carrier or other third party while the patient account is in an uninsured discount financial class the account will be updated to reflect the correct insurance plan and the uninsured discount will be reversed.

6. **Non-Covered Services-** If a patient has health insurance and the service they are scheduled to receive has been determined to be a non-covered service, the patient would not be eligible for an uninsured discount (i.e Mammography, audiology).

7. **Package Pricing- For Illinois Hospitals** the package pricing for medically necessary services (i.e. Emergency Room services) will be offered to Uninsured patients provided the package pricing does not exceed 135% of the hospital costs. If the package price collected is higher than 135% of Hospitals costs the patient will be refunded the difference.

8. **Package Pricing – For All Other Hospitals** any existing package pricing for medically necessary services (i.e Emergency Room services) will be offered to all Uninsured patients. The discount will be set up to be up to the greater of 65% of charges or the package price. Collection of package prices will be expected at the time of service or within the agreed number of days from date of service. The difference will be manually adjusted using the appropriate Package plan adjustment code.

9. **System Netting of Uninsured Accounts** - Upon final bill drop from Hospitals legacy system, all uninsured patient bills will be netted down using the discount percentage or package price. The uninsured patient bill will show the discount amount and the patient will be responsible for the net balance after the discount.

10. **Reversal of Uninsured discount** – If a patient has applied for financial assistance and has been approved under the company's Charity care guidelines, the uninsured discount will be

reversed and the entire qualified balance will be written off to Charity Care using the appropriate transaction code.

11. **Invoice Statements or Enclosures.** When sending a bill to uninsured patients, the Hospital should include a statement on the bill or in an enclosure to the bill that indicates that if the patient meets certain income requirements, the patient may be eligible for a government-sponsored program or for financial assistance. The statement should also provide the patient a customer service telephone number or office where additional information about such financial assistance can be obtained. All Statements to uninsured patients should state that they have been provided a discount due to their uninsured status and the balance is reflective of the amount due after the discount.

12. **Notices.** Each of the Company's hospitals should post notices regarding the both a financial assistance and discounts available to uninsured patients. These notices should be posted in visible locations throughout the hospital such as admitting/registration, billing office and emergency department. The notices also should include a contact telephone number that a patient or family member can call for more information. The following specific language complies the above notice requirements of this Section B.4.: "For help with your Hospital bill or Financial Assistance, please call or ask to see our Financial Counselor or call (XXX) XXX-XXXX (M-F 8:30 am to 4:30 pm)."

C. **RESERVATION OF RIGHTS AGAINST THIRD PARTIES.**

Nothing in this Policy shall preclude the Company's hospitals from pursuing reimbursement from third party payors, third party liability settlements or tortfeasors or other legally responsible third parties.

REFERENCES

VANGUARD
HEALTH SYSTEMS

POLICIES & PROCEDURES

Deposit Requirements .....

Date October 2004	Approved By
Section **BUSINESS OFFICE**	
Subsection Admissions – Deposit Requirements	
Policy Procedure No. **11-0312**	
Effective Date October 2004	Previous Date April 15, 1998

Purpose

To provide guidelines for establishing financial arrangements for a patient who can not satisfy their obligations when services are received.

Related Policies

1. Cash Price for Flat Fee Programs and Services.
2. Most Common Diagnosis Average Charge List
3. Collection Policies
4. Financial Programs
5. Billing Policies

Policies

1. Payment is due and payable at time of service. Medical facilities are not lending institutions; however, as a courtesy to our patients we will bill all third-party payers on behalf of the patient:

   a. Third-party payers are defined as Medicare, Medicaid, H.M.O.s, P.P.O.s, group or private insurance policies.

   b. The facility will offer extended payment plans for patients who require assistance in meeting their obligation. The patient must meet established criteria to be eligible for these programs.

2. Self Pay patients will be required to pay at time of service:

   a. In emergency situations, patients will be treated without regard to financial status.

   b. Inpatient and outpatient non-emergency services should not be provided until payment is received for total estimated charges.

3. Verified third-party payers patients may utilize their covered benefit portion in lieu of deposit requirements but will be obligated to pay co-insurance and deductible balances.

4. Verified Worker's Compensation patients will have no patient liabilities due:

   Exception: Personal items received.

5. The facility will not accept personal injury liability coverage as the primary payer unless the patient has no group insurance coverage.

6. Private room differences will be collected, based on anticipated length of stay, at time of admission.

7. Medicare patients will be notified at time of admission, in writing, that personal items will be their liability and will be collected at time of discharge.

8. Every patient receiving treatment will be registered into the hospital information system.

9. Payment methods accepted are cash, check, money orders and credit cards.

10. With a verified 80% insurance coverage, Medicare or Medicaid, the patient may make arrangements on the patient portion of the bill without delay in service.

11. All cash patients, who will be indebted to the hospital for an amount greater than $500, must be approved by the Chief Executive Officer or his designee.

12. Emergency room patients will have payment requested if their condition is non-emergent:

    a. Upon receipt of a Medicaid spin-down and/or share of cost form, admission clerks will request payment from the patient for the amount due. Patients who can not satisfy their obligation will be referred to a financial counselor.

13. H.M.O./P.P.O. non-emergency patients will be expected to pay their deductible and co-pay amounts prior to service. Emergency patients will satisfy these requirements at time of discharge. The policy will include all patient types.

Procedure

1. For a self-pay patient (non-emergency) who is unable to pay prior to service being provided, the following procedures should be followed:

    a. Call physician to inform him of the patient's financial status:

        1) Inquire if the patient can be rescheduled should the admission be elective.

        2) If the physician states the patient must receive service now, call the Patient Accounts Manager for approval.

    b. Sufficient information must be provided to the Patient Accounts Manager or his designee at the time of the notification:

        1) Name of patient.
        2) Name of the patient's private physician.
        3) Diagnosis and/or procedures requested.
        4) Nature of the services (emergency room, inpatient with expected length of stay, outpatient surgery, etc.).
        5) Transferability of patient.
        6) Proposed methods of payment, including amounts available for deposits and date for final payment.

    c. Verbal authorization is to be documented:

1) Admitting/registration personnel are responsible for recording the date, time, and person who authorizes treatment.

2) The Admitting Supervisor will prepare a financial responsibility form for all cash patients receiving services for each twenty-four (24) hour period:

   a) The form will include the anticipated length of stay for inpatients.
   b) Payments and/or arrangements will be documented on the form for review by the Patient Accounts Manager and/or designee.

3) The Patient Accounts Manager/designee will comment and/or acknowledge his review of the form by his signature.

4) The forms will be maintained in chronological order by the Admitting Supervisor.

5) Forms must be reviewed daily for possible exhaustion of approval limits:

   a) When the patient exceeds the approved limit, approval must be obtained for additional anticipated charges.

6) One copy of the patient responsibility form will be placed in the patient financial folder.

7) One copy of the form will be maintained for a monthly report, by attending physician. This will enable the Chief Executive Officer to readily identify potential bad debt by physician.

8) All cash inpatients will be followed daily by the UR/DRG team:

   a) Treatments and charges will be discussed in the daily UR/DRG meeting.

9) The group or private insurance carrier will be utilized for potential third-party liability injury cases instead of the liability carrier.

10) The hospital will post its deposit requirements at each registration site.

West Suburban Medical Center

Patient Transfer Agreements

(to be retained)

ATTACHMENT 18C

21C

HEALTH CARE SYSTEM

The proposed change of ownership will not restrict the use of other area facilities, nor will it have an impact on other area providers.

Impact of the Proposed Transaction on Other Area Providers

Following the change of ownership, West Suburban Medical Center will continue to operate with an "open" Medical Staff model, meaning that qualified physicians both can apply for admitting privileges at the hospital, and admit patients to the hospital on a voluntary basis—the physicians will not be required to admit only to West Suburban Medical Center. In addition, the hospital's Emergency Department will maintain its current designated level, that being "comprehensive". As a result, ambulance and paramedic transport patterns will not be altered because of the change of ownership. Last, because the current admissions policies of the hospital will not be changed, patients will not be "deflected" from West Suburban Medical Center to other area facilities as a result of the change of ownership.

Other Facilities Within the Acquiring Co-Applicants' Health Care System

Vanguard Health Systems, the parent of the acquiring co-applicants owns two other general acute care hospitals in the Chicago area: Louis A. Weiss Memorial Hospital, located at 4646 North Marine Drive in Chicago and MacNeal Memorial Hospital, located at 3249 South Oak Park Avenue, in Berwyn. Weiss Memorial is

located 16.4 miles (30 minutes) from West Suburban Medical Center and MacNeal Memorial is located 5.1 miles (15 minutes) from West Suburban Medical Center.

MacNeal Memorial is designated as a disproportionate share hospital, and both hospitals provide a high percentage of their care to Medicaid recipients. During 2008, 21.4% and 20.5% of the patients admitted to Weiss and MacNeal, respectively, were Medicaid recipients.

The table below presents the 2008 utilization, bed complements and services provided by each of the two above-identified hospitals.

	Weiss Memorial		MacNeal Memorial	
	Number	Utilization	Number	Utilization
Beds				
Med/Surg	184	43.8%	272	62.9%
Pediatrics	0		10	38.7%
ICU	16	89.9%	26	53.4%
OB/Gyn	0		25	51.6%
Acute Mentall Illness	10	80.5%	64	60.1%
Rehabilitation	26	48.2%	0	
	236	48.9%	397	60.5%
Other Services				
Surgery (ORs/hrs)	10	7,634	12	12,953
Cardiac Cath (rms/proc)	1	760	3	1,753
Emergency Dept (vistits)		22,674		54,884
Outpatients (visits)		81,943		177,849
Imaging (rms/proc)				
General R & F	11	36,271	7	63,336
Nuclear Medicine	3	3,847	3	7,375
Mammography	2	3,543	3	20,603
Ultrasound	2	3,836	7	23,636
Diag. Angiography	1	608	2	2,100
Interventional Angiog.	1	880	0	
CT	1	10,829	3	27,518
MRI	1	2,526	3	7,928
Lithotripsy (proc)				45
Linear Accelerator (proc)	1	121		

ATTACHMENT 18C

Referral Agreements

Copies of West Suburban Medical Center's current referral agreements are attached. It is the intent of the prospective licensee, VHS West Suburban Medical Center, Inc., to retain all of West Suburban Medical Center's referral agreements, and each provider with which a referral agreement exists will be notified of the change of ownership. Each of the existing referral agreements will continue in their current form until those agreements are revised and/or supplemented by VHS West Suburban Medical Center, Inc. That revision process is anticipated to take 6-12 months from the date of the change of ownership.

Below are listed the facilities with which West Suburban Medical Center currently maintains transfer agreements, along with the facility's distance from West Suburban Medical Center:

- Northwestern Medical Center (11.4 miles/20 minutes)
- Children's Memorial Hospital (13.0 miles/24 minutes)

Referrals from West Suburban Medical Center will typically be made at the discretion of the patient's physician, in consultation with the patient and family. There will not be a policy in place regarding any preference of referrals to health care system members over other facilities.

Duplication of Services

As certified in this application, the acquiring co-applicants fully intend to retain West Suburban Medical Center's clinical programmatic complement for a minimum of

two years. An initial evaluation of the clinical services provided by West Suburban Medical Center would suggest that the hospital provides few, if any, clinical services not typically provided by general acute care hospitals.

Availability of Community Services

West Suburban Medical Center is a primary provider of both hospital- and community-based health care programs in its community, and it is the intent of the acquiring co-applicants to provide a very similar community-based program complement, understanding that in the case of all hospitals, the complement of community programs is not static, and that from time-to-time programs are added or eliminated. Due in major part to the broad scope of community programs and services currently provided, the acquiring co-applicants have not at this time identified additional programs to be offered, though it is fully anticipated that additional programs will be identified following the change of ownership.

The community will continue to be made aware of programs offered by the hospital through a variety of avenues, including hospital publications, local newspapers, public service announcements, information provided in physicians' offices, and information provided to patients by staff.

Below is a list of community programs currently offered by West Suburban Medical Center, and as of the writing of this document, it is not the intent of the acquiring co-applicants to eliminate any of these programs.

- sponsoring and participation in 24 area health fairs

- "Simple Steps to Fitness" program, focusing on diabetes, heart disease, obesity, and hypertension
- community walks with screenings
- School of Nursing
- Family Medicine Residency Program
- Internal Medicine residency program
- dietician visits to 12 elementary schools to discuss emotional and physical care
- prostate screenings and educational programs
- "Just for You" women's health event
- free month of mammograms
- geriatric depression program
- community education programs on stroke prevention, diabetes management, and healthy
- free fitness assessments
- "Family Birthplace", through which bilingual prenatal programs are provided on breastfeeding, infant and child CPR and sibling harmony
- post-partum infant follow-up program
- infant car seat program
- hosted numerous community meetings, including: Alcoholic's Anonymous, Alliance to End Homelessness, Catholic Health Association of India, Narcotic's Anonymous, Proviso Children's Advocacy Center, Recovery education for the Family and Sara's Inn
- senior programming focusing on cholesterol, healthy living, diabetes, osteoporosis, and fall prevention
- SIDS prevention program
- Westlake Medical Associates community clinic
- language assistance programs
- participation in the community welcome center for new immigrants
- organized tours for school groups
- school supply and clothing drive
- blood drive
- scholarship program in conjunction with Triton Community College
- internships and mentoring programs for students interested in nursing, radiology, physical therapy and health ministry

TRANSFER AGREEMENT
BY AND BETWEEN
CHILDREN'S MEMORIAL HOSPITAL AND

THIS TRANSFER AGREEMENT (this "Agreement") is entered into as of the first day of August, 2004, by and between Children's Memorial Hospital, an Illinois non-profit corporation ("Receiving Hospital") and West Suburban Medical Center, an Illinois not for profit corporation ("Transferring Facility") (each a "Party" and collectively "Parties").

WHEREAS, Transferring Facility owns and operates a general acute care hospital;

WHEREAS, Receiving Hospital owns and operates a general acute hospital and ancillary facilities specializing in pediatric care;

WHEREAS, Transferring Facility receives from time to time patients who are need of specialized services not available at Transferring Facility;

WHEREAS, the Parties are legally separate organizations and are not related in any way to one another through common ownership or control; and

WHEREAS, the Parties desire to establish a transfer arrangement in order to assure continuity of care for patients and to ensure accessibility of services to patients.

NOW, THEREFORE, for and in consideration of the terms, conditions, covenants, agreements and obligations contained herein, and for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, it is hereby mutually agreed by the Parties as follows:

ARTICLE I.

Patient Transfers

1.1. Acceptance of Patients. Upon recommendation of an attending physician and pursuant to the provisions of this Agreement, Receiving Hospital agrees to admit a patient as promptly as possible, provided customary admission requirements are met, State and Federal laws and regulations are met, and Receiving Hospital has the capacity to treat the patient. Notice of the transfer shall be given by Transferring Facility as far in advance as possible. Receiving Hospital shall give prompt confirmation of whether it can provide health care appropriate to the patient's medical needs. Receiving Hospital agrees to exercise its best efforts to provide for prompt admission of transferred patients and, to the extent reasonably possible under the circumstances, give preference to patients requiring transfer from Transferring Facility.

1.2. Appropriate Transfer. It shall be Transferring Facility's responsibility to arrange for appropriate and safe transportation and to arrange for the care of the patient during a transfer. The Transferring Facility shall ensure that the transfer is an "appropriate transfer" under the Emergency Medical Treatment and Active Labor Act, as may be amended ("EMTALA"), and is carried out in accordance with all applicable laws and regulations. The Transferring Facility

shall provide in advance sufficient information to permit a determination as to whether the Receiving Hospital can provide the necessary patient care. The patient's medical record shall contain a physician's order transferring the patient. When reasonably possible, a physician from the Transferring Facility shall communicate directly with a physician from the Receiving Hospital before the patient is transferred.

1.3. Transfer Log. The Transferring Facility shall keep an accurate and current log of all patients transferred to the Receiving Hospital and the disposition of such patient transfers.

1.4. Admission to the Receiving Hospital from Transferring Facility. When a patient's need for admission to a center specialized in pediatric care is determined by his/her attending physician, Receiving Hospital shall admit the patient in accordance with the provisions of this Agreement as follows:

(a) Patients determined to be emergent by the attending physician shall be admitted, subject to bed, space, qualified personnel and equipment availability, provided that all usual conditions of admission to Receiving Hospital are met.

(b) All other patients shall be admitted according to the established routine of Receiving Hospital.

1.5. Standard of Performance. Each Party shall, in performing its obligations under this Agreement, provide patient care services in accordance with the same standards as services provided under similar circumstances to all other patients of such Party, and as required by federal and state laws and Medicare/Medicaid certification standards. Each Party shall maintain all legally required certifications and licenses from all applicable governmental and accrediting bodies, and shall maintain full eligibility for participation in Medicare and Medicaid. Receiving Hospital shall maintain accreditation by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO").

1.6. Billing and Collections. Each Party shall be entitled to bill patients, payors, managed care plans and any other third party responsible for paying a patient's bill, for services rendered to patients by such Party and its employees, agents and representatives, and neither Party will have any liability to the other Party for such charges. Each Party shall be solely responsible for all matters pertaining to its billing and collection of such charges. The Parties shall reasonably cooperate with each other in the preparation and completion of all necessary forms and documentation and the determination of insurance coverage and managed care requirements for each transferred patient. Each Party shall have the sole final responsibility for all forms, documentation, and insurance verification.

1.7. Personal Effects. Personal effects of any transferred patient shall be delivered to the transfer team or admissions department of the Receiving Hospital. Personal effects include money, jewelry, personal papers and articles for personal hygiene.

ARTICLE II.

Medical Records

Subject to applicable confidentiality requirements, the Parties shall exchange all information which may be necessary or useful in the care and treatment of the transferred patient or which may be relevant in determining whether such patient can be adequately cared for by the other Party. All such information shall be provided by the Transferring Facility in advance, where possible, and in any event, at the time of the transfer. The Transferring Facility shall send a copy of all patient medical records that are available at the time of transfer to the Receiving Hospital. Other records shall be sent as soon as practicable after the transfer. The patient's medical record shall contain evidence that the patient was transferred promptly, safely and in accordance with all applicable laws and regulations. Each Party shall and shall cause its employees and agents to protect the confidentiality of all patient information (including, but not limited to, medical records, electronic data, radiology films, laboratory blocks, slides and billing information), and comply with all applicable state and federal laws and regulations protecting the confidentiality of patients' records, including the Health Insurance Portability and Accountability Act of 1996 and the corresponding Standards for Privacy of Individually Identifiable Health Information regulations.

ARTICLE III.

Term and Termination

3.1. Term. This Agreement shall be effective as of the day and year written above and shall remain in effect until terminated as provided herein.

3.2. Termination. This Agreement may be terminated as follows:

(a) Termination by Mutual Consent. The Parties may terminate this Agreement at any time by mutual written consent, and such termination shall be effective upon the date stated in the consent.

(b) Termination Without Cause. Either Party may terminate this Agreement, without cause, upon thirty (30) days prior written notice.

(c) Termination for Cause. A Party shall have the right to immediately terminate this Agreement for cause upon the happening of any of the following:

(i) If such Party determines that the continuation of this Agreement would endanger patient care.

(ii) Violation by the other Party of any material provision of this Agreement, provided such violation continues for a period of fifteen (15) days after receipt of written notice by the other Party specifying such violation with particularity.

(iii) A general assignment by the other Party for the benefit of creditors; the institution by or against the other Party, as debtor, of proceedings of any nature under any law of the United States or any state, whether now existing or currently enacted or amended, for the relief of debtors, provided that in the event such proceedings are instituted against the other Party remain unstayed or undismissed for thirty (30) days; the liquidation of the other Party for any reason; or the appointment of a receiver to take charge of the other Party's affairs, provided such appointment remains undischarged for thirty (30) days. Such termination of the provisions of this Agreement shall not affect obligations which accrued prior to the effective date of such termination.

(iv) Exclusion of either Party from participation in the Medicare or Medicaid programs or conviction of either Party of a felony.

(v) Either Party's loss or suspension of any certification, license, accreditation (including JCAHO or other accreditation as applicable), or other approval necessary to render patient care services.

ARTICLE IV.

Non-Exclusive Relationship

This Agreement shall be non-exclusive. Either Party shall be free to enter into any other similar arrangement at any time and nothing in this Agreement shall be construed as limiting the right of either Party to affiliate or contract with any other hospital, nursing home, home health agency, school or other entity on either a limited or general basis while this Agreement is in effect. Neither Party shall use the other Party's name or marks in any promotional or advertising material without first obtaining the written consent of the other Party.

ARTICLE V.

Certification and Insurance

5.1. Licenses, Permits, and Certification. Each Party represents to the other that it and all of its employees, agents and representatives possess and shall maintain in valid and current status during the term of this Agreement all required licenses, permits and certifications enabling such Party to provide the services set forth in this Agreement.

5.2. Insurance. Both Parties shall, at their own cost and expense, obtain and maintain in force during the term of this Agreement appropriate levels of general and professional liability insurance coverage, in accordance with good business practice for acute-care hospitals in the Chicagoland area. Such insurance shall be provided by insurance company(ies) acceptable to Parties and licensed to conduct business in the State of Illinois or by a self-insurance program. Verification of insurance shall be in the possession of both Parties at all times while this Agreement is in effect. Both Parties shall be notified at least thirty (30) days prior to cancellation, notice of cancellation, reduction, or material change in coverage to either policy. In

the event the form of insurance is claims made, both Parties warrant and represent that they will purchase appropriate tail coverage for claims, demands, or actions reported in future years for acts of omissions during the term of this Agreement. In the event of insufficient coverage as defined in this Section, or lapse of coverage, the non-breaching Party reserves the right to immediately and unilaterally terminate this Agreement.

5.3. Notification of Claims. Each Party shall notify the other in writing, by certified mail, of any action or suit filed and shall give prompt notice of any claim made against either by any person or entity which may result in litigation related in any way to this Agreement.

ARTICLE VI.

Indemnification

Each Party shall indemnify and hold harmless the other Party from and against any and all manner of claims, demands, causes of action, liabilities, damages, costs, and expenses (including costs and reasonable attorney's fees) arising from or incident to the performance of such indemnifying Party's duties hereunder, except for negligent or willful acts or omissions of the other Party. Notwithstanding anything to the contrary, a Party's obligations with respect to indemnification for acts described in this article shall not apply to the extent that such application would nullify any existing insurance coverage of such Party or as to that portion of any claim of loss in which insurer is obligated to defend or satisfy.

ARTICLE VII.

Compliance With Laws

At all times, both Parties shall comply with all federal, state and local laws, rules and regulations now in effect or later adopted relating to the services to be provided hereunder and that may be applicable to the Parties including, but not limited to, laws, rules and regulations regarding confidentiality, disclosure and retention of patient records, such as the regulations promulgated under the Health Insurance Portability and Accountability Act of 1996. A Party shall promptly notify the other Party if it receives notice of any actual or alleged infraction, violation, default or breach of the same. Neither Transferring Facility or Receiving Hospital, nor any employee, officer, director or agent thereof, is an "excluded person" under the Medicare rules and regulations.

As of the date hereof and throughout the term of this Agreement: (a) Transferring Facility represents, warrants and covenants to Receiving Hospital that Transferring Hospital is licensed to operate a general acute care hospital in Illinois and is a participating facility in Medicare and Medicaid; and (b) Receiving Hospital represents, warrants and covenants to Transferring Facility that Receiving Hospital is licensed to operate a general acute hospital and ancillary facilities specializing in pediatric care and to participate in Medicare and Medicaid.

ARTICLE VIII.

Miscellaneous

8.1. Non-Referral of Patients. Neither Party is under any obligation to refer or transfer patients to the other Party and neither Party will receive any payment for any patient referred or transferred to the other Party. A Party may refer or transfer patients to any facility based on the professional judgment of the treating physician and the individual needs and wishes of the patients.

8.2. Relationship of the Parties. The Parties expressly acknowledge that in performing their respective obligations under this Agreement, they are each acting as independent contractors. Transferring Facility and Hospital are not and shall not be considered joint venturers or partners, and nothing herein shall be construed to authorize either Party to act as general agent for the other. Neither Party, by virtue of this Agreement, assumes any liability for any debts or obligations of either a financial or legal nature incurred by the other Party. Each Party shall disclose in its respective dealings that they are separate entities.

8.3. Notices. All notices and other communications under this Agreement shall be in writing and shall be deemed received when delivered personally or when deposited in the U.S. mail, postage prepaid, sent registered or certified mail, return receipt requested or sent via a nationally recognized and receipted overnight courier service, to the Parties at their respective principal office of record as set forth below or designated in writing from time to time. No notice of a change of address shall be effective until received by the other Party.

To Receiving Hospital:

Children's Memorial Hospital
2300 Children's Plaza
Chicago, IL 60614
Attention: Gordon Bass, COO
Fax No.: (773) 880-4126

To Transferring Facility:

Jay E. Kreuzer, CEO
West Suburban Medical Center
3 Erie Court
Oak Park, IL 60302

With a copy to:

Jeannie Carmedelle Frey, Esq.
Senior Vice President
Legal Affairs/General Counsel
Resurrection Health Care
7435 West Talcott Avenue

Chicago, IL 60631
(773) 792-5875 (fax)

8.4. Assignment. Neither Party may assign its rights or delegate its obligations under this Agreement without the prior written consent of the other, except that either Party may assign all or part of its rights and delegate all or part of its obligations under this Agreement to any entity controlled by or under common control with such Party.

8.5. Entire Agreement; Amendment. This Agreement contains the entire agreement of the Parties with respect to the subject matter hereof and may not be amended or modified except in a writing signed by both Parties. All continuing covenants, duties, and obligations contained herein shall survive the expiration or termination of this Agreement.

8.6. Governing Law. This Agreement shall be construed and all of the rights, powers and liabilities of the Parties hereunder shall be determined in accordance with the laws of the State of Illinois; provided, however, that the conflicts of law principles of the State of Illinois shall not apply to the extent that they would operate to apply the laws of another state.

8.7. Headings. The headings of articles and sections contained in this Agreement are for reference purposes only and will not affect in any way the meaning or interpretation of this Agreement.

8.8. Non-discrimination. Neither Party shall discriminate against any individuals on the basis of race, color, sex, age, religion, national origin, or disability in providing services under this Agreement.

8.9. Severability. If any provision of this Agreement, or the application thereof to any person or circumstance, shall be held to be invalid, illegal or unenforceable in any respect by any court or other entity having the authority to do so, the remainder of this Agreement, or the application of such affected provision to persons or circumstances other than those to which it is held invalid or unenforceable, shall be in no way affected, prejudiced or disturbed, and each provision of this Agreement shall be valid and shall be enforced to the fullest extent permitted by law.

8.10. Successors and Assigns. This Agreement shall be binding upon, and shall inure to the benefit of the Parties hereto, their respective successors and permitted assigns.

8.11. Waiver. No failure by a Party to insist upon the strict performance of any covenant, agreement, term or condition of this Agreement, shall constitute a waiver of any such breach of such covenant, agreement, term or condition. Any Party may waive compliance by the other Party with any of the provisions of this Agreement if done so in writing. No waiver of any provision shall be construed as a waiver of any other provision or any subsequent waiver of the same provision.

8.12 Counterparts. This Agreement may be executed in any number of counterparts, each of which shall be deemed an original, but all such counterparts together shall constitute one and the same instrument.

IN WITNESS WHEREOF, the Parties have caused this Agreement to be executed and delivered as of the day and year written above.

West Suburban Medical Center
an Illinois not for profit corporation

By: Jay E. Kreuzer

Name: Jay E. Kreuzer

Title: Executive Vice President/CEO

CHILDREN'S MEMORIAL HOSPITAL

By: Tom Schubnell MHSA

Name: Tom Schubnell

Title: Administrator of Surgical & ER Services

ATTACHMENT 18C

PATIENT TRANSFER AGREEMENT
WEST SUBURBAN HOSPITAL MEDICAL CENTER
PEDIATRIC CRITICAL CARE CENTER

This Agreement is made and is effective as of the 1st day of September, 2003 by and between Children's Memorial Hospital ("Children's Memorial"), 2300 Children's Plaza, Chicago, IL 60614 and West Suburban Hospital Medical Center ("West Suburban Hospital"), 3 Erie Court, Oak Park, IL 60302.

WHEREAS, West Suburban Hospital has submitted an application to the Illinois Department of Public health ("IDPH") for recognition as a Pediatric Critical Care Center ("PCCC"); and

WHEREAS, in connection with the recognition of West Suburban Hospital as a PCCC by IDPH, West Suburban Hospital desires to enter into this transfer agreement to assure continuity of care and treatment appropriate for critically ill Pediatric patients whose medical or surgical condition requires specialized treatment modalities unavailable at West Suburban Hospital.

NOW THEREFORE, in consideration of the mutual promises and covenants contained herein, Children's Memorial and West Suburban Hospital hereby agree as follows:

1. When it is determined that a West Suburban Hospital patient will benefit from a higher level Pediatric Intensive Care ("tertiary care"), and when a Children's Memorial physician accepts transfer of a West Suburban Hospital patient, then Children's Memorial agrees to accept such a patient transfer as promptly as possible provided transfer requirements are met and adequate staff and bed space to accommodate such a patient are available.

2. When it is determined by a Children's Memorial physician that the West Suburban Hospital patient no longer requires tertiary care, then West Suburban Hospital agrees to accept the transfer back of the West Suburban Hospital patient. This transfer will occur as promptly as possible pending the acceptance of the transfer by a West Suburban Hospital physician and the availability of adequate staff and bed space to accommodate the patient.

3. The parties agree to devote their best efforts to promoting cooperation and effective communication between the parties in rendering services hereunder, to foster the prompt and effective evaluation, treatment and continuing care of recipients of these services.

4. The parties agree that the services provided by each party in connection with this Agreement will be provided in conformity with all applicable federal, state and local laws, standards, rulings, or regulations, including, but not limited to, the emergency Medical Treatment and Active Labor Act (EMTALA). This shall also include the obligation to comply with all State of Illinois and federal laws and regulations governing

the confidentiality and release of patient medical record and health information, including, but not limited to, the privacy standards of the Privacy Rules under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the regulations promulgated thereunder. In connection with HIPAA compliance, the parties agree to negotiate and execute an agreement, as business associates, with respect to the exchange of protected health information of patients receiving services from either party, in substantially the form attached hereto as Attachment B, by April 14, 2003. The parties also agree to comply with the accreditation standards of the Joint Commission on Accreditation of healthcare Organizations ("JCAHO").

5. Charges for services performed by either institution in connection with this Agreement shall be collected by the institution rendering such services directly from the patient, third party payor or other sources normally billed by the institution. Neither party shall have any liability to the other party for such charges.

6. Each party acknowledges the non-exclusive nature of the Agreement, and nothing in this Agreement shall be construed as limiting the right of either party to contract under similar agreements with any other institution while this Agreement is in effect.

7. The relationship between Children's Memorial and West Suburban Hospital shall be that of independent contractors. The governing body of each institution shall have exclusive control of policies, management, assets and affairs of its respective institution. Each party will maintain professional and general liability insurance as will fully protect it from any and all claims of any nature for damage to property or from personal injury including death, made by anyone which may arise from operations carried on by either party under this Agreement, or from the acts or omissions of any of their respective officers, directors, employees or agents. Such insurance shall be maintained at such minimum levels as are determined to be mutually acceptable. In the event that such insurance is not on an "occurrence basis" and is cancelled or terminated, the party canceling or terminating such insurance shall at all times, including without limitation, after the expiration and termination of this Agreement for any reason, maintain continuing insurance coverage for such cancelled policy of insurance through the purchase of "prior acts" coverage with a subsequent policy of insurance, which provides for a retroactive date of coverage equal to the retroactive date of the insurance policy that was canceled or terminated, the purchase of an extended reporting endorsement or "tail coverage" for the policy that was canceled or terminated, or such other method which assures continuing coverage. Each party shall provide the other party with a certificate of insurance or other reasonable evidence that the insurance coverage requirements of this Agreement have been met. Such evidence shall be provided upon the execution of this Agreement, and thereafter in the event of any modification or change in coverage, or upon the other party's request. Each party shall notify the other party, in writing, at least thirty (30) days prior to cancellation, modification or non-renewal of its liability coverage. Each party shall notify the other in writing within fifteen (15) days after any notice is received of cancellation or non-renewal of its liability coverage.

8. The parties agree to assume the risk of liability for and to indemnify and hold each other and their respective officers, agents and employees harmless from and against all claims, causes of action, damages, suits, judgments, liabilities, losses, and expenses, including damages for the death of any person or persons and damages to any property ("Losses"), resulting from, arising out of, or connected with the negligent acts or omissions of their respective employees or agents. This covenant shall survive any termination of this Agreement.

9. The term of the Agreement shall be one year from the date of execution, and shall automatically renew for successive one (1) year periods, thereafter unless terminated as follows: i) either party may terminate this Agreement at any time, without cause, with ninety (90) days advance written notice to the other party; ii) either party provides notice to the other party that the other party has materially defaulted in the performance of any obligation under this Agreement, and other party fails to cure such default within thirty (30) days following the receipt of such written notice, or such other longer time as may be mutually agreed to by the parties in writing. Any such notice of default shall include a reasonable description or explanation of the nature of the default. All notices, requests, demands, and other communications required or permitted hereunder shall be in writing and shall be deemed to have been duly delivered ten (10) days after date of mailing via regular mail, or sooner upon presentation of adequate proof of earlier delivery, if delivered in person or if sent via overnight courier or by registered, or certified, first class mail, postage prepaid. Notices shall be sent to the signatories to this Agreement, with a copy to the Pediatric Intensive Care Medical Director at the respective institutions.

10. This Agreement shall automatically terminate without regard to notice upon the date that either party to this Agreement: a) ceases to have a valid provider agreement with the Secretary of the Department of Health and Human Services; b) fails to renew, has suspended, or revoked its State license to operation as an acute care hospital in Illinois; or c) either party dissolves or ceases its operations as an acute care hospital in the State of Illinois or files a petition in bankruptcy or is adjudicated bankrupt.

11. In providing services under this Agreement, each party agrees not to discriminate on the basis of race, color, sex, age, religion, national origin, handicap or any other legally prohibited factor.

12. This Agreement constitutes the entire agreement between the parties hereto, and there are no representations, warranties, or prior understandings except as expressly set forth herein. Neither this Agreement nor any term or provision hereof may be changed, waived, discharged, terminated or otherwise modified, except in writing executed with the same formalities as this Agreement. This Agreement shall be deemed to have been made and shall be construed and interpreted in accordance with the laws of the State of Illinois.

13. Neither party to this Agreement may assign any of the rights or obligations under this Agreement without the express written consent of the other party. Any attempt to assign this Agreement without consent shall be void.

14. The waiver by any party of a breach or violation of any provision of this Agreement shall not operate as, or be construed to be, a waiver of any subsequent breach of the same or other provisions.

15. If any provision of this Agreement, or the application of such provision to any person or circumstance, shall be held invalid, the remainder of this Agreement or the application of such provision to any person or circumstance other than those to which it is held invalid, shall not be affected thereby, each of such provisions being severable in any such instance.

IN WITNESS WHEREOF, this Agreement has been executed by the parties on the date first written above.

FOR WEST SUBURBAN HOSPITAL MEDICAL CENTER

Signature
Name Printed: Jay Kreuzer
Title: President & CEO
Date: 8/20/03

FOR CHILDREN'S MEMORIAL HOSPITAL

Signature
Name Printed: Patrick M. Magoon
Title: President & CEO
Date: 9/8/03

NORTHWESTERN PERINATAL CENTER
AFFILIATION AGREEMENT
Level II

I. Introduction

In November of 1974 the Department of Public Health, State of Illinois, designated the McGaw Medical Center of Northwestern University, hereinafter referred to as the "Center," as a regional perinatal center. The Northwestern Perinatal Center is composed of the following Level III institutions:

(1) Prentice Women's Hospital of Northwestern Memorial Hospital;

(2) Evanston Women's Hospital of Evanston Northwestern Healthcare; and

(3) Children's Memorial Medical Center.

It is the goal of the Center to provide quality maternal-fetal and neonatal care services to the families in the Center's region of responsibility. It is the Center's belief that it can best affect the quality of perinatal outcomes by providing leadership within the framework of a regionally integrated system of perinatal services designed to maximize outcomes and to promote appropriate use of services and resources. Facilitating the recognition of high-risk conditions and perinatal consultation, referral, or transfer are important to improve outcomes. It is further recognized that perinatal services must be provided in an environment which is both professionally challenging to those who chose to serve in this area, as well as cost-effective in its delivery for the benefit of all involved.

Subchapter I: Part 640 of the ADOPTED RULES OF THE ILLINOIS DEPARTMENT OF PUBLIC HEALTH - REGIONALIZED PERINATAL HEALTH CARE CODE (77 Ill. Adm. Code 640) hereinafter referred to as the "Illinois Rules," and the CITY OF CHICAGO HOSPITAL REGULATIONS FOR MATERNITY AND NEWBORN NURSING DIVISIONS, hereinafter referred to as the "Chicago Regulations," require letters of agreement between the Perinatal Center and each Affiliated Referral Hospital. As part of this letter of agreement both the Perinatal Center and Affiliated Referral Hospital agree to abide by the Illinois Rules and the Chicago Regulations appropriate for its respective level of care.

The Northwestern Perinatal Center, representing the institutions of Northwestern Memorial Hospital, Evanston Hospital, and Children's Memorial Medical Center, has agreed to enter into this Affiliation Agreement with West Suburban Medical Center.

II. Definitions

A. The Definitions contained in the Section 640.20 of the Illinois Rules dated August 2000 and the Chicago Regulations dated November 2000 apply to this Affiliation Agreement and to the activities of the Northwestern Perinatal Network. The definitions described above are attached to and made a part of the Affiliation Agreement. All references in this Affiliation Agreement to either the Illinois Rules or the Chicago Regulations are for the dates mentioned above.

B. Center. The Northwestern Perinatal Center includes the campuses of the three designated Level III institutions which are: the Prentice Women's Hospital of Northwestern Memorial Hospital; the Evanston Women's Hospital of Evanston Northwestern Healthcare; and the Children's Memorial Medical Center. By definition, each of these separate campuses of the Northwestern Perinatal Center must meet the requirements for Level III designation.

C. Directors of the Center. The Center Directors are the maternal-fetal medicine subspecialist and neonatologist who have been designated by the Chairman of the Department of Obstetrics and Gynecology and the Chairman of the Department of Pediatrics at the Northwestern University Medical School.

D. Referral Hospital. Each individual hospital which formally affiliates with the Center by execution of an Affiliation Agreement, including West Suburban Medical Center.

E. Network. The Northwestern Perinatal Network shall include the three Level III institutions that comprise the Center and all of the Referral Hospitals.

F. Perinatal Center Executive Committee (PEC). A committee composed of individuals representing the areas of Obstetrics, Pediatrics, Nursing, and Hospital Administration from the three designated Level III hospitals of the Center.

G. Regional Quality Council (RQC). A council composed of at least one individual from each hospital, health departments, and organization within the Network. The Regional Quality Council reports to the Perinatal Center Executive Committee and is responsible for the implementation of a network continuous quality improvement program as defined by the Illinois Department of Public Health/Statewide Quality Council.

H. Network Nursing Leadership. A regional perinatal management group consisting of nursing leadership representatives from each hospital and service

related agency and organization within the Network. The Network Nursing Leadership provides a forum for communication, education and collaboration in the establishment of Network priorities for system support activities and resources.

III. Northwestern Perinatal Center Organization

A. The Northwestern Perinatal Center shall have a Perinatal Center Executive Committee which will be responsible for the overall operations of the Network.

1. The Perinatal Center Executive Committee shall be composed of no more than twelve (12) voting members, four (4) members from each of the respective Level III institutions. The four (4) members from each institution shall be appointed by that institution, and shall represent the areas of Maternal-Fetal Medicine, Neonatology, Nursing, and Hospital Administration. The four (4) members of Children's Memorial may include two pediatricians. The Administrative Coordinator of the Center shall also serve as ex-officio members of the Committee.

2. The chairman of the Perinatal Center Executive Committee shall be one of the Directors of the Center.

3. The Perinatal Center Executive Committee shall at the Committee's discretion form subcommittees as appropriate representing the areas of Obstetrics, Pediatrics, Nursing, and Hospital Administration. Each subcommittee should be responsible to the Perinatal Center Executive Committee for issues that fall within their respective area of expertise.

4. The committee shall meet annually and as needed.

B. An Administrative Coordinator, reporting jointly to the Directors of the Center, shall be responsible for ensuring coordination of all Network related activities.

1. Each of the Level III institutions will designate an Outreach Education Coordinator who will be responsible for: coordinating the flow of perinatal information from and to that institution; maintaining a transport database; facilitating review of all perinatal mortalities; as well as educational and quality improvement activities.

2. The Administrative Coordinator shall be responsible for all fiscal activities related to the administration of the State of Illinois Perinatal Agreement.

C. The Northwestern Perinatal Center shall have a Regional Quality Council (RQC) responsible for implementation of a network continuous quality improvement program as defined by the Illinois Department of Public Health/Statewide Quality Council.

1. The Regional Quality Council shall be composed of at least one individual from each hospital, health department, and organization within the Network.

2. The co-chairmen of the Regional Quality Council shall be appointed by the Perinatal Center Executive Committee and shall represent the specialties of maternal-fetal medicine and neonatology.

3. The Regional Quality Council shall meet quarterly and as needed.

D. The Northwestern Perinatal Center shall have a network Nursing Leadership Group for the purpose of communication, education, and the planning and evaluation of network programs and services.

1. The Network Nursing Leadership Group will be composed of nursing leadership representatives from each hospital, health department agency, and organization within the Network.

2. The Network Nursing Leadership Group will meet quarterly and as needed.

IV. Perinatal Center Clinical Services

A. Maternal and Neonatal Transport

1. Each of the three Level III institutions of the Northwestern Perinatal Center provide maternal and/or neonatal transport systems 24 hours a day, 7 days a week. These systems are accessed through the obstetrical or neonatal hotlines at each of the Level III institutions. All tertiary-based transport teams have education, orientation, and certification processes.

2. The Northwestern Perinatal Center is responsible for providing transport of all medically eligible perinatal patients requiring care at a Level III facility and must assure that appropriate personnel attend patients during transport. Medical eligibility will be determined by the Perinatal Center with decisions relating to transports being made collaboratively based upon the clinical judgments of the referring and receiving physicians. Should the Perinatal Center not be able to accept a Network patient for transport because of a lack of beds (obstetrical or neonatal),

the Center assumes responsibility for placing that patient at another facility capable of providing the appropriate level of care.

3. Transportation of the patient remains the responsibility of the accepting Level III. Decisions regarding composition of a transport team and mode of transport will be determined collaboratively by the receiving and referring physicians and nurses. Transport team members may include paramedics, nurses, and physicians.

4. Written protocols for the mechanism of transport will be distributed by the Perinatal Center to the Referral Hospital.

5. The Center will transfer patients back to the referring hospital as soon as medically feasible. All decisions will be made collaboratively by referring and receiving physicians.

B. Referral Services

1. The three tertiary centers of the Northwestern Perinatal Center each have complete genetic services including counseling, diagnostic procedures, laboratory research, and follow-up. Counseling and diagnostics are available preconception through adulthood. Genetics consultations and services are available to all network hospitals and professionals daily and via obstetric hotline for emergencies.

2. Patients with a prenatal diagnosis of a fetal anomaly are cared for in special programs located at Evanston Hospital and Prentice Women's Hospital. Women with a suspected or confirmed diagnosis of intrauterine anomaly may be referred from community hospitals into one of the two tertiary center programs. The Evanston Hospital program provides evaluation and care of the patient with suspected or diagnosed anomalies utilizing a team approach that includes maternal-fetal medicine, genetic counseling, neonatology, Perinatal Family Support services, and various pediatric sub-specialists. Professionals from Prentice Women's Hospital and Children's Memorial Hospital combine to form a Fetal Assessment and Intervention Team that meets monthly at Prentice. The Team consists of maternal-fetal medicine; neonatology; pediatric sub-specialties such as pediatric neurosurgery, pediatric surgery, pediatric urology, and pediatric cardiology; obstetric and pediatric ultrasound; social service; nursing; chaplain services; neonatal and infant developmental follow-up services; and psychiatry. Families with fetal anomalies are provided with coordinated and comprehensive services through this team.

C. Follow-up

1. Follow-up is available for selected high-risk infants through comprehensive Developmental Services at Prentice, Evanston and Children's Memorial Hospital. Specific developmental strengths and weaknesses are delineated for parents and referrals to community early intervention programs are made when necessary. The Center makes all appropriate referrals to the Early Intervention Medical Diagnostic Network Discharge from Developmental Follow-up is determined jointly by staff and parents when the child is appropriately placed academically and has no need of further service.

2. The Center, in compliance with Illinois Rules, refers all high risk perinatal patients to the Illinois Department of Public Health as well as the local health agency to insure that those patients are assessed at appropriate intervals, receive intervention as needed, and are referred for needed support services. This is done through the Adverse Pregnancy Outcome Reporting System (neonatal) and the Perinatal Tracking Program (maternal). A Maternal Discharge Record is filed for each high-risk pregnant or post-partum patient treated in the tertiary centers. A High Risk Infant Discharge Record is filed for each high-risk infant treated in the centers. The local health department or other designated local health agency providing follow-up services to high risk pregnant post partum women and to high-risk infants prepare a Follow-up Report which is submitted to IDPH with a copy to the tertiary center. Monthly reports are compiled by IDPH listing all hospital referrals to each health department/agency.

V. Perinatal Network Communication

A. The Maternal-Fetal Medicine Director of the Center will oversee:

1. The maintenance of 24-hour obstetric hotlines—

847/570-2230 at Evanston Hospital
312/472-0953 at Prentice Women's Hospital

for immediate consultation, referral, and transport of obstetric patients;

2. The prompt verbal and/or written communication regarding patient management and outcome from the Center Maternal-Fetal Medicine Subspecialist who cared for the patient to the referring physician at his/her office, if available.

B. The Neonatal Director of the Center will oversee:

1. The maintenance of 24-hour neonatal hotlines—

800/540-4131 (Transport) at Children's Memorial Hospital
773/880-3940 (Consults) at Children's Memorial Hospital
847/570-2244 at Evanston Hospital
312/472-1002 at Prentice Women's Hospital

for immediate consultation, referral, and transport of neonatal patients;

2. The prompt sending of patient management and outcome information from the Perinatal Center Neonatologist who cared for the patient to the primary care physician at his/her office, if available.

C. While the Center physicians will endeavor to keep the referring physician informed concerning the continuing progress of transferred/transported patients, the referring physician is encouraged to call the Center frequently to check on interim developments.

VI. Perinatal Center Financial Operations

A. Program Costs

1. The Administrative Coordinator of the Center will be responsible for developing an operating budget on an annual basis associated with the direct operating expenses for the Center-wide program. This operating budget will include such expenses as cost of personnel (both administrative and secretarial), data collection and processing, educational programming, and other costs that may be essential to the operation of the Northwestern Perinatal Center. The fiscal year for the Center shall be from July 1st through June 30th.

2. The Center and Referral Hospital may agree to additional services. Costs for these services will be negotiated between the Center and the Referral Hospital. A written and signed addendum to this agreement will be added for these services.

3. The cost of programs such as an annual meeting, educational seminars, and special projects will be covered by the Center to the extent possible. Minimal fees will be charged to participating individuals/institutions from the Network to help defray the costs. Educational programs that do not have sufficient participation to cover the cost of the program may, at the discretion of the presenting party, be canceled for "lack of funds."

B. Grants, Contracts, and Research Costs

All Network institutions are encouraged but not required to submit grant proposals to state, local, and national agencies to undertake research endeavors on behalf of the Center. In conjunction with the granting agency's request, these monies will be exclusively used for the research protocol to which they have been approved. Grants or research proposals submitted on behalf of the Center or which utilize multiple hospital resources (e.g., patients, data, etc.) of the Center will require the prior approval of the Perinatal Center Executive Committee.

VII. Perinatal Center Education Services

A. Medical Educational Services

Medical education is an integral component of the Joint Mortality and Morbidity Reviews provided by the Center. The Center will make every effort to respond to all additional requests for medical education.

B. Nursing Educational Services

The Center will establish, coordinate and maintain a yearly calendar of educational programming for perinatal nurses including those at Network hospitals including courses on basic fetal monitoring, breastfeeding support, neonatal resuscitation, high risk maternal and neonatal assessment and stabilization for transport. Additional programming will be planned in response to educational needs assessments by the Center. A tuition fee may be charged to participants so that course will be financially self-sustaining.

VIII. Joint Mortality and Morbidity Reviews

A. The Center will conduct quarterly Joint Mortality and Morbidity Review Conferences ("Joint M&M Review") with each Referral Hospital. The Center will collaborate with the Referral Hospital to establish the format and schedule for the Reviews. Modifications in the quarterly schedule may be made jointly by the Perinatal Center and referral hospital.

B. The Joint M&M Review shall include selected perinatal mortality and transport cases for the purpose of communication, education, and quality improvement. A maternal-fetal medicine subspecialist, a neonatologist, and a perinatal nurse will attend from the Center. Review shall include a determination of the appropriateness of risk assessment,

diagnosis and the adequacy of procedures to prevent disabilities or loss of life. Both system logistics and clinical management will be discussed.

C. The Center will provide periodic institutional and Network data comparison reports, including a synopsis of perinatal mortalities and attributable factors, to be used as a basis for establishing priorities to improve maternal and neonatal outcomes.

D. Except for submissions to the Regional and Statewide Quality Councils, the Center will share no Referral Hospital's statistical data or patient review information with any other institution or agency, except on an anonymous de-identified basis, unless otherwise authorized by the Referral Hospital in writing.

E. Referral Hospitals may request data reports regarding their institution from the Center.

IX. Referral Hospital Obligations

A. The Referral Hospital will be responsible for communication of the conditions of this Letter of Agreement to all appropriate professional and administrative staff.

B. The Referral Hospital Physicians will utilize the "hot-line system" established by the Center for consultation, referral, and transport.

C. The Referral Hospital physicians will, within a reasonable time frame after identification of the condition, consult and/or transfer to the Center obstetrical and neonatal patients who require the services of the Center, including but not limited to, patients outlined in the Illinois Rules and attached Addendum I: Patient Care Services.

D. The Referral Hospital will accept all medically eligible obstetrical/neonatal patients for return transport subject to bed, space, qualified personnel and equipment availability and provided all usual conditions for return are met. Medical eligibility will be determined jointly by transferring and receiving physician.

E. The Referral Hospital staff will participate in the quarterly Joint Morbidity and Mortality Review Conference. Written case summaries will be prepared and submitted to the Center prior to the review. Complete chart and FHR tracings should be available as well as laboratory results, i.e. autopsy, blood work, etc. The expected attendance is seventy-five percent of all reviews for all perinatal medical staff.

F. The Referral Hospital will maintain and provide perinatal data to the Center as required by the Illinois Rules for Joint M&M Reviews, and any other reasonable information requests which are required to support Regional and Statewide Quality Council

activities and have been approved by the Northwestern Perinatal Center Executive Committee.

G. The Referral Hospital will participate in continuing educational programs for both nurses and physicians developed by the Center.

H. The Referral Hospital shall maintain an ongoing in-house continuing education program for all perinatal staff with documentation of competency as required by the Illinois Rules.

I. The Referral Hospital administration will designate at least one representative to serve on the Regional Quality Council and at least one representative to attend Network Nursing Leadership meetings. These representatives will be responsible for bringing information back to the Referral Hospital.

J. The Referral Hospital shall have in place a policy that outlines clinical situations in which a Referral Hospital Family Practice must consult on site with a board eligible/board certified Obstetrician or Neonatologist.

K. The Referral Hospital shall have in place a policy that outlines clinical situations in which a Referral Hospital pediatric hospitalist must consult on site with a board eligible/board certified Neonatologist.

L. The Referral Hospital shall have in place an internal quality assurance mechanism to review perinatal outcomes and appropriateness of Obstetric & Neonatal consultations and transports.

M. The Referral Hospital will assure the appropriate follow-up of neonates with handicapping conditions, including compliance with requirements of the Adverse Outcomes of Pregnancy Reporting System (APORS) and HIV Rapid Testing documentation.

X. Amendments to the Affiliation Agreement

Amendments to this basic Affiliation Letter of Agreement ("Basic Agreement") may be recommended by the Referral Hospital or the Perinatal Center Executive Committee. Any amendments made to the Basic Agreement will be set forth in a signed writing and require the approval of the Perinatal Center Executive Committee and the concurrence of the individual Referral Hospital which originally signed the Basic Agreement. Thirty days' written notice of any proposed amendment to the Basic Agreement will be provided to each of the individual Referral Hospitals prior to the request for their signature.

Individual changes relating to patient care services or procedural matters in the addenda of

each Basic Agreement will be made with the approval of the Perinatal Center Executive Committee and the Referral Hospital.

This Basic Agreement shall take effect when signed by both parties. The Basic Agreement including any addenda hereto ("Agreement") will continue in effect for a period of three (3) years. **Thereafter this Agreement shall automatically renew for successive one year terms unless terminated as follows**:

(a) by one of the institutions by giving 90 days advance written notice to the other institution of its intention to terminate;

(b) by a party immediately upon the happening of:

(i) Such party's determination that continuation of this Basic Agreement would endanger patient care;

(ii) Violation by the other party of any material provision of this Basic Agreement, which violation continues for a period of fifteen (15) days after receipt of written notice by the other party specifying the violation;

(iii) The other party is debarred, suspended or excluded from Medicare, Medicaid or any other federal or state funded health care program;

(iv) Except with respect to a change from one accrediting organization to another the other party's loss of suspension of any certification, license, accreditation or other approval as necessary to render patient care services, and particularly, perinatal and neonatal services hereunder; and

(v) The other party's failure to maintain the insurance required hereunder.

(c) by a party to the extent necessary to comply with any legal order issued to it by a federal, state or local department, agency or commission, or accrediting organization, or if reasonably determined that continued participation in this Agreement would be consistent with the party's status as a Medicare or Medicaid participant or an organization described in Article 501(c) (3) of the Internal Revenue Code of 1986, as amended, or would expose the party to undue risk of being deemed to have violated any law applicable to health care providers. Prior to termination pursuant to this subsection, the party shall first reasonably attempt to amend this Basic Agreement in a manner that will achieve the business purposes hereof. If the party proposes an amendment to this Agreement hereunder, and such amendment is unacceptable to the other party, the other party may choose to

terminate this Basic Agreement immediately upon notice at any time thereafter.

XI. Additional Provisions

A. Each party shall and shall cause its employees and agents to protect the confidentiality of all patient information exchanged hereunder and comply with all applicable state and federal laws, rules and regulations protecting the confidentiality of patient records, including the Health Insurance Portability and Accountability Act of 1996 and the corresponding privacy and security regulations promulgated pursuant thereto ("**HIPAA**").

B. Each party shall maintain all legally required certifications and licenses from all applicable governmental and accrediting bodies and shall maintain full eligibility for participation in Medicare and Medicaid.

C. Each party shall be entitled to bill patients, payors, managed care plans and any other third party responsible for paying a patient's bill, for services rendered to patients by such party and its employees, agents and representatives, and neither party will have any liability to the other party for such charges. Each party shall be solely responsible for all matters pertaining to its billing and collection of such charges. The parties shall reasonably cooperate with each other in the preparation and completion of all necessary forms and documentation and the determination of insurance coverage and managed care requirements for each patient transferred hereunder. Each party shall have the sole final responsibility for all forms, documentation, and insurance verification.

D. Each party shall, at its own cost and expense, obtain and maintain in force during the term of this Agreement appropriate levels of general and professional liability insurance coverage, in accordance with good business practice for similarly situated health care providers. Such insurance shall be provided by insurance company(ies) acceptable to the other party and licensed to conduct business in the State of Illinois, or by an appropriately designed and operated self-insurance program. Verification of insurance coverage shall be in the possession of each party at all times while this Agreement is in effect and shall be promptly provided to the other party upon request. Each party shall notify the other party at least thirty (30) days prior to termination, lapse or loss of adequate insurance coverage as provided herein. In the event the form of insurance held by a party is claims made, such party warrants and represents that it will purchase appropriate tail coverage for claims, demands, or actions reported in future years for acts of omissions during the term of this Agreement. In the event of insufficient coverage as defined in this Section, or lapse of coverage, the non-breaching party reserves the right to immediately and unilaterally terminate this Agreement.

E. Each party shall indemnify and hold harmless the other party, together with its officers, directors, agents, employees, affiliates, successors and assigns, from and against any and all manner of claims, demands, causes of action, liabilities, damages, costs and reasonable expenses (including costs and reasonable attorney's fees) arising from or incident to the negligent or willful misconduct in such indemnifying party's performance of its duties hereunder.

F. The parties agree that nothing contained in this Agreement shall require any party to refer or admit patients to, or order any goods or services from the other party.

G. Center certifies that neither it nor any of its employees or agents providing services hereunder ("**Personnel**") have been excluded from participation in Medicare/Medicaid or any other federal or state funded health care program. In addition, Center agrees to promptly notify WSMC in the event of an investigation of Center's or its Personnel's participation in a federal or state health care program by federal, state or local officials. Should Center become suspended, debarred or excluded from participation in Medicare, Medicaid or any other federal or state funded health care program, this Agreement shall immediately terminate as of the date of such suspension, debarment or exclusion. Additionally, should any Personnel become suspended, debarred or excluded from participation in Medicare, Medicaid or any other federal or state health care program, Center shall immediately remove such member of its Personnel from the performance of Services hereunder.

H. No party may assign this Agreement without the prior written consent of the other party.

I. The invalidity or unenforceability of any particular provision of this Agreement shall not affect the other provisions hereof, and this Agreement shall be construed in all respects as if such invalid or unenforceable provision were omitted.

J. No covenant or condition of this Agreement can be waived, except to the extent set forth in writing by the waiving Party.

K. Notices. All notices that may be given under this Agreement shall be in writing, addressed to the receiving party's address set forth below or to such other address as the receiving party may designate by notice hereunder, and shall be delivered by hand or by traceable courier service (such as Federal Express) or sent by certified or registered mail, return receipt requested:

WSMC:	West Suburban Medical Center 3 Erie Court Oak Park, Illinois 60302 Attention: Chief Executive Officer
Northwestern Perinatal Center:	Northwestern Memorial Hospital Prentice – Perinatal Center 250 E. Superior St. Suite 9-2243 Chicago, IL. 60611

All notices shall be deemed to have been given, if by hand or traceable courier service, at the time of the delivery to the receiving party at the address set forth above or to such other address as the receiving party may designate by notice hereunder, or if sent by certified or registered mail, on the 2nd business day after such mailing.

No portion of this Agreement shall be construed to indicate that the Center is establishing the standard of care or responsible for the monitoring and performance of care in any of affiliate institutions. These responsibilities remain vested with the Board of Directors and Professional Staff of each individual institution. The responsibility for provision of appropriate levels of malpractice and liability coverage rests with each affiliate institution.

For Referral Hospital

Chairman of Obstetrics and Gynecology
Referral Hospital

Chairman of Pediatrics
Referral Hospital

Chief Executive Officer
Referral Hospital

For the Northwestern Perinatal Center

Director, Maternal-Fetal Medicine
Northwestern Perinatal Center

Director, Neonatology
Northwestern Perinatal Center

Signed: Date 6/12/2009

Revised: 4/2009

ADDENDUM I: Patient Care Services – Level II Facility

The Departments of Obstetrics and Pediatrics of West Suburban Medical Center have agreed upon the following categories of high-risk maternal and neonatal patients for whom consultation and/or transport should be considered, as required by Section 640.42 of the Illinois Regulations.

I. Consultation, Referral, and Transport Guidelines - Maternal

A. The following maternal patients are considered to be appropriate for management and delivery by the primary physician at Level II facilities without requirement for a maternal-fetal medicine consultation:

1. Normal current pregnancy although obstetric history may be suggestive of potential difficulties;

2. Selected medical conditions controlled with medical treatment such as: mild chronic hypertension, thyroid disease, illicit drug use, urinary tract infection, and non-systemic steroid dependent reactive airway disease;

3. Selected obstetric complications that present after 32 weeks gestation such as: mild pre-eclampsia/pregnancy induced hypertension, placenta previa, abruptio placenta, premature rupture of membranes, or premature labor;

4. Other selected obstetric conditions that do not adversely affect maternal health or fetal;
well-being, such as: normal twin gestation, hyperemesis gravidium, suspected fetal macrosomia, or incompetent cervical os;

5. Gestational diabetes, Class A1 (White's criteria).

B. For the following maternal conditions, consultation with a maternal-fetal medicine subspecialist with subsequent management and delivery at the appropriate facility as determined by mutual collaboration is recommended:

1. Current obstetric history suggestive of potential difficulties such as: intrauterine growth restriction, prior neonatal death, two or more previous preterm deliveries less than 34 weeks, a single previous preterm delivery less than 30 weeks, birth of a neonate with serious complications resulting in a handicapping condition, recurrent spontaneous abortion or fetal demise, family history of genetic disease;

2. Active chronic medical problems with known increase in perinatal mortality,

such as cardiovascular disease Class I and Class II, autoimmune disease, reactive airway disease requiring treatment with systemic corticosteroids, seizure disorder, controlled hyperthyroidism on replacement therapy, hypertension controlled on a single medication, idiopathic thrombocytopenia pupura, thromboembolic disease, malignant disease (especially when active), renal disease with functional impairment, human immunodeficiency viral infection (consultation may be with maternal-fetal medicine or infectious disease subspecialist);

3. Selected obstetric complications that present prior to 34 weeks gestation such as: suspected intrauterine growth restriction, polyhydramnios, oligohydramnios, pre-eclampsia/pregnancy-induced hypertension, congenital viral disease, maternal surgical conditions, suspected fetal abnormality or anomaly, isoimmunization with antibody titers greater than 1:8, antiphospholipid syndrome;

4. Abnormalities of the reproductive tract known to be associated with an increase in preterm delivery, such as uterine anomalies or diethyl-stilbesterol exposure;

5. Insulin dependent diabetes Class A2 and B or greater (White's criteria).

C. For the following maternal conditions, referral to a maternal-fetal medicine subspecialist for evaluation shall occur. Subsequent patient management and site of delivery shall be determined by mutual collaboration between the patient's physician and the maternal-fetal medicine subspecialist:

1. Selected chronic medical conditions with a known increase in perinatal mortality such
as: cardiovascular disease with functional impairment (Class III or greater), respiratory failure requiring mechanical ventilation, acute coagulopathy, intractable seizures, coma, sepsis, solid organ transplantation, active autoimmune disease requiring corticosteroid treatment, unstable reactive airway disease, renal disease requiring dialysis or with a serum creatinine concentration greater than 1.5 mg%, active hyperthyroidism, hypertension that is unstable or requires more than one medication to control, severe hemoglobinopathy;

2. Selected obstetric complications that present prior to 32 weeks gestation such as: multiple gestation with more than two fetuses, twin gestation complicated by demise, discordance, maldevelopment of one fetus or by fetal-fetal transfusion, premature labor unresponsive to first-line tocolysis, premature rupture of membranes, medical and obstetrical complications of pregnancy possibly requiring induction of labor or non-emergent cesarean section for maternal or fetal indications such as severe pre-eclampsia;

3. Isoimmunization with possible need for intrauterine transfusion;

4. Insulin-dependent diabetes mellitus Classes C,D,R,F, or H (White's criteria);

5. Suspected congenital anomaly or abnormality requiring invasive fetal procedure, neonatal surgery or postnatal medical intervention to preserve life such as: fetal hydrops, pleural effusion, ascites, persistent fetal arrhythmia, major organ system malformation/malfunction, or genetic condition.

II. **Consultation, Referral, Transport Guidelines -Neonatal**

A. The following neonatal patients are considered appropriate for Level II facilities without a requirement for neonatology consultation:

1. Mild to moderate respiratory distress (not requiring mechanical ventilation in excess of 6 hours);

2. Suspected neonatal sepsis, hypoglycemia responsive to glucose infusion, and asymptomatic neonates of diabetic mothers;

3. Nursery care of infants with a birth weight greater than 1500 grams who are otherwise well.

B. For the following neonatal conditions, neonatology consultation is recommended:

1. Premature birth with gestation less than 32 weeks, but greater than or equal to 30 weeks;

2. Infants with a birth weight less than 1500 grams, but greater than 1250 grams;

3. Infants with 10 minute Apgar scores of 5 or less;

4. Stable infants identified as having handicapping conditions or developmental disabilities
that threaten subsequent development.

C. Transfer shall occur upon recommendation of the Perinatal Center for each of the following neonatal conditions:

1. Premature birth that is less than 30 weeks gestation;

2. Birth weight less than or equal to 1250 grams;

3. Infants requiring mechanical ventilation beyond the initial stabilization period of 6 hours;

4. Infants who require a sustained inhaled oxygen concentration in excess of 50% in order to maintain a transcutaneous or arterial oxygen saturation greater than or equal to 92%;

5. Infants with significant congenital heart disease associated with cyanosis, congestive heart failure, or impaired peripheral blood flow;

6. Infants with major congenital malformations requiring immediate comprehensive evaluation or neonatal surgery;

7. Infants requiring neonatal surgery with general anesthesia;

8. Infants with sepsis, unresponsive to therapy, associated with persistent shock or other organ system failure;

9. Infants with uncontrolled seizures;

10. Infants with stupor, coma, hypoxic ischemic encephalopathy Stage II or greater;

11. Infants requiring double-volume exchange transfusion;

12. Infants with metabolic derangement persisting after initial correction therapy;

13. Infants identified as having handicapping conditions that threaten life for which transfer can improve outcome.

REQUIRED FINANCIAL STATEMENTS
FOR EACH APPLICANT
ARE LOCATED AT THE END OF
THE APPLICATION DOCUMENT

ATTACHMENT 75

Vanguard Health Management, Inc.
Financial Viability Ratios

	2007	2008	2009	Projected (FYE Jun 2012)	Standard
Current ratio					
(a) Current assets	$518,099,132	$599,858,956	$731,622,425	$684,614,447	
(b) Current liabilities	361,652,645	382,030,232	480,048,811	566,618,102	
Current ratio [a/b]	**1.43x**	**1.57x**	**1.52x**	**1.21x**	**1.50x**
Net margin percentage					
(a) Net income	($132,708,644)	($696,165)	$28,626,734	$48,547,795	
(b) Net operating revenue	2,580,724,086	2,790,695,303	3,199,706,273	3,752,752,331	
Net margin percentage [a/b]	**(5.1%)**	**(0.0%)**	**0.9%**	**1.3%**	**3.5%**
Percent debt to total capitalization					
(a) Long-term debt	1,520,737,217	1,529,543,051	1,543,624,950	1,732,137,510	
(b) Equity	566,679,019	573,796,487	595,864,030	392,341,013	
Percent debt to total capitalization [a/(a+b)]	**72.9%**	**72.7%**	**72.1%**	**81.5%**	**60.0%**
Projected debt service coverage					
(a) Net income	($132,708,644)	($696,165)	$28,626,734	$48,547,795	
(b) Depreciation	115,379,004	127,753,505	126,864,684	144,892,315	
(c) Interest	131,556,788	128,380,452	113,999,310	135,337,468	
(d) Amortization	3,260,000	3,260,000	3,708,358	3,415,415	
(e) Principal and Interest	131,552,912	129,852,018	119,419,930	143,337,468	
Projected debt service coverage [(a+b+c+d)/e]	**0.89x**	**1.99x**	**2.29x**	**2.32x**	**1.75x**
Days Cash on Hand					
(a) Cash and investments	$126,286,541	$143,685,061	$310,050,104	150,776,018	
(b) Board designated funds	-	-	-	-	
(c) Operating expense	2,335,714,427	2,524,283,522	2,897,351,592	3,377,598,811	
(d) Depreciation expense	115,379,004	127,753,505	126,864,684	144,892,315	
Days cash on hand [(a+b) / ((c-d) / 365)]	**20.8**	**21.9**	**40.8**	**17.0**	**90.0**
Cushion ratio					
(a) Cash and investments	$126,286,541	$143,685,061	$310,050,104	$150,776,018	
(b) Board designated funds	-	-	-	-	
(c) Maximum annual debt service	131,552,912	129,852,018	119,419,930	143,337,468	
Cushion ratio [(a+b)/c]	**1.0**	**1.1**	**2.6**	**1.1**	**5.0**

ATTACHMENT 75A

Vanguard Health Financial Corporation, LLC
Financial Viability Ratios

	2007	2008	2009	Projected (FYE Jun 2012)	Standard
Current ratio					
(a) Current assets	$518,099,132	$599,858,956	$731,622,425	$684,614,447	
(b) Current liabilities	361,652,645	382,030,232	480,048,811	566,618,102	
Current ratio [a/b]	**1.43x**	**1.57x**	**1.52x**	**1.21x**	**1.50x**
Net margin percentage					
(a) Net income	($98,035,133)	$57,608,361	$110,179,471	$89,150,724	
(b) Net operating revenue	2,580,317,758	2,788,610,054	3,199,148,237	3,738,929,920	
Net margin percentage [a/b]	**(3.8%)**	**2.1%**	**3.4%**	**2.4%**	**3.5%**
Percent debt to total capitalization					
(a) Long-term debt	1,520,737,217	1,529,543,051	1,543,624,950	1,732,137,510	
(b) Equity	566,679,019	573,796,487	595,864,030	392,341,013	
Percent debt to total capitalization [a/(a+b)]	**72.9%**	**72.7%**	**72.1%**	**81.5%**	**60.0%**
Projected debt service coverage					
(a) Net income	($98,035,133)	$57,608,361	$110,179,471	$89,150,724	
(b) Depreciation	115,379,004	127,753,505	126,864,684	144,892,315	
(c) Interest	123,763,513	122,140,222	111,614,613	135,337,468	
(d) Amortization	3,260,000	3,260,000	3,708,358	3,415,415	
(e) Principal and Interest	123,759,637	123,611,788	117,035,233	143,337,468	
Projected debt service coverage [(a+b+c+d)/e]	**1.17x**	**2.51x**	**3.01x**	**2.60x**	**1.75x**
Days Cash on Hand					
(a) Cash and investments	126,286,541	143,685,061	310,050,104	150,776,018	
(b) Board designated funds	-	-	-	-	
(c) Operating expense	2,300,634,587	2,463,893,747	2,815,240,819	3,323,173,472	
(d) Depreciation expense	115,379,004	127,753,505	126,864,684	144,892,315	
Days cash on hand [(a+b) / ((c-d) / 365)]	**21.1**	**22.4**	**42.1**	**17.3**	**90.0**
Cushion ratio					
(a) Cash and investments	$126,286,541	$143,685,061	$310,050,104	$150,776,018	
(b) Board designated funds	-	-	-	-	
(c) Maximum annual debt service	123,759,637	123,611,788	117,035,233	143,337,468	
Cushion ratio [(a+b)/c]	**1.0**	**1.2**	**2.6**	**1.1**	**5.0**

ATTACHMENT 75A

VHS West Suburban Medical Center, Inc.
Financial Viability Ratios

	Projected (FYE Jun 2012)	Standard
Current ratio		
(a) Current assets	$32,915	
(b) Current liabilities	29,333	
Current ratio [a/b]	**1.12x**	**1.50x**
Net margin percentage		
(a) Net income	$387	
(b) Net operating revenue	250,430	
Net margin percentage [a/b]	**0.2%**	**3.5%**
Percent debt to total capitalization		
(a) Long-term debt	8,000	
(b) Equity	13,417	
Percent debt to total capitalization [a/(a+b)]	**37.4%**	**60.0%**
Projected debt service coverage		
(a) Net Income	$387	
(b) Depreciation	9,377	
(c) Interest	640	
(d) Amortization	-	
(e) Principal and Interest	640	
Projected debt service coverage [(a+b+c+d)/e]	**16.26x**	**1.75x**
Days Cash on Hand		
(a) Cash and investments	100	
(b) Board designated funds	-	
(c) Operating expense	240,026	
(d) Depreciation expense	9,377	
Days cash on hand [(a+b) / ((c-d) / 365)]	**0.2**	**90.0**
Cushion ratio		
(a) Cash and investments	100	
(b) Board designated funds	-	
(c) Maximum annual debt service	640	
Cushion ratio [(a+b)/c]	**0.2**	**5.0**

ATTACHMENT 75A

Resurrection Health Care										
Calculation of Current Ratio										
in 000s										
					Less:			*Adjusted*	*Estimated*	*Projected*
	June 30, 2009	**June 30, 2008**	**June 30, 2007**		***WSMC***	***WL***	***Other***	***June 30, 2009***	***Proceeds***	***June 30, 2009***
Current Assets (A)	678,332	662,396	410,653		20,337	10,321	3,854	643,820	60,800	704,620
Current Liabilities (B)	676,529	651,670	349,652		5,190	1,113	873	669,353		669,353
Current Ratio (A / B)	1.00	1.02	1.17							1.05

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ATTACHMENT 75A

Resurrection Health Care								
Calculation of Net Margin Percentage								
in 000s								
					Less:			Projected
	June 30, 2009	**June 30, 2008**	**June 30, 2007**		***WSMC***	***WL***	***Other***	***June 30, 2009***
Net Income (A)	(111,620)	(73,022)	42,362		(29,231)	(827)	(1,910)	(79,652)
Net Operating Revenue (B)	1,697,885	1,687,696	1,669,799		173,159	99,742	10,469	1,414,515
Net Margin Percentage (A / B x 100)	-6.57%	-4.33%	2.54%					-5.63%

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ATTACHMENT 75A

Resurrection Health Care										
Calculation of Debt to Total Capitalization										
in 000s										
					Less:			Adjusted	Sale Impact	Projected
	June 30, 2009	June 30, 2008	June 30, 2007		WSMC	WL	Other	June 30, 2009		June 30, 2009
Long-Term Debt (A)	636,249	651,110	748,709		-	b	b	636,249		636,249
Unrestricted Fund Balance (B)	416,932	586,307	656,929		a	a	a	416,932	(78,477)	338,455
Debt to Total Capitalization (A / (A+B) x 100)	60.41%	52.62%	53.26%							65.28%
NOTE: Long-term debt balance includes current installments										
a.) Fund balance is eliminated with the intercompany balances. (no impact)										
b.) Existing long-term debt on Westlake is an intercompany balance with the parent. (no impact)										

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ATTACHMENT 75A

Resurrection Health Care								
Calculation of Projected Debt Service Coverage								
in 000s								
					Less:			Projected
	June 30, 2009	**June 30, 2008**	**June 30, 2007**		***WSMC***	***WL***	***Other***	***June 30, 2009***
Net Income (A)	(111,620)	(73,022)	42,362		(29,231)	(827)	(1,910)	(79,652)
Depreciation (B)	90,346	86,468	81,210		9,269	4,231	1,972	74,874
Interest (C)	23,141	31,464	32,421	a	-	-	-	23,141
Amortization (D) - Included in Interest	-	-	-		-	-	-	-
Maximum Annual Debt Service (P&I) (C)	40,734	40,734	40,734		-	-	-	40,734
Projected Debt Service Coverage ((A+B+C+D)/E)	0.05	1.10	3.83					0.45
Maximum Annual Debt Service based on Illinois Finance Authority Official Statement for $110,000,000 Revenue Refunding								
Bonds, Series 2009 (Resurrection Health Care Corporation), dated December 11, 2009								
a.) Interest expense adjusted to include interest expense reflected as non-operating.								

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ATTACHMENT 75A

Resurrection Health Care										
Calculation of Days Cash on Hand										
in 000s										
					Less:			Adjusted	Estimated	Projected
	June 30, 2009	June 30, 2008	June 30, 2007		WSMC	WL	Other	June 30, 2009	Proceeds	June 30, 2009
Cash and Investments (A)	420,899	377,693	52,768		a	a	a	420,899	60,800	481,699
Board Designated Funds (B)	297,342	458,985	932,693		-	-	-	297,342	-	297,342
Operating Expense (C)	1,766,616	1,768,827	1,684,739	b	203,001	100,578	12,379	1,450,658	-	1,450,658
Depreciation Expense (D)	90,346	86,468	81,210		9,269	4,231	1,972	74,874	-	74,874
Days Cash on Hand ((A+B)/(C-D))/365))	156.39	181.52	224.31					190.55		206.68
Cash and investments includes assets whose use is liminted - required for current liabilities										
a.) Cash stays with RHC.										
b.)Operating expense adjusted to include interest expense.										

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ATTACHMENT 75A

Resurrection Health Care										
Calculation of Cushion Ratio										
in 000s										
					Less:			Adjusted	Estimated	Projected
	June 30, 2009	June 30, 2008	June 30, 2007		WSMC	WL	Other	June 30, 2009	Proceeds	June 30, 2009
Cash and Investments (A)	420,899	377,693	52,768		a	a	a	420,899	60,800	481,699
Board Designated Funds (B)	297,342	458,985	932,693		-	-	-	297,342		297,342
Under Bond Indenture agreements-held by trustee	29,260	5,680	7,008		-	-	-	29,260		29,260
Maximum Annual Debt Service (P&I) (C)	40,734	40,734	40,734		-	-	-	40,734		40,734
Cushion Ratio (A+B)/C	18.35	20.68	24.36					18.35		19.84
Maximum Annual Debt Service based on Illinois Finance Authority Official Statement for $110,000,000 Revenue Refunding										
Bonds, Series 2009 (Resurrection Health Care Corporation), dated December 11, 2009										
a.) Cash stays with RHC.										

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ATTACHMENT 75A

VANGUARD
HEALTH SYSTEMS

February , 2010

Illinois Health Facilities
and Services Review Board

RE: Acquisition of Westlake Hospital and
West Suburban Medical Center

To Whom It May Concern:

Please be advised that, consistent with the financial statements provided in the Applications for Permit (Attachment 75A), the acquiring applicants have sufficient funds in the form of cash and short-term investments to address all costs associated with the acquisition of Westlake Hospital in Melrose Park, Illinois and West Suburban Medical Center in Oak Park, Illinois.

Sincerely,

Vanguard Health Systems 20 Burton Hills Boulevard, Suite 100 • Nashville, TN 37215 • 615.665.6000 • Fax 615.665.6099

OPERATING START-UP COSTS

Due to the nature of this project, which is limited to a change-of-ownership of a currently operating hospital, no operating start-up costs are anticipated. Further, the hospital is not anticipated to operate at a deficit during its first year of operation.

ATTACHMENT 75C

MISCELLANEOUS COSTS

The "Consulting and Other Fees" ($739,500) include an estimate of the costs associated with outside legal and accounting services, community relations-related consulting, CON development, CON-related review fees, and miscellaneous costs associated with the acquisition.

ATTACHMENT 76C

PROJECTED OPERATING and CAPITAL COSTS per ADJUSTED PATIENT DAY

West Suburban Medical Center
2012

ADJUSTED PATIENT DAYS:

	$78,385,000		
$	2,450	=	31,995

OPERATING COSTS

salaries & benefits	$98,419,000
supplies	$17,912,000
TOTAL	$116,331,000

Operating cost/adjusted pt day:	**$3,635.86**

CAPITAL COSTS

interest	$640,000
depreciation & amortization	$9,377,000
	$10,017,000

Capital cost/adjusted pt day:	**$**	**313.08**

ATTACHMENT 76D E

Vanguard Health Management, Inc.
Income Statement

	2007	2008	2009	Projected (FYE Jun 2012)
Net revenue	**$2,580,724,086**	**$2,790,695,303**	**$3,199,706,273**	**$3,752,752,331**
Operating Expenses				
Salaries	833,694,979	905,553,101	1,011,789,078	1,248,737,822
Contract Labor	76,050,277	82,625,393	66,673,670	32,806,285
Benefits	156,949,763	161,926,006	157,207,895	200,793,264
Supplies	421,801,485	434,549,105	456,301,195	523,287,756
Professional fees	43,636,866	41,608,884	44,094,474	60,592,125
Health plan claims expense	297,055,005	328,181,885	525,661,510	674,445,127
Purchased services	97,540,053	107,901,585	123,252,498	129,595,128
Repairs	20,119,184	21,763,061	21,443,646	21,885,791
Maintenance	28,800,476	34,186,081	37,435,122	44,819,876
Marketing	9,226,821	8,840,850	8,140,005	11,488,112
Utilities	39,345,851	43,423,035	46,101,415	50,585,883
Insurance	27,373,304	29,725,889	41,423,597	38,053,733
Other operating exp	42,957,302	48,285,772	51,283,630	65,830,116
				-
Non-income taxes	28,634,590	28,268,844	52,222,965	60,154,478
Rents and leases	37,370,885	41,797,515	43,521,419	50,895,484
Provision for doubtful accounts	175,157,587	205,646,516	210,799,473	163,627,830
Total operating expense	2,335,714,427	2,524,283,522	2,897,351,592	3,377,598,811
EBITDA	**245,009,659**	**266,411,781**	**302,354,681**	**375,153,520**
Depreciation and amortization	118,639,005	131,013,505	130,573,043	148,307,730
Interest, net	123,763,513	122,140,222	111,614,613	135,337,468
Other non-operating expense	(40,580)	(21,089)	615,470	-
Equity method income	(948,049)	(704,381)	(814,516)	(974,204)
Loss/(gain) asset sales	(4,060,484)	852,743	(2,285,205)	-
Monitoring fee	5,200,000	6,350,592	5,208,576	5,199,996
Stock comp expense	1,164,876	2,569,469	4,366,987	5,846,103
Impairment loss	123,800,000	0	6,198,018	-
Total non-operating expenses	367,518,280	262,201,062	255,476,986	293,717,093
Income from cont ops before income taxes	($122,508,621)	$4,210,720	$46,877,695	$81,436,427
Income tax expense	(11,576,910)	1,655,846	15,984,716	30,388,632
Income from continuing operations	($110,931,711)	$2,554,874	$30,892,979	$51,047,795
Income from discontinued operations, net of taxes	19,130,903	282,967	(901,790)	-
Net income	($130,062,614)	$2,271,907	$31,794,769	$51,047,795
Net income attributable to non-controlling interes	2,646,030	2,968,072	3,168,035	2,500,000
Net income attributable to controlling interest	**($132,708,644)**	**($696,165)**	**$28,626,734**	**$48,547,795**

ATTACHMENT 75

Vanguard Health Management, Inc.
Balance Sheet

	2007	2008	2009	Projected (FYE Jun 2012)
ASSETS				
Cash and short-term investments	126,286,541	143,685,061	310,050,104	150,776,018
Net patient receivables	287,268,881	300,413,207	275,292,627	371,777,786
Other receivables	32,540,667	37,141,330	45,379,473	84,796,980
Inventory	46,820,030	49,191,373	48,301,610	57,176,530
Other current	25,183,013	69,427,986	52,598,612	20,087,134
Total current assets	$518,099,132	$599,858,956	$731,622,425	$684,614,447
Gross PP&E	1,457,350,687	1,568,965,521	1,692,608,367	2,280,899,246
Accumulated depreciation	(270,782,216)	(395,008,122)	(518,510,971)	(932,709,281)
Net PP&E	$1,186,568,471	$1,173,957,399	$1,174,097,396	$1,348,189,965
Goodwill and intangibles	757,151,742	750,628,091	746,693,057	743,945,523
Investment in subs	7,303,190	6,038,323	5,371,441	5,732,153
Other assets	62,250,519	51,837,335	73,316,279	35,772,746
Total assets	**$2,531,373,054**	**$2,582,320,103**	**$2,731,100,598**	**$2,818,254,835**
LIABILITIES & EQUITY				
Accounts payable	144,091,308	155,119,270	127,916,344	181,472,219
Accrued claims	61,308,931	51,082,279	117,623,285	135,044,100
Accrued expenses & other	148,295,531	167,871,808	226,552,307	242,101,783
Current maturities of long-term debt	7,956,875	7,956,875	7,956,875	8,000,000
Total current liabilities	361,652,645	382,030,232	480,048,811	566,618,102
Professional and general liability and workers com	61,570,571	74,086,604	76,724,943	86,499,475
Other liabilities	20,733,602	22,863,729	34,837,864	40,658,735
Long-term debt (less current portion)	1,520,737,217	1,529,543,051	1,543,624,950	1,732,137,510
Total liabilities	**1,964,694,035**	**2,008,523,616**	**2,135,236,568**	**2,425,913,822**
Equity	566,679,019	573,796,487	595,864,030	392,341,013
Total liabilities and equity	**2,531,373,054**	**2,582,320,103**	**2,731,100,598**	**2,818,254,835**

ATTACHMENT 75

Vanguard Health Financial Corporation, LLC
Income Statement

	2007	2008	2009	Projected (FYE Jun 2012)
Net revenue	**$2,580,317,758**	**$2,788,610,054**	**$3,199,148,237**	**$3,738,929,920**
Operating Expenses				
Salaries	812,457,371	872,382,817	967,723,287	1,195,256,875
Contract Labor	75,908,424	82,490,544	66,353,706	32,543,047
Benefits	155,033,455	160,141,783	154,345,763	195,568,174
Supplies	421,604,724	434,740,870	457,947,281	523,167,070
Professional fees	44,745,510	42,071,151	43,392,811	59,847,730
Health plan claims expense	297,055,005	328,181,885	525,661,510	674,445,127
Purchased services	89,750,041	96,595,049	111,236,219	121,340,301
Repairs	19,752,113	21,404,722	20,949,338	20,980,986
Maintenance	27,676,346	32,537,907	36,019,011	42,095,786
Marketing	9,010,848	8,663,869	7,906,221	10,729,637
Utilities	39,025,339	43,025,330	45,549,713	49,654,813
Insurance	26,938,733	29,625,254	30,743,451	34,796,520
Other operating exp	38,142,497	42,523,419	44,024,396	55,162,032
	-	-	-	37,753,231
Non-income taxes	28,127,197	28,009,873	51,873,389	59,702,520
Rents and leases	34,273,077	38,294,561	39,715,250	46,501,792
Provision for doubtful accounts	181,133,908	203,204,711	211,799,473	163,627,830
Total operating expense	2,300,634,587	2,463,893,747	2,815,240,819	3,323,173,472
EBITDA	**279,683,170**	**324,716,307**	**383,907,418**	**415,756,448**
Depreciation and amortization	118,639,005	131,013,505	130,573,043	148,307,730
Interest, net	123,763,513	122,140,222	111,614,613	135,337,468
Other non-operating expense	(40,580)	(21,089)	615,470	-
Equity method income	(948,049)	(704,381)	(814,516)	(974,204)
Loss/(gain) asset sales	(4,060,484)	852,743	(2,285,205)	-
Monitoring fee	5,200,000	6,350,592	5,208,576	5,199,996
Stock comp expense	1,164,876	2,569,469	4,366,987	5,846,103
Impairment loss	123,800,000	-	6,198,018	-
Total non-operating expenses	367,518,280	262,201,062	255,476,986	293,717,093
Income from cont ops before income taxes	($87,835,110)	$62,515,246	$128,430,432	$122,039,356
Income tax expense	(11,576,910)	1,655,846	15,984,716	30,388,632
Income from continuing operations	($76,258,200)	$60,859,400	$112,445,717	$91,650,724
Income from discontinued operations, net of taxes	19,130,903	282,967	(901,790)	-
Net income	($95,389,103)	$60,576,433	$113,347,506	$91,650,724
Net income attributable to non-controlling interes	2,646,030	2,968,072	3,168,035	2,500,000
Net income attributable to controlling interest	**($98,035,133)**	**$57,608,361**	**$110,179,471**	**$89,150,724**

ATTACHMENT 75

Vanguard Health Financial Corporation, LLC
Balance Sheet

	2007	2008	2009	Projected (FYE Jun 2012)
ASSETS				
Cash and short-term investments	$126,286,541	$143,685,061	$310,050,104	$150,776,018
Net patient receivables	287,268,881	300,413,207	275,292,627	371,777,786
Other receivables	32,540,667	37,141,330	45,379,473	84,796,980
Inventory	46,820,030	49,191,373	48,301,610	57,176,530
Other current	25,183,013	69,427,986	52,598,612	20,087,134
Total current assets	$518,099,132	$599,858,956	$731,622,425	$684,614,447
Gross PP&E	1,457,350,687	1,568,965,521	1,692,608,367	2,280,899,246
Accumulated depreciation	(270,782,216)	(395,008,122)	(518,510,971)	(932,709,281)
Net PP&E	$1,186,568,471	$1,173,957,399	$1,174,097,396	$1,348,189,965
Goodwill and intangibles	757,151,742	750,628,091	746,693,057	743,945,523
Investment in subs	7,303,190	6,038,323	5,371,441	5,732,153
Other assets	62,250,519	51,837,335	73,316,279	35,772,746
Total assets	**$2,531,373,054**	**$2,582,320,103**	**$2,731,100,598**	**$2,818,254,835**
LIABILITIES & EQUITY				
Accounts payable	$144,091,308	$155,119,270	5127,916,344	$181,472,219
Accrued claims	61,308,931	51,082,279	117,623,285	135,044,100
Accrued expenses & other	148,295,531	167,871,808	226,552,307	242,101,783
Current maturities of long-term debt	7,956,875	7,956,875	7,956,875	8,000,000
Total current liabilities	$361,652,645	$382,030,232	$480,048,811	$566,618,102
Professional and general liability and workers com	61,570,571	74,086,604	76,724,943	86,499,475
Other liabilities	20,733,602	22,863,729	34,837,864	40,658,735
Long-term debt (less current portion)	1,520,737,217	1,529,543,051	1,543,624,950	1,732,137,510
Total liabilities	**$1,964,694,035**	**$2,008,523,616**	**$2,135,236,568**	**$2,425,913,822**
Equity	566,679,019	573,796,487	595,864,030	392,341,013
Total liabilities and equity	**$2,531,373,054**	**$2,582,320,103**	**$2,731,100,598**	**$2,818,254,835**

ATTACHMENT 75

VHS West Suburban Medical Center, Inc.
Income Statement

	Projected (FYE Jun 2012)
Net revenue	**$250,430**
Operating Expenses	
Salaries and wages	98,419
Payroll taxes and fringe benefits	17,912
Physicians' fees	6,762
Supplies	29,801
Other	19,119
Management services	7,873
Purchased services	10,518
Insurance	8,515
Taxes	2,740
Provision for uncollectible accounts	32,806
Assessments and taxes	5,560
Total operating expense	240,026
EBITDA	**10,404**
Depreciation and amortization	9,377
Interest, net	640
Impairment costs	-
Investment (income) / loss, net	-
Unrestricted contributions	-
Total non-operating expenses	10,017
Income from cont ops before net assets	$387
Net assets released	-
Change in pension funding status	-
Net income	**$387**

VHS West Suburban Medical Center, Inc.
Balance Sheet

	Projected (FYE Jun 2012)
ASSETS	
Cash and cash equivalents	$100
Assets, limited in use	-
Patient A/R, net	28,946
Other receivables	-
Inventory	2,126
Other current assets	1,743
Total current assets	$32,915
Assets, limited or restricted	-
Net PP&E	73,970
Deferred finance charges	-
Other assets	-
Total assets	**$106,886**
LIABILITIES & EQUITY	
Current maturities of long-term debt	$0
Accounts payables & accrued expense	11,150
Accrued payroll & benefits	8,719
Due to affiliates & other	9,464
Total current liabilities	$29,333
Long-term debt (less current portion)	8,000
Estimated liability claims	56,135
Other liabilities	-
Total liabilities	**$93,468**
Net assets / (deficit)	13,417
Total liabilities and equity	**$106,886**

VANGUARD HEALTH SYSTEMS, INC

FORM 10-K

2007-2009

ATTACHMENT 75

RESURRECTION HEALTH CARE CORPORATION AND AFFILIATES

HISTORICAL FINANCIAL STATEMENTS

ATTACHMENT 75

VANGUARD HEALTH SYSTEMS, INC

FORM 10-K

2007-2009

ATTACHMENT 75

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, D.C. 20549

FORM 10-K

(Mark One)

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the fiscal year ended June 30, 2009

OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from _____ to _____

Commission File Number: 333-71934

VANGUARD
HEALTH SYSTEMS

VANGUARD HEALTH SYSTEMS, INC.

(Exact name of registrant as specified in its charter)

Delaware	**62-1698183**
(State or other jurisdiction of incorporation or organization)	*(I.R.S. Employer Identification No.)*

20 Burton Hills Boulevard, Suite 100
Nashville, TN 37215
(Address and zip code of principal executive offices)

(615) 665-6000
(Registrant's telephone number, including area code)

Securities Registered Pursuant to Section 12(b) of the Act: None
Securities Registered Pursuant to Section 12(g) of the Act: None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. ☐Yes ☒No

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. ☒Yes ☐No

Indicate by check mark whether the registrant (1) has filed all reports required to be filed under Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports) and (2) has been subject to such filing requirements for the past 90 days. ☒Yes ☐No

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of the Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files.) Yes☐ No☐

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer or a smaller reporting company. See the definitions of "large accelerated filer", "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer ☐	Accelerated filer ☐
Non-accelerated filer ☒ (Do not check if a smaller reporting company)	Smaller reporting company ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). ☐Yes ☒No

There were 749,550 shares of registrant's common stock outstanding as of September 1, 2009 (all of which are privately owned and not traded on a public market).

Documents incorporated by reference: None

VANGUARD HEALTH SYSTEMS, INC.
ANNUAL REPORT ON FORM 10-K
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VANGUARD HEALTH SYSTEMS, INC.

CAUTIONARY STATEMENT REGARDING FORWARD-LOOKING STATEMENTS

This annual report on Form 10-K contains "forward-looking statements" within the meaning of the federal securities laws that are intended to be covered by safe harbors created thereby. Forward-looking statements are those statements that are based upon management's plans, objectives, goals, strategies, future events, future revenue or performance, capital expenditures, financing needs, plans or intentions relating to acquisitions, business trends and other information that is not historical information. These statements are based upon estimates and assumptions made by the Company's management that, although believed to be reasonable, are subject to numerous factors, risks and uncertainties that could cause actual outcomes and results to be materially different from those projected. When used in this annual report on Form 10-K, the words "estimates," "expects," "anticipates," "projects," "plans," "intends," "believes," "forecasts," "continues," or future or conditional verbs, such as "will," "should," "could" or "may," and variations of such words or similar expressions are intended to identify forward-looking statements.

These factors, risks and uncertainties include, among other things, statements relating to:

- Our high degree of leverage
- Our ability to incur substantially more debt
- Operating and financial restrictions in our debt agreements
- The impact of the tightened credit markets and economic recession on our ability to service or refinance our debt
- Our ability to successfully implement our business strategies
- Our ability to successfully integrate our recent and any future acquisitions
- The highly competitive nature of the healthcare industry
- Governmental regulation of the industry, including Medicare and Medicaid reimbursement levels
- Pressures to contain costs by managed care organizations and other insurers and our ability to negotiate acceptable terms with these third party payers
- Our ability to attract and retain qualified management and healthcare professionals, including physicians and nurses
- Potential federal or state reform of healthcare
- Future governmental investigations
- Potential management information systems failures and the significant costs of systems integrations
- The availability of capital to fund our corporate growth strategy
- Potential lawsuits or other claims asserted against us
- Our ability to maintain or increase patient membership and control costs of our managed healthcare plans
- Changes in general economic conditions, including the current U.S. economic recession, that could adversely impact our operating results, financial position and cash flows
- Our exposure to the increased amounts of and collection risks associated with uninsured accounts and the co-pay and deductible portions of insured accounts
- Cost of professional and general liability insurance and increases in the quantity and severity of professional liability claims
- Our ability to maintain and increase patient volumes and control the costs of providing services, including salaries and benefits, supplies and bad debts
- Our failure to comply, or allegations of our failure to comply, with applicable laws and regulations
- The geographic concentration of our operations
- Technological and pharmaceutical improvements that increase the cost of providing, or reduce the demand for, healthcare services
- Potential substantial liabilities arising from unfavorable retrospective reviews by governmental or other payers of the medical necessity of medical procedures performed at our hospitals
- Lost future revenues from payer contract terminations resulting from their unfavorable retrospective reviews of the medical necessity of medical procedures performed at our hospitals

See "Item 1A – Risk Factors" for further discussion. We assume no obligation to update any forward-looking statements.

PART I

Item 1. Business.

Company Overview

We own and operate acute care hospitals, complementary outpatient facilities and related health plans principally located in urban and suburban markets. We currently operate 15 acute care hospitals which, as of June 30, 2009, had a total of 4,135 beds in the following four locations:

- San Antonio, Texas
- metropolitan Phoenix, Arizona
- metropolitan Chicago, Illinois
- Massachusetts

Historically, we have concentrated our operations in markets with high population growth and median income in excess of the national average. Our objective is to help communities achieve health for life by delivering an ideal patient-centered experience in a highly reliable environment of care. We must continue to strengthen our financial operations to fund further investment in these communities. During the year ended June 30, 2009, we generated revenues of $3,199.7 million. During this period 78.8% of our total revenues were derived from acute care hospitals and complementary outpatient facilities.

Our general acute care hospitals offer a variety of medical and surgical services including emergency services, general surgery, internal medicine, cardiology, obstetrics, orthopedics and neurology. In addition, certain of our facilities provide on-campus and off-campus services including outpatient surgery, physical therapy, radiation therapy, diagnostic imaging and laboratory services. We also own three strategically important managed care health plans: a Medicaid managed health plan, Phoenix Health Plan, that served approximately 176,200 members as of June 30, 2009 in Arizona; Abrazo Advantage Health Plan, a managed Medicare and dual-eligible health plan that served approximately 2,800 members as of June 30, 2009 in Arizona; and MacNeal Health Providers a preferred provider network that served approximately 39,700 member lives in metropolitan Chicago as of June 30, 2009 under capitated contracts covering only outpatient and physician services.

We are a Delaware corporation formed in July 1997. Our principal executive offices are located at 20 Burton Hills Boulevard, Suite 100, Nashville, Tennessee, 37215 and our telephone number at that address is (615) 665-6000. Our corporate website address is www.vanguardhealth.com. Information contained on our website does not constitute part of this Annual Report on Form 10-K. The terms "we", "our", "the Company", "us", "registrant" and "Vanguard" as used in this report refer to Vanguard Health Systems, Inc. and its subsidiaries as a consolidated entity, except where it is clear from the context that such terms mean only Vanguard Health Systems, Inc. "Subsidiaries" means direct and indirect corporate subsidiaries of Vanguard Health Systems, Inc. and partnerships, joint ventures and limited liability companies in which such subsidiaries are partners or members.

The Merger

On July 23, 2004, Vanguard executed an agreement and plan of merger (the "Merger Agreement") with VHS Holdings LLC ("Holdings") and Health Systems Acquisition Corp., a newly formed Delaware corporation ("Acquisition Corp."), pursuant to which on September 23, 2004 Acquisition Corp. merged with and into Vanguard, with Vanguard being the surviving corporation (the "Merger"). In the Merger, holders of the outstanding Vanguard capital stock, options to acquire Vanguard common stock and other securities convertible into Vanguard common stock received aggregate consideration of approximately $1,248.6 million.

The Blackstone Group, together with its affiliates (collectively, "Blackstone"), funded the Merger in part by subscribing for and purchasing approximately $494.9 million aggregate amount of (1) Class A membership units in Holdings and (2) common stock of Acquisition Corp. (merged with and into Vanguard), in an amount equal to

$125.0 million of such common stock. In addition, Morgan Stanley Capital Partners, together with its affiliates (collectively, "MSCP"), subscribed for and purchased Class A membership units in Holdings by contributing to Holdings a number of shares of Vanguard common stock equal to (1) $130.0 million divided by (2) the per share consideration payable for each share of Vanguard common stock in connection with the Merger. Certain senior members of management and certain other stockholders of Vanguard (the "Rollover Management Investors") subscribed for and purchased Class A membership units in Holdings, having an aggregate purchase price of approximately $119.1 million, by (a) paying cash using the proceeds of consideration received in connection with the Merger and/or (b) contributing shares of Vanguard common stock in the same manner as MSCP. Baptist Health Services ("Baptist"), the former owner of our division, Baptist Health System of San Antonio, also purchased $5.0 million of Class A membership units in Holdings. Immediately after completion of the Merger in September 2004, Blackstone, MSCP (together with Baptist) and the Rollover Management Investors held approximately 66.1%, 18.0% and 15.9%, respectively, of the common equity of Vanguard (most of which is indirectly held through the ownership of the Class A membership units in Holdings). Certain members of senior management also purchased $5.7 million of the equity incentive units in Holdings.

Our Mission and Business Strategies

Our mission is to help communities achieve health for life. We expect to change the way healthcare is delivered in our communities through our corporate and regional business strategies. We have established a corporate values framework that includes safety, excellence, respect, integrity and accountability to support both our mission and the corporate and regional business strategies that will define our future success. Some of the more key elements of our business strategy are outlined below.

Delivery of an ideal patient-centered experience

We expect all of our facilities to provide the best available experience for our patients. To achieve this goal, we must create a highly reliable environment of care that yields superior safety and quality outcomes. We have implemented and will continue to implement various programs to improve the quality of care we provide including our patient safety initiative. We are working with an external consulting group to implement a company-wide patient safety model that will combine information technology advancement such as bedside medication barcoding with nursing process improvements to create a high reliability organization. Our commitment to quality of care starts at the top of our organization and spreads to all levels. Not only must our care be reliable, but our care must also be efficient and compassionate.

Providing efficient and compassionate care requires collaboration and open communication lines between the patients, physicians, nurses and payers. We have implemented best practices to provide our patients quick access to key services they need to improve their health. We have rapid response teams and hourly nurse rounding in place at all of our hospitals to ensure that any patient health issues are communicated and addressed in a timely manner. We have invested and will continue to invest significant capital to strengthen information technology within our facilities that enable physicians, nurses and other clinicians to coordinate patient care from the time the patients arrive at our facilities to the time they leave.

We have implemented a comprehensive patient satisfaction monitoring program to measure our success in providing an ideal patient-centered experience. The patient satisfaction results are shared with all of our leadership teams and are a component of incentive compensation plans for those leaders.

Nurse leadership initiatives

Our most valuable resource in improving the health of our patients is our nurse workforce. We are in the early stages of implementing a nursing professional practice model that will transform our delivery of patient care. This externally-validated model incorporates leadership, clinical practice, professional development and interdisciplinary collaboration to foster nursing practice that is evidence-based, innovative and patient-focused. The model will identify the most important goals to achieve clinical excellence and will incorporate best practices and process input from all levels within the nursing organization. The goals established as part of the model will be formally measured against nationally recognized sources for core measure benchmarking and will establish nursing peer reviews and detailed action plans to improve upon any areas where goals are not met.

The success of this model depends upon our ability to gain the trust and loyalty of our nurse leadership teams and line staff. We will continue to invest in nurse recruiting and retention programs that provide our nurses clinical advancement opportunities, preceptor and training programs, work-life balance flexibility and competitive compensation necessary to engage our nurses in this professional practice model. We are currently considering initiatives such as talent evaluations, coaching programs, premier preceptor programs and hospital nurse advisory councils to incorporate into our professional practice model. We believe that an engaged nurse workforce that shares our values and commitment to exemplary nursing care will improve the care experience for our patients, inspire the confidence of physicians practicing in our hospitals and reduce our financial costs of replacing nursing professionals or utilizing costly temporary nursing resources. We will utilize comprehensive nurse satisfaction surveys to measure whether the model is being embraced by the nursing staff and if the initiatives included in the model result in a more engaged workforce.

Physician collaboration and alignment

In order to help our communities achieve health for life, we must work collaboratively with physicians to provide clinically superior healthcare services. The first step in this process is to ensure that physician resources are available to provide the necessary services to our patients. During fiscal 2009, we recruited approximately 150 physicians to the communities we serve through both employment and non-employment initiatives. During fiscal 2010, we expect to recruit approximately 200 additional physicians primarily through employment arrangements. Most of these recruiting initiatives relate to primary care or hospitalist physicians, but certain specialists will also be targeted such as: cardiovascular, neurology, obstetrics/gynecology, orthopedics and urology. We will continue to provide significant corporate and regional resources to assist in the relocation and management of these new physician practices.

Delivering an ideal patient-centered experience requires that we align the goals of the physicians who practice in our hospitals to the goals previously discussed in our nursing professional practice model while respecting physician care decisions and methods of practice. We have implemented multiple initiatives including physician leadership councils, physician training programs and information technology upgrades to ease the flow of on-site and off-site communication between physicians, nurses and patients in order to effectively align the interest of all patient caregivers. These initiatives are just some of those included in our clinical integration roadmap.

Two significant initiatives that are currently underway to achieve physician alignment are our employed hospitalist strategy and our medical officer leadership strategy. We have currently implemented our new hospitalist model in most of our Arizona hospitals and are beginning implementation in a second market. We intend to commit significant resources during fiscal 2010 to grow our employed hospitalist program. We believe that hospitalists provide an effective means through which care can be coordinated between specialist physicians and our nursing staff. The existence of a strong, reputable group of hospitalists provides confidence to admitting physicians that their patients will receive high-quality, coordinated care on a 24-hour, 7-day basis while in our hospitals. The hospitalist model should improve patient satisfaction due to the increase in the number of specialized physician encounters the patients experience. To facilitate care standards for our physicians, we have established chief medical officers at each of our corporate, regional and hospital levels. These officers work with our physician leadership councils to drive our quality of core initiatives. We will continue to utilize physician satisfaction surveys and physician leadership council discussions to measure our physician integration success.

Expansion of services and care efficiencies

We continue to identify services that are in demand in the communities we serve that we do not provide or else only provide on a limited basis. Some of our more significant planned service additions during fiscal year 2010 include the following: women's and children's services in Phoenix; radiology and urology services in Chicago; cardiology services in Massachusetts and orthopedics and women's services in San Antonio. We also plan to launch standardization projects for our emergency and operating room departments across the company during fiscal 2010 that will result in process improvements, better patient throughput and more satisfied patients.

One area where we plan to use technology to improve care efficiencies is in our intensive care units. Due to shortages in the availability of intensivists, we are working to implement electronic intensive care units ("EICUs") at certain of our hospitals. EICUs will provide constant monitoring of intensive care patients even when an intensivist

is not available at the bedside and will enhance communications to both the hospitalist and the specialty physicians of patient conditions. We expect this initiative to improve lengths of stay by shortening the transition time between intensive care beds and general beds and to improve mortality rates.

Strengthening our financial operations to fund continuing community investment

In order to continue to invest in the capital, information and human resources necessary to improve health in our communities, we must continue to generate strong financial returns. We believe that payment mechanisms for hospital providers will continue to transition during the upcoming years, and hospitals will need to transform their delivery of care in order to be successful. We expect to combine a population health strategy with a complex clinical program strategy based on fee for episode as reimbursement transitions away from fee for service. Additionally, quality of care measures have become an increasingly important factor in governmental and managed care reimbursement. We monitor core measures and other quality of care indicators on a monthly basis and continuously implement process improvements to improve clinical quality.

Many payers, including Medicare and several large managed care organizations, currently require providers to report certain quality measures in order to receive the full amount of payment increases that were awarded automatically in the past. For federal fiscal year 2010, Medicare expanded the number of quality measures to 47 from 43 during federal fiscal year 2009. These measures include risk-adjusted outcomes measures such as 30-day mortality measures for patients who suffered a heart attack, heart failure or pneumonia; additional measures related to patients who underwent surgical procedures such as hospital-acquired infections data; and several patient satisfaction indicators. Many large managed care organizations have developed quality measurement criteria that are similar to or even more stringent than the Medicare requirements. We believe that pay for performance reimbursement will continue to evolve, and that quality measure scores themselves will determine reimbursement. This is evidenced by the Center for Medicare Services' ("CMS") new reforms effective October 1, 2008 that took the first steps toward preventing Medicare from making additional payments to hospitals for treating patients that acquired one of eleven identified hospital-acquired conditions during a hospital stay.

In addition to meeting the reporting or adherence requirements related to core measure scores, we must also continue to successfully negotiate favorable payment rates with our most significant managed care payers. Our service expansion initiatives and organic market growth gives us an expanded presence in the markets we serve and provides opportunities for us to negotiate better rates with these managed care organizations. During fiscal 2009, our San Antonio hospitals also were awarded participation in the CMS ACE demonstration project for cardiology and orthopedic services. We believe that this reimbursement program will be beneficial to us if we are able to efficiently manage the care of those patients.

Our Competitive Strengths

Concentrated Local Market Positions in Attractive Markets

We believe that our markets are attractive because of their favorable demographics, competitive landscape, payer mix and opportunities for expansion. Ten of our 15 hospitals are located in markets with long-term population growth rates in excess of the national average and all of our acute care hospitals are located in markets in which the median household income is above the national average. For the fiscal year ended June 30, 2009, we derived approximately 67% of our total revenues from the San Antonio and metropolitan Phoenix markets, which have high long-term growth projections. Our facilities in these markets primarily serve Bexar County, Texas, which encompasses most of the metropolitan San Antonio area and Maricopa County, Arizona, which encompasses most of the metropolitan Phoenix area. Our strong market positions provide us with opportunities to offer integrated services to patients, receive more favorable reimbursement terms from a broader range of third party payers and realize regional operating efficiencies. The U.S. Census Bureau projects that the number of individuals aged 65 and older will increase by an average of 3.0% each year during the years 2010 to 2020 so that those individuals aged 65 and older would represent approximately 18.6% of the total U.S. population by 2020. Our presence in high growth markets combined with the general aging of the United States population and expected longer life expectancies should result in higher demand for healthcare services and provide growth opportunities for us well into the future.

Strong Management Team with Significant Equity Investment

Our senior management has an average of more than 20 years of experience in the healthcare industry at various organizations, including OrNda Healthcorp, HCA Inc. and HealthTrust, Inc. Many of our senior managers have been with Vanguard since its founding in 1997, and 11 of our 20 members of senior management have worked together managing healthcare companies for up to 30 years, either continuously or from time to time. In connection with consummation of the Merger, the Rollover Management Investors purchased Class A membership units in Holdings having an aggregate purchase price of approximately $119.1 million which then represented approximately 15.9% of our equity interests.

Proven Ability to Complete and Integrate Acquisitions

Including our first acquisition in 1998, we have selectively acquired 18 hospitals, 12 of which were formerly not-for-profit hospitals. We have subsequently sold 3 of these hospitals and ceased acute care operations in another. We believe our success in completing acquisitions is due in large part to our disciplined approach to making acquisitions. Prior to completing an acquisition, we carefully review the operations of the target facility and develop a strategic plan to improve performance. We have routinely rejected acquisition candidates that did not meet our financial and operational criteria.

We believe our historical performance demonstrates our ability to identify underperforming facilities and improve the operations of acquired facilities. When we acquire a hospital, we generally implement a number of measures to lower costs, and we often make significant investments in the facility to expand existing services and introduce new services, strengthen the medical staff and improve our overall market position. We expect to continue to grow revenues and profitability in the markets in which we operate by improving quality of care, increasing the depth and breadth of services provided and through the implementation of additional operational enhancements.

The Markets We Serve

San Antonio, Texas

In the San Antonio market, as of June 30, 2009, we owned and operated 5 hospitals with a total of 1,741 licensed beds and related outpatient service locations complementary to the hospitals. We acquired these hospitals in January 2003 from the non-profit Baptist Health Services (formerly known as Baptist Health System) and continue to operate the hospitals as the Baptist Health System. The acquisition followed our strategy of acquiring a significant market share in a growing market, San Antonio, Texas. Our facilities primarily serve the residents of Bexar County which encompasses most of the metropolitan San Antonio area.

During the years ended June 30, 2008 and 2009, we generated approximately 32.1% and 29.6% of our total revenues, respectively, in this market. We have invested approximately $461.0 million of capital in this market since we purchased these hospitals.

Metropolitan Phoenix, Arizona

In the Phoenix market, as of June 30, 2009, we owned and operated 5 hospitals with a total of 988 licensed beds and related outpatient service locations complementary to the hospitals, a prepaid Medicaid managed health plan, Phoenix Health Plan ("PHP"), and a managed Medicare and dual-eligible health plan, Abrazo Advantage Health Plan ("AAHP"). Phoenix is the fifth largest city in the U.S. and has been one of the fastest growing major metropolitan areas during the past ten years. Our facilities primarily serve the residents of Maricopa County, which encompasses most of the metropolitan Phoenix area.

During the years ended June 30, 2008 and 2009, exclusive of PHP and AAHP, we generated approximately 18.8% and 17.9% of our total revenues, respectively, in this market. Three of our hospitals in this market were formerly not-for-profit hospitals. We believe that payers will choose to contract with us in order to give their enrollees a comprehensive choice of providers in the western and northern Phoenix areas. Recently, we have negotiated improvements in our payer rates at our Phoenix hospitals generally, and Arizona's state Medicaid program remains a comprehensive provider of healthcare coverage to low income individuals and families. We

believe our network strategy will position us to continue to negotiate favorable rate increases with managed care payers and to build upon our network's comprehensive range of integrated services. In addition, our ownership of PHP and AAHP will allow us to enroll eligible patients, who would not otherwise be able to pay for healthcare services, into our health plan or into other state-approved plans.

Metropolitan Chicago, Illinois

In the Chicago metropolitan area, as of June 30, 2009, we owned and operated 2 hospitals with 766 licensed beds, and related outpatient service locations complementary to the hospitals. Weiss Hospital is operated by us in a consolidated joint venture corporation in which we own 80.1% and the University of Chicago Hospitals owns 19.9% of the equity interests. During the years ended June 30, 2008 and 2009, we generated approximately 14.9% and 14.6%, respectively, of our total revenues in this market.

We chose MacNeal Hospital and Weiss Hospital, both former not-for-profit facilities, as our first two entries into the largely not-for-profit metropolitan Chicago area. Both MacNeal and Weiss Hospitals are large, well-equipped, university-affiliated hospitals with strong reputations and medical staffs. We believe we have captured a large share of the patients in MacNeal Hospital's immediate surrounding service area, which encompasses the cities of Berwyn and Cicero, Illinois. MacNeal offers tertiary services such as open heart surgery that patients would otherwise have to travel outside the local community to receive. We have also established fully-integrated healthcare systems at MacNeal and Weiss Hospitals by operating free-standing primary care and occupational medicine centers and a large commercial reference laboratory. As of June 30, 2009, these health systems employed 67 physicians including 32 primary care physicians. Our network of 21 primary care and occupational medicine centers allows us to draw patients to MacNeal and Weiss from around the metropolitan Chicago area. Both hospitals partner with various medical schools, the most significant being the University of Chicago Medical School and the University of Illinois Medical School, to provide medical training through residency programs in multiple specialties. In addition, MacNeal Hospital runs a successful free-standing program in family practice, one of the oldest such programs in the state of Illinois, and Weiss Hospital also runs a successful free-standing residency program in internal medicine. Our medical education programs help us to attract quality physicians to both the hospitals and our network of primary care and occupational medicine centers.

Massachusetts

In Massachusetts, as of June 30, 2009, we owned and operated 3 hospitals with a total of 640 licensed beds and related healthcare services complementary to the hospitals. These hospitals include Saint Vincent Hospital located in Worcester and MetroWest Medical Center, a two-campus hospital system comprised of Framingham Union Hospital in Framingham and Leonard Morse Hospital in Natick. These hospitals were acquired by us on December 31, 2004. We believe that opportunities for growth through increased market share exist in the Massachusetts area through the possible addition of new services, partnerships and the implementation of a strong primary care physician strategy. During the years ended June 30, 2008 and 2009, the Massachusetts facilities represented 19.7% and 18.3% of our total revenues, respectively.

Saint Vincent Hospital, located in Worcester, is a 321-bed teaching hospital with an extensive residency program. Worcester is located in central Massachusetts and is the second largest city in Massachusetts. The service area is characterized by a patient base that is older, more affluent and well-insured. Saint Vincent Hospital is focused on strengthening its payer relationships, developing its primary care physician base and expanding its offerings in cardiology, orthopedics, radiology and minimally-invasive surgery capabilities.

MetroWest Medical Center's two campus system has a combined total of 319 licensed beds with locations in Framingham and Natick, in the suburbs west of Boston. These facilities serve communities that are generally well-insured. We are seeking to develop strong ambulatory care capabilities in these service areas, as well as to expand our oncology, radiology, women's services and cardiology services.

Our Facilities

We owned and operated 15 acute care hospitals as of June 30, 2009. The following table contains information concerning our hospitals:

Hospital	City	Licensed Beds	Date Acquired
Texas			
Baptist Medical Center	San Antonio	636	January 1, 2003
Northeast Baptist Hospital	San Antonio	367	January 1, 2003
North Central Baptist Hospital	San Antonio	268	January 1, 2003
Southeast Baptist Hospital	San Antonio	175	January 1, 2003
St. Luke's Baptist Hospital	San Antonio	295	January 1, 2003
Arizona			
Maryvale Hospital	Phoenix	232	June 1, 1998
Arrowhead Hospital	Glendale	220	June 1, 2000
Phoenix Baptist Hospital	Phoenix	236	June 1, 2000
Paradise Valley Hospital	Phoenix	136	November 1, 2001
West Valley Hospital (1)	Goodyear	164	September 4, 2003
Illinois			
MacNeal Hospital	Berwyn	427	February 1, 2000
Louis A. Weiss Memorial Hospital (2)	Chicago	339	June 1, 2002
Massachusetts			
MetroWest Medical Center – Leonard Morse Hospital	Natick	141	December 31, 2004
MetroWest Medical Center - Framingham Union Hospital	Framingham	178	December 31, 2004
Saint Vincent Hospital at Worcester Medical Center	Worcester	321	December 31, 2004
Total Licensed Beds		4,135	

(1) This hospital was constructed, not acquired.

(2) This hospital is operated by us in a consolidated joint venture corporation in which we own 80.1% of the equity interests and the University of Chicago Hospitals owns 19.9% of the equity interests.

In addition to the hospitals listed in the table above, as of June 30, 2009, we owned certain outpatient service locations complementary to our hospitals and two surgery centers in Orange County, California. We also own and operate a limited number of medical office buildings in conjunction with our hospitals which are primarily occupied by physicians practicing at our hospitals.

Our Hospital Operations

Acute Care Services

Our hospitals typically provide the full range of services commonly available in acute care hospitals, such as internal medicine, general surgery, cardiology, oncology, neurosurgery, orthopedics, obstetrics, diagnostic and emergency services, as well as select tertiary services such as open-heart surgery and level II and III neonatal intensive care. Our hospitals also generally provide outpatient and ancillary healthcare services such as outpatient surgery, laboratory, radiology, respiratory therapy and physical therapy. We also provide outpatient services at our imaging centers and ambulatory surgery centers. Certain of our hospitals have a limited number of psychiatric, skilled nursing and rehabilitation beds.

Management and Oversight

Our senior management team has extensive experience in operating multi-facility hospital networks and plays a vital role in the strategic planning for our facilities. A hospital's local management team is generally comprised of a chief executive officer, chief operating officer, chief financial officer and chief nursing officer. Local management teams, in consultation with our corporate staff, develop annual operating plans setting forth revenue growth strategies through the expansion of offered services and the recruitment of physicians in each community, as well as plans to improve operating efficiencies and reduce costs. We believe that the ability of each local management team to identify and meet the needs of our patients, medical staffs and the community as a whole is critical to the success of our hospitals. We base the compensation for each local management team in part on its ability to achieve the goals set forth in the annual operating plan, including quality of care, patient satisfaction and financial measures.

Boards of trustees at each hospital, consisting of local community leaders, members of the medical staff and the hospital chief executive officer, advise the local management teams. Members of each board of trustees are identified and recommended by our local management teams and serve three-year staggered terms. The boards of trustees establish policies concerning medical, professional and ethical practices, monitor these practices and ensure that they conform to our high standards. We have recently formed Physician Advisory Councils at each of our hospitals that focus on quality of care, clinical integration and other issues important to physicians and make recommendations to the boards of trustees as necessary. We maintain company-wide compliance and quality assurance programs and use patient care evaluations and other assessment methods to support and monitor quality of care standards and to meet accreditation and regulatory requirements.

We also provide support to the local management teams through our corporate resources in areas such as revenue cycle, business office, legal, managed care, clinical efficiency, physician services and other administrative functions. These resources also allow for sharing best practices and standardization of policies and processes among all of our hospitals.

Attracting Patients

We believe that the most important factors affecting a patient's choice in hospitals are the reputation of the hospital's nursing staff for delivering quality care, the availability and expertise of physicians caring for patients at the facility and the location and convenience of the hospital. Other factors that affect utilization include local demographics and population growth, local economic conditions and the hospital's success in contracting with a wide range of local payers.

Outpatient Services

The healthcare industry has experienced a general shift during recent years from inpatient services to outpatient services as Medicare, Medicaid and managed care payers have sought to reduce costs by shifting lower-acuity cases to an outpatient setting. Advances in medical equipment technology and pharmacology have supported the shift to outpatient utilization, which has resulted in an increase in the acuity of inpatient admissions. However, we expect inpatient admissions to recover over the long-term as the baby boomer population reaches ages where inpatient admissions become more prevalent. We have responded to the shift to outpatient services through expanding service offerings and increasing the throughput and convenience of our emergency departments, outpatient surgery facilities and other ancillary units in our hospitals. We also own two ambulatory surgery centers in Orange County, California, interests in diagnostic imaging centers in San Antonio, Texas, outpatient diagnostic imaging centers in metropolitan Phoenix, Arizona and a network of primary care and occupational medicine centers in metropolitan Chicago, Illinois. We continually upgrade our resources, including procuring excellent physicians and nursing staff and utilizing technologically advanced equipment, to support our comprehensive service offerings to capture inpatient volumes from the baby boomers. We have focused on core services including cardiology, neurology, oncology, orthopedics and women's services. We also operate sub-acute units such as rehabilitation, skilled nursing facilities and psychiatric services, where appropriate, to meet the needs of our patients while increasing volumes and increasing care management efficiencies.

Operating Statistics

The following table sets forth certain operating statistics from continuing operations for the periods indicated. Acute care hospital operations are subject to fluctuations due to seasonal cycles of illness and weather, including increased patient utilization during the cold weather months and decreases during holiday periods.

	Year Ended June 30,				
	2005	2006	2007	2008	2009
Number of hospitals at end of period (a)	15	15	15	15	15
Number of licensed beds at end of period (b)	3,907	3,937	4,143	4,181	4,135
Discharges (c)	147,798	162,446	166,873	169,668	167,880
Adjusted discharges - hospitals (d)	231,322	261,056	264,698	270,076	274,767
Average length of stay (days) (e)	4.2	4.3	4.3	4.3	4.2
Average daily census (f)	1,708	1,921	1,978	2,008	1,945
Net patient revenue per adjusted hospital discharge (g)	$ 6,859	$ 7,319	$ 7,766	$ 8,110	$ 8,623
Total surgeries (h)	101,368	113,043	113,833	110,877	114,348
Member lives (i)	146,700	146,200	145,600	149,600	218,700

(a) The number of hospitals at the end of each period represents hospitals included in continuing operations.

(b) Licensed beds are those beds for which a facility has been granted approval to operate from the applicable state licensing agency.

(c) Represents the total number of patients discharged (in the facility for an overnight stay) from our hospitals and is used by management and certain investors as a general measure of inpatient volumes.

(d) Adjusted discharges-hospitals is used by management and certain investors as a general measure of combined inpatient and outpatient volumes and is computed by multiplying discharges by the sum of gross hospital inpatient and outpatient revenues and then dividing the result by gross hospital inpatient revenues. This computation enables management to assess hospital volumes by a combined measure of inpatient and outpatient volumes.

(e) Average length of stay represents the average number of days admitted patients stay in our hospitals.

(f) Average daily census represents the average number of patients in our hospitals each day during our ownership.

(g) Net revenue per adjusted hospital discharge is calculated by dividing hospital net patient revenues by hospital adjusted discharges and measures the average net payment expected to be received for a patient's hospital stay.

(h) Total surgeries represent the sum of inpatient surgeries and outpatient surgeries performed at our hospitals or ambulatory surgery centers.

(i) Member lives represents the total number of enrollees in our Arizona prepaid managed health plans and our Chicago capitated health plan as of the end of the respective period.

Our Health Plan Operations

Phoenix Health Plan

In addition to our hospital operations, we own three health plans. PHP is a prepaid Medicaid managed health plan that currently serves nine counties in the Phoenix, Arizona area. We acquired PHP in May 2001. We are able to enroll eligible patients in our hospitals into PHP or other approved Medicaid managed health plans who otherwise would not be able to pay for their hospital expenses. We believe the volume of patients generated through our health plans will help attract quality physicians to the communities our hospitals serve.

For the year ended June 30, 2009, we derived approximately $577.7 million of our total revenues from PHP. PHP had approximately 176,200 enrollees as of June 30, 2009, and derives substantially all of its revenues through a contract with the Arizona Health Care Cost Containment System ("AHCCCS"), which is Arizona's state Medicaid

program. The contract requires PHP to arrange for healthcare services for enrolled Medicaid patients in exchange for monthly capitation payments and supplemental payments from AHCCCS. PHP subcontracts with physicians, hospitals and other healthcare providers to provide services to its enrollees. These services are provided regardless of the actual costs incurred to provide these services. We receive reinsurance and other supplemental payments from AHCCCS to cover certain costs of healthcare services that exceed certain thresholds.

As part of its contract with AHCCCS, PHP is required to maintain a performance guarantee in the amount of $40.0 million. Vanguard maintains this performance guarantee on behalf of PHP in the form of surety bonds totaling $40.0 million with independent third party insurers that expire on October 1, 2009. We were also required to arrange for $5.0 million in letters of credit to collateralize our $40.0 million in surety bonds with the third party insurers. The amount of the performance guaranty that AHCCCS requires is based upon the membership in the health plan and the related capitation amounts paid to us.

Our current contract with AHCCCS commenced on October 1, 2008 and covers members in nine Arizona counties: Apache, Conconino, Gila, Maricopa, Mohave, Navajo, Pima, Pinal and Yavapai. This contract covers the three-year period beginning October 1, 2008 and ending September 30, 2011. Our previous contract with AHCCCS covered only Gila, Maricopa and Pinal counties. AHCCCS has the option to renew the new contract, in whole or in part, for two additional one-year periods commencing on October 1, 2011 and on October 1, 2012.

Abrazo Advantage Health Plan

Effective January 1, 2009, AAHP became a Medicare Advantage Prescription Drug Special Needs Plan provider under a contract with CMS. This allows AAHP to offer Medicare and Part D drug benefit coverage for Medicare members and dual-eligible members (those that are eligible for Medicare and Medicaid). PHP has historically served dual-eligible members through its AHCCCS contract. As of June 30, 2009, approximately 2,800 members were enrolled in AAHP, most of whom were previously enrolled in PHP. For the year ended June 30, 2009, we derived approximately $40.1 million of our total revenues from AAHP.

MacNeal Health Providers

The operations of MHP are somewhat integrated with our MacNeal Hospital in Berwyn, Illinois. For the year ended June 30, 2009, we derived approximately $60.2 million of our total revenues from MHP. MHP generates revenues from its contracts with health maintenance organizations from whom it took assignment of capitated member lives as well as third party administration services for other providers. As of June 30, 2009, MHP had contracts in effect covering approximately 39,700 capitated member lives. Such capitation is limited to physician services and outpatient ancillary services and does not cover inpatient hospital services. We try to utilize MacNeal Hospital and its medical staff as much as possible for the physician and outpatient ancillary services that are required by such capitation arrangements. Revenues of MHP are dependent upon health maintenance organizations in the metropolitan Chicago area continuing to assign capitated-member lives to health plans like MHP as opposed to entering into direct fee-for-service arrangements with healthcare providers.

Competition

The hospital industry is highly competitive. We currently face competition from established, not-for-profit healthcare systems, investor-owned hospital companies, large tertiary care hospitals, specialty hospitals and outpatient service providers. In the future, we expect to encounter increased competition from companies, like ours, that consolidate hospitals and healthcare companies in specific geographic markets. Continued consolidation in the healthcare industry will be a leading factor contributing to increased competition in our current markets and markets we may enter in the future. Due to the shift to outpatient care and more stringent payer-imposed pre-authorization requirements during the past few years, most hospitals have significant unused capacity resulting in increased competition for patients. Many of our competitors are larger than us and have more financial resources available than we do. Other not-for-profit competitors have endowment and charitable contribution resources available to them and can purchase equipment and other assets on a tax-free basis.

One of the most important factors in the competitive position of a hospital is its location, including its geographic coverage and access to patients. A location convenient to a large population of potential patients or a

wide geographic coverage area through hospital networks can make a hospital significantly more competitive. Another important factor is the scope and quality of services a hospital offers, whether at a single facility or a network of facilities, compared to the services offered by its competitors. A hospital or network of hospitals that offers a broad range of services and has a strong local market presence is more likely to obtain favorable managed care contracts. We intend to evaluate changing circumstances in the geographic areas in which we operate on an ongoing basis to ensure that we offer the services and have the access to patients necessary to compete in these managed care markets and, as appropriate, to form our own, or join with others to form, local hospital networks.

A hospital's competitive position also depends in large measure on the quality and specialties of physicians associated with the hospital. Physicians refer patients to a hospital primarily on the basis of the quality and breadth of services provided by the hospital, the quality of the nursing staff and other professionals affiliated with the hospital, the hospital's location and the availability of modern equipment and facilities. Although physicians may terminate their affiliation with our hospitals, we seek to retain physicians of varied specialties on our medical staffs and to recruit other qualified physicians by maintaining or improving our level of services and providing quality facilities, equipment and nursing care for our patients.

Another major factor in the competitive position of a hospital is the ability of its management to obtain contracts with managed care plans and other group payers. The importance of obtaining managed care contracts has increased in recent years due primarily to consolidations of health plans and is expected to continue to increase as private and government payers increasingly turn to managed care organizations to help control rising healthcare costs. Our markets have experienced significant managed care penetration. The revenues and operating results of our hospitals are significantly affected by our hospitals' ability to negotiate favorable contracts with managed care plans. Health maintenance organizations and preferred provider organizations use managed care contracts to encourage patients to use certain hospitals in exchange for discounts from the hospitals' established charges. Traditional health insurers and large employers also are interested in containing costs through similar contracts with hospitals.

The hospital industry and our hospitals continue to have significant unused capacity. Inpatient utilization, average lengths of stay and average occupancy rates have historically been negatively affected by payer-required pre-admission authorization, utilization review and payer pressure to maximize outpatient and alternative healthcare delivery services for less acutely ill patients. Admissions constraints, payer pressures and increased competition are expected to continue. We expect to meet these challenges first and foremost by our continued focus on our previously discussed quality of care initiatives, which should increase patient, nursing and physician satisfaction. We also may expand our outpatient facilities, strengthen our managed care relationships, upgrade facilities and equipment and offer new or expanded programs and services.

Employees and Medical Staff

As of June 30, 2009, we had approximately 19,200 employees, including approximately 2,100 part-time employees. Approximately 1,600 of our full-time employees at our three Massachusetts hospitals are unionized. Overall, we consider our employee relations to be good. While some of our non-unionized hospitals experience union organizing activity from time to time, we do not currently expect these efforts to materially affect our future operations. Our hospitals, like most hospitals, have experienced labor costs rising faster than the general inflation rate.

While the national nursing shortage has abated somewhat as a result of the weakended U.S. economy, certain pockets of the markets we serve continue to have limited available nursing resources. Nursing shortages often result in our using more contract labor resources to meet increased demand especially during the peak winter months. We expect our nurse leadership and recruiting initiatives to mitigate the impact of the nursing shortage. These initiatives include more involvement with nursing schools, participation in more job fairs, recruiting nurses from abroad, implementing preceptor programs, providing flexible work hours, improving performance leadership training, creating awareness of our quality of care and patient safety initiatives and providing competitive pay and benefits. We anticipate that demand for nurses will continue to exceed supply especially as the baby boomer population reaches the ages where inpatient stays become more frequent. We continue to implement best practices to reduce turnover and to stabilize our nursing workforce over time.

One of our primary nurse recruiting strategies for our San Antonio hospitals is our continued investment in the Baptist Health System School of Health Professions ("SHP"), our nursing school in San Antonio. SHP offers seven different healthcare educational programs with its greatest enrollment in the professional nursing program. SHP trains approximately 450 students each year. The majority of these students have historically chosen permanent employment with our hospitals. We have changed SHP's nursing program from a diploma program to a degree program and may improve other SHP programs in future periods. We completed the necessary steps during fiscal 2009 to make SHP students eligible for participation in the Pell Grant and other federal grant and loan programs. We expect these enhancements will make SHP more attractive to potential students.

Our hospitals grant staff privileges to licensed physicians who may serve on the medical staffs of multiple hospitals, including hospitals not owned by us. A physician who is not an employee can terminate his or her affiliation with our hospital at any time. Although we employ a growing number of physicians, a physician does not have to be our employee to be a member of the medical staff of one of our hospitals. Any licensed physician may apply to be admitted to the medical staff of any of our hospitals, but admission to the staff must be approved by each hospital's medical staff and board of trustees in accordance with established credentialing criteria. Under state laws and other licensing standards, hospital medical staffs are generally self-governing organizations subject to ultimate oversight by the hospital's local governing board. Although we were generally successful in our physician recruiting efforts during fiscal 2009, we face continued challenges in some of our markets to recruit certain types of physician specialists who are in high demand. We expect that our previously described physician recruiting and alignment initiatives will make our hospitals more desirable environments in which more physicians will choose to practice.

Compliance Program

We voluntarily maintain a company-wide compliance program designed to ensure that we maintain high standards of ethics and conduct in the operation of our business and implement policies and procedures so that all our employees act in compliance with all applicable laws, regulations and company policies. The organizational structure of our compliance program includes oversight by our board of directors and a high-level corporate management compliance committee. The board of directors and compliance committee are responsible for ensuring that the compliance program meets its stated goals and remains up-to-date to address the current regulatory environment and other issues affecting the healthcare industry. Our Senior Vice President of Compliance and Ethics reports jointly to our Chairman and Chief Executive Officer and to our board of directors, serves as our Chief Compliance Officer and is charged with direct responsibility for the day-to-day management of our compliance program. Other features of our compliance program include Regional Compliance Officers who report to our Chief Compliance Officer in all four of our operating regions, initial and periodic ethics and compliance training and effectiveness reviews, a toll-free hotline for employees to report, without fear of retaliation, any suspected legal or ethical violations, annual "fraud and abuse" audits to examine all of our payments to physicians and other referral sources and annual "coding audits" to make sure our hospitals bill the proper service codes for reimbursement from the Medicare program.

Our compliance program also oversees the implementation and monitoring of the standards set forth by the Health Insurance Portability and Accountability Act ("HIPAA") for privacy and security. To facilitate reporting of potential HIPAA compliance concerns by patients, family or employees, we established a second toll-free hotline dedicated to HIPAA and other privacy matters. Corporate HIPAA compliance staff monitors all reports to the privacy hotline and each phone call is responded to appropriately. Ongoing HIPAA compliance also includes self-monitoring of HIPAA policy and procedure implementation by each of our healthcare facilities and corporate compliance oversight.

Our Information Systems

We believe that our information systems must cost-effectively meet the needs of our hospital management, medical staff and nurses in the following areas of our business operations:

- patient accounting, including billing and collection of revenues;
- accounting, financial reporting and payroll;
- coding and compliance;
- laboratory, radiology and pharmacy systems;

- medical records and document storage;
- remote physician access to patient data;
- quality indicators;
- materials and asset management; and
- negotiating, pricing and administering our managed care contracts.

During fiscal 2009, we invested significantly in clinical information technology. We believe that the importance of and reliance upon clinical information technology will continue to increase in the future. Accordingly, we expect to make additional significant investments in clinical information technology during fiscal years 2010 and 2011 as part of our business strategy to increase the efficiency and quality of patient care.

Although we map the financial information systems from each of our hospitals to one centralized database, we do not automatically standardize our financial information systems among all of our hospitals. We carefully review the existing systems at the hospitals we acquire. If a particular information system is unable to cost-effectively meet the operational needs of the hospital, we will convert or upgrade the information system at that hospital to one of several standardized information systems that can cost-effectively meet these needs.

Professional and General Liability Insurance

As is typical in the healthcare industry, we are subject to claims and legal actions by patients and others in the ordinary course of business. For claims incurred on or after June 1, 2002 through May 31, 2006, our wholly owned captive insurance subsidiary insured our professional and general liability risks at a $10.0 million retention level. For professional and general liability claims incurred from June 1, 2006 to June 30, 2009, we self-insured the first $9.0 million of each claim, and the captive subsidiary insured the next $1.0 million. We maintain excess coverage from independent third-party carriers for individual claims exceeding $10.0 million per occurrence up to $75.0 million, but limited to total annual payments of $65.0 million in the aggregate. The captive insurance subsidiary funds its portion of claims costs from proceeds of premium payments received from us.

The malpractice insurance environment remains volatile. Some states in which we operate, including Texas and Illinois, have passed in recent years tort reform legislation to place limits on non-economic damages. However, in November 2007 a judge in the Illinois Cook County Circuit Court declared that these Illinois malpractice limits were unconstitutional under state law. While such ruling is being considered in an appeal to the Illinois Supreme Court, we understand that the trial courts are not enforcing the non-economic damages limits under that Illinois tort reform statute. Additionally, in Texas an action has been brought to declare its tort reform legislation unconstitutional under federal law. Thus, while we have taken multiple steps at our facilities to reduce our professional liability exposures, absent significant legislation (not later declared unconstitutional) to curb the size of malpractice judgments in the states in which we operate, our insurance costs may increase in the future.

Sources of Revenues

Hospital revenues depend upon inpatient occupancy levels, the medical and ancillary services ordered by physicians and provided to patients, the volume of outpatient procedures and the charges or payment rates for such services. Charges and reimbursement rates for inpatient services vary significantly depending on the type of payer, the type of service (e.g., acute care, intensive care or subacute) and the geographic location of the hospital. Inpatient occupancy levels fluctuate for various reasons, many of which are beyond our control.

We receive payment for patient services from:

- the federal government, primarily under the Medicare program;
- state Medicaid programs;
- health maintenance organizations, preferred provider organizations, managed Medicare providers, managed Medicaid providers and other private insurers; and
- individual patients

The table below presents the approximate percentage of net patient revenues we received from the following sources for the periods indicated:

	Year ended June 30,		
Payer Source	2007	2008	2009
Medicare	26%	26%	25%
Medicaid	9	8	8
Managed Medicare	13	14	14
Managed Medicaid	7	7	9
Other managed care plans	32	35	35
Self-pay	10	9	8
Commercial	3	1	1
Total	100%	100%	100%

The Medicare program, the nation's largest health insurance program, is administered by CMS. Medicare provides certain hospital and medical insurance benefits to persons age 65 and over, some disabled persons and persons with end-stage renal disease without regard to beneficiary income or assets. Medicaid is a federal-state program, administered by the states, which provides hospital and medical benefits to qualifying individuals who are unable to afford healthcare. All of our general, acute care hospitals located in the United States are certified as healthcare services providers for persons covered under the Medicare and the various state Medicaid programs. Amounts received under these programs are generally significantly less than established hospital gross charges for the services provided.

Our hospitals offer discounts from established charges to certain group purchasers of healthcare services, including private insurance companies, employers, health maintenance organizations, preferred provider organizations and other managed care plans. These discount programs limit our ability to increase net revenues in response to increasing costs. Patients generally are not responsible for any difference between established hospital charges and amounts reimbursed for such services under Medicare, Medicaid and managed care programs, but are generally responsible for exclusions, deductibles and coinsurance features of their coverages. Due to rising healthcare costs, many payers have increased the number of excluded services and the levels of deductibles and coinsurance resulting in a higher portion of the contracted rate due from the individual patients. Collecting amounts due from individual patients is typically more difficult than collecting from governmental or private managed care plans.

Traditional Medicare

One of the ways Medicare beneficiaries can elect to receive their medical benefits is through the traditional Medicare program, which provides reimbursement under a prospective payment fee-for-service system. A general description of the types of payments we receive for services provided to patients enrolled in the traditional Medicare program is provided below. The impact of recent changes to reimbursement for these types of services is included in the section entitled "Annual Medicare Regulatory Update."

Medicare Inpatient Acute Care Reimbursement

Medicare Severity-Adjusted Diagnosis-Related Group Payments. Sections 1886(d) and 1886(g) of the Social Security Act (the "Act") set forth a system of payments for the operating and capital costs of inpatient acute care hospital admissions based on a prospective payment system. Under the inpatient prospective payment system, Medicare payments for hospital inpatient operating services are made at predetermined rates for each hospital discharge. Discharges are classified according to a system of Medicare severity-adjusted diagnosis-related groups ("MS-DRGs"), which categorize patients with similar clinical characteristics that are expected to require similar amounts of hospital resources to treat. CMS assigns to each MS-DRG a relative weight that represents the average resources required to treat cases in that particular MS-DRG, relative to the average resources used to treat cases in all MS-DRGs.

The base payment amount for the operating component of the MS-DRG payment is comprised of an average standardized amount that is divided into a labor-related share and a nonlabor-related share. Both the labor-related share of operating base payments and the base payment amount for capital costs are adjusted for geographic variations in labor and capital costs, respectively. These base payments are multiplied by the relative weight of the MS-DRG assigned to each case. The MS-DRG operating and capital base rates, relative weights and geographic adjustment factors are updated annually, with consideration given to: the increased cost of goods and services purchased by hospitals; the relative costs associated with each MS-DRG; and changes in labor data by geographic area. Although these payments are adjusted for area labor and capital cost differentials, the adjustments do not consider an individual hospital's operating and capital costs. Historically, the average operating and capital costs for our hospitals have exceeded the Medicare rate increases. These annual adjustments are effective for the Medicare fiscal year beginning October 1 of each year and are indicated by the "market basket index" for that year.

Outlier Payments. Outlier payments are additional payments made to hospitals for treating Medicare patients that are costlier to treat than the average patient in the same MS-DRG. To qualify as a cost outlier, a hospital's billed charges, adjusted to cost, must exceed the payment rate for the MS-DRG by a fixed threshold established annually by CMS. The Medicare fiscal intermediary calculates the cost of a claim by multiplying the billed charges by a cost-to-charge ratio that is typically based upon the hospital's most recently filed cost report. Generally, if the computed cost exceeds the sum of the MS-DRG payment plus the fixed threshold, the hospital receives 80% of the difference as an outlier payment.

Under the Act, CMS must project aggregate annual outlier payments to all prospective payment system hospitals to be not less than 5% or more than 6% of total MS-DRG payments. CMS adjusts the fixed threshold on an annual basis to bring the outlier percentage within the 5% to 6% parameters. Changes to the outlier fixed threshold amount can impact a hospital's number of cases that qualify for the additional payment and the amount of reimbursement the hospital receives for those cases that qualify. The most recently filed cost reports for our hospitals as of June 30, 2007, 2008 and 2009 reflected outlier payments of $5.8 million, $4.3 million and $4.2 million, respectively.

Disproportionate Share Hospital Payments. Hospitals that treat a disproportionately large number of low-income patients currently receive additional payments from Medicare in the form of disproportionate share hospital ("DSH") payments. DSH payments are determined annually based upon certain statistical information defined by CMS and are calculated as a percentage add-on to the MS-DRG payments. This percentage varies, depending on several factors that include the percentage of low-income patients served. CMS has recommended certain changes to the DSH formula, including a change that would give greater weight to the amount of uncompensated care provided by a hospital than it would to the number of low-income patients treated. During the years ended June 30, 2008 and 2009, we recognized $59.4 million and $53.4 million of Medicare DSH revenues, respectively.

Direct Graduate and Indirect Medical Education. The Medicare program provides additional reimbursement to approved teaching hospitals for additional expenses incurred by such institutions. This additional reimbursement, which is subject to certain limits, including intern and resident full-time equivalent limits established in 1996, is made in the form of Direct Graduate Medical Education ("GME") and Indirect Medical Education ("IME") payments. During our fiscal year 2009, five of our hospitals were affiliated with academic institutions and received GME or IME payments.

Medicare Outpatient Services Reimbursement

CMS reimburses hospital outpatient services and certain Medicare Part B services furnished to hospital inpatients who have no Part A coverage on a prospective payment system basis. CMS utilizes existing fee schedules to pay for physical, occupational and speech therapies, durable medical equipment, clinical diagnostic laboratory services and nonimplantable orthotics and prosthetics. Freestanding surgery centers and independent diagnostic testing facilities also receive reimbursement from Medicare on a fee schedule basis.

Those hospital outpatient services subject to prospective payment reimbursement are classified into groups called ambulatory payment classifications ("APCs"). Services in each APC are similar clinically and in terms of the resources they require. A payment rate is established for each APC. Depending upon the services provided, a hospital may be paid for more than one APC for a patient visit. CMS periodically updates the APCs and annually

adjusts the rates paid for each APC. As part of a final rule published in November 2007, CMS outlined the requirements for hospitals to submit quality data relating to outpatient care in order to receive the full market basket index increase starting in 2009. This rule required submission of seven quality measures in 2009 or else the market basket index increase would be reduced by two percentage points. We submitted the required quality data for 2009

Rehabilitation Units

CMS reimburses inpatient rehabilitation designated units pursuant to a prospective payment system. Under this prospective payment system, patients are classified into case mix groups based upon impairment, age, comorbidities and functional capability. Inpatient rehabilitation units are paid a predetermined amount per discharge that reflects the patient's case mix group and is adjusted for area wage levels, low-income patients, rural areas and high-cost outliers. As of June 30, 2009, we operated three inpatient rehabilitation units within our acute care hospitals.

Skilled Nursing Units

From July 1998 to June 2002, Medicare phased in a prospective payment system for Medicare skilled nursing units, under which the units are paid a federal per diem rate for virtually all covered services. The effect of this new payment system generally has been to significantly reduce reimbursement for skilled nursing services, which has led many hospitals to close such units. We will monitor closely and evaluate the few remaining skilled nursing units in our hospitals and related facilities to determine whether it is feasible to continue to offer such services under this reimbursement system. As of June 30, 2009, we operated one skilled nursing unit within our acute care hospitals.

Psychiatric Units

Medicare utilizes a prospective payment system to pay inpatient psychiatric hospitals and units. This system is a per diem prospective payment system with adjustments to account for certain patient and facility characteristics. Additionally, this system includes a stop-loss provision, an "outlier" policy authorizing additional payments for extraordinarily costly cases and an adjustment to the base payment if the facility maintains a full-service emergency department which all of our units qualified for. As of June 30, 2009, we operated six even psychiatric units within our acute care hospitals.

Annual Medicare Regulatory Update

The annual Medicare regulatory update published by CMS on August 27, 2009 in the Federal Register provided for the following adjustments in Medicare reimbursement for the Medicare fiscal year 2010 (October 1, 2009 through September 30, 2010):

- A market basket index increase of 2.1% for MS-DRG operating payments for hospitals who reported the 43 patient quality care indicators from 2009 and 0.1% for those who did not (this compares to 3.6% for 2009 and 3.3% for 2008, both of which are subject to a 2.0% reduction for those hospitals who did not report the patient quality care indicators applicable to those years).

- No across-the-board reduction to the to the MS-DRG base payment rate to offset the effect of documentation and/or coding changes or the classification of discharges not related to case mix changes (2009 and 2008 included reductions of 0.9% and 0.6%, respectively). However, CMS will consider phasing in future adjustments over an extended period beginning in fiscal 2011.

- Continuation of the capital indirect medical adjustment to payment rates for teaching hospitals.

- Continuation of a provision of the Deficit Reduction Act of 2005 that precludes hospitals from receiving additional payments to treat costs associated with 10 specifically identified patient hospital-acquired conditions including infections (the same 10 identified conditions as for 2009, but compares to 8 identified conditions for 2008).

- An increase in the inpatient cost outlier threshold to $23,140 from $20,045 in 2009 and $22,185 in 2008.

- An increase in the capital federal MS-DRG rate of 1.4% (compares to a 1.9% increase for federal fiscal year 2009).

- A market basket increase of 2.2% for hospital skilled nursing unit payment rates (this compares to 3.4% for 2009 and 3.3% for 2008).

- A market basket increase of 2.5% for hospital rehabilitation unit payment rates (this compares to 0% for both 2009 and 2008).

We have submitted the required patient care quality indicators for our hospitals to receive the full market basket index increases for the both the inpatient and outpatient prospective payment systems for 2009. We intend to submit the necessary information to realize the full federal fiscal year 2010 inpatient and outpatient increases as well. However, as additional patient quality indicator reporting requirements are added, system limitations or other difficulties could result in CMS deeming our submissions not timely or not complete to qualify for the full market basket index increases. Additionally, Congress has given CMS the ability to continue to evaluate whether the 2008 and 2009 inpatient reductions for documentation and coding adjustments were sufficient to account for payment changes not related to case mix changes. This continuing evaluation could negatively impact MS-DRG payment rates for federal fiscal years 2011 and 2012. Further realignments in the MS-DRG system could also reduce the payments we receive for certain specialties, including cardiology and orthopedics. The more widespread development of specialty hospitals in recent years has caused CMS to focus on payment levels for these specialty services. Changes in the payments for specialty services could adversely impact our revenues. We do not believe that the final Medicare payment updates for federal fiscal year 2010 will have a significant impact on our future financial position, results of operations or cash flows.

Contractor Reform

CMS has a significant initiative underway that could affect the administration of the Medicare program and impact how hospitals bill and receive payment for covered Medicare services. In accordance with the Medicare Modernization Act ("MMA"), CMS has begun implementation of contractor reform whereby CMS will competitively bid the Medicare fiscal intermediary and Medicare carrier functions to 15 Medicare Administrative Contractors ("MACs"). Hospital management companies like Vanguard will have the option to work with the selected MAC in the jurisdiction where a given hospital is located or to use the MAC in the jurisdiction where our home office is located. For hospital management companies, either all hospitals in the system must choose to stay with the MAC chosen for their locality or all hospitals must opt to use the home office MAC. We have filed a request for our single home office MAC to serve all of our hospitals. CMS has now completed the process of awarding contracts for all 15 MAC jurisdictions. Individual MAC jurisdictions are in varying phases of transition. All of these changes could impact claims processing functions and the resulting cash flows; however, we are unable to predict the impact that these changes could have, if any, to our cash flows.

Recovery Audit Contractors

The MMA established the Recovery Audit Contractor ("RAC") three-year demonstration program to detect Medicare overpayments not identified through existing claims review mechanisms. The RAC program relies on private auditing firms to examine Medicare claims filed by healthcare providers. Fees to the RACs are paid on a contingency basis. The RAC program began as a demonstration project in 2005 in three states (New York, California and Florida) which was expanded into the three additional states of Arizona, Massachusetts and South Carolina in July 2007. No RAC audits, however, were initiated at our Arizona or Massachusetts hospitals during the demonstration project. The program was made permanent by the Tax Relief and Health Care Act of 2006 enacted in December 2006. CMS ended the demonstration project in March 2008 and commenced the permanent RAC program in all states beginning in 2009 with plans to have RACs in full operation in all 50 states by 2010.

In a report issued in July 2008, CMS reported that the RACs in the demonstration project corrected over $1 billion of Medicare improper payments from 2005 through March 2008. Roughly 96% of the improper payments ($992.7 million) were overpayments collected from providers, while the remaining 4% ($37.8 million) were underpayments repaid to providers. Of the overpayments, 85% were collected from inpatient hospital providers,

while the other principal collections were 6% from inpatient rehabilitation facilities, and 4% from outpatient hospital providers.

RACs utilize a post-payment targeted review process employing data analysis techniques in order to identify those Medicare claims most likely to contain overpayments, such as incorrectly coded services, incorrect payment amounts, non-covered services and duplicate payments. The RAC review is either "automated", for which a decision can be made without reviewing a medical record, or "complex", for which the RAC must contact the provider in order to procure and review the medical record to make a decision about the payment. CMS has given RACs the authority to look back at claims up to three years old, provided that the claim was paid on or after October 1, 2007. Claims identified as overpayments will be subject to the Medicare appeals process.

As to "automated" reviews where a review of the medical record is not required, RACs make claim determinations using proprietary software designed to detect certain kinds of errors where both of the following conditions must apply. First, there must be certainty that the service is not covered or is coded incorrectly. Second, there must be a written Medicare policy, Medicare article or Medicare-sanctioned coding guideline supporting the determination. For example, an automated review could identify when a provider is billing for more units than allowed on one day. However, the RAC may also use automated review even if such written policies don't exist on certain CMS-approved "clinically unbelievable issues" and when making certain other types of administrative determinations (e.g., duplicate claims, pricing mistakes) when there is certainty that an error exists.

As to "complex" reviews where a review of the medical review is required, RACs make claim determinations when there is a high probability (but not certainty) that a service is not covered, or where no Medicare policy, guidance or Medicare-sanctioned coding guideline exists. It is expected that many complex reviews will be medical necessity audits that assess whether care provided was medically necessary and provided in the appropriate setting. It is currently expected that, while RACs will make complex reviews in calendar year 2009 related to DRG validation and coding, the RACs will not conduct complex reviews for medical necessity cases until calendar year 2010.

RACs are paid a contingency fee based on the overpayments they identify and collect. Therefore, we expect that the RACs will look very closely at claims submitted by our facilities in an attempt to identify possible overpayments. We believe the claims for reimbursement submitted to the Medicare program by our facilities have been accurate. However, we cannot predict, once our facilities are subject to RAC reviews in all subject matters in the future, the results of such reviews. It is reasonably possible that the aggregate payments that our facilities will be required to return to the Medicare program pursuant to these RAC reviews may have a material adverse effect on our financial position, results of operations or cash flows.

Managed Medicare

Managed Medicare plans represent arrangements where a private company contracts with CMS to provide members with Medicare Part A, Part B and Part D benefits. Managed Medicare plans can be structured as health maintenance organizations, preferred provider organizations or private fee-for-service plans. The Medicare program allows beneficiaries to choose enrollment in certain managed Medicare care plans. MMA increased reimbursement to managed Medicare plans and included provisions limiting, to some extent, the financial risk to the companies offering the plans. Following these changes, the number of beneficiaries choosing to receive their Medicare benefits through such plans increased significantly. However, the Medicare Improvement for Patients and Providers Act of 2008 reduced payments to managed Medicare plans, and CMS has recently proposed additional payment cuts to managed Medicare plans. Future changes may result in reduced premium payments to managed Medicare plans and may lead to decreased enrollment in such plans.

Medicaid

Medicaid programs are funded jointly by the federal government and the states and are administered by states under approved plans. Most state Medicaid program payments are made under a prospective payment system or are based on negotiated payment levels with individual hospitals. Medicaid reimbursement is less than Medicare reimbursement for the same services and is often less than a hospital's cost of services. The federal government and many states have recently reduced or are currently considering legislation to reduce the level of Medicaid funding

(including upper payment limits) or program eligibility that could adversely affect future levels of Medicaid reimbursement received by our hospitals. As permitted by law, certain states in which we operate have adopted broad-based provider taxes to fund their Medicaid programs. Since states must operate with balanced budgets and since the Medicaid program is often the state's largest program, states may consider further reductions in their Medicaid expenditures.

As to recent federal action affecting Medicaid, the Deficit Reduction Act of 2005 ("DRA 2005") included Medicaid cuts in federal funding of approximately $4.8 billion over five years. Additionally, on May 29, 2007, CMS published a final rule entitled "Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership" which was estimated to reduce federal Medicaid funding from $12 to $20 billion over five years. Congress enacted two moratoria in respect of this rule that delayed six of the seven proposed Medicaid regulations in this final CMS rule until July 1, 2009. On June 30, 2009, three more of the Medicaid regulations that had been under a congressional moratorium set to expire July 1, 2009 were officially rescinded all or in part by CMS, and CMS also delayed until June 30, 2010 the enforcement of the fourth of the six regulations. As a result of these changes in implementing the final CMS 2007 rule, the impact on us of the final rule can not be quantified.

Disproportionate Share Payments

Certain states in which we operate provide disproportionate share payments to hospitals that treat a disproportionately large number of low-income patients as part of their state Medicaid programs, similar to disproportionate share payments received from Medicare. During the years ended June 30, 2008 and 2009, we recognized revenues of approximately $20.2 million and $26.0 million, respectively, related to Medicaid disproportionate share reimbursement payments. These amounts do not include our revenues recognized from payments related to the Texas UPL program and the Illinois PTA program, which totaled $44.4 million during fiscal 2009, since these programs are separate from DSH. These states continually assess the level of expenditures for disproportionate share reimbursement and may reduce these payments or restructure this portion of their Medicaid programs.

Given the recent budgetary challenges that most states faced (including those in which we operate) for their new fiscal years, it is reasonable to believe that Medicaid payment rates, coverage levels or patient eligibility could be reduced in future periods as new tax collections data is received. Such legislation could also include taxes assessed on hospitals to help fund or expand the states' Medicaid programs or else to balance their general budgets. Future federal or state legislation or other changes in the administration or interpretation of government health programs by the federal government or by the states in which we operate could have a material, adverse effect on our financial position, results of operations and cash flows.

Managed Medicaid

Managed Medicaid programs represent arrangements where states contract with one or more entities for patient enrollment, care management and claims adjudication for enrollees in their state Medicaid programs. The states usually do not give up program responsibilities for financing, eligibility criteria and core benefit plan design. We generally contract directly with one of the designated entities, usually a managed care organization. The provisions of these programs are state-specific.

Annual Cost Reports

All hospitals participating in the Medicare and Medicaid programs are required to meet specific 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. Moreover, annual cost reports required under the Medicare and Medicaid programs are subject to routine audits, which may result in adjustments to the amounts ultimately determined to be due to us under these reimbursement programs. The audit process takes several years to reach the final determination of allowable amounts under the programs. Providers also have the right of appeal, and it is common to contest issues raised in audits of prior years' reports.

Many prior year cost reports of our facilities are still open. If any of our facilities are found to have been in violation of federal or state laws relating to preparing and filing of Medicare or Medicaid cost reports, whether prior to or after our ownership of these facilities, we and our facilities could be subject to substantial monetary fines, civil and criminal penalties and exclusion from participation in the Medicare and Medicaid programs. If an allegation is lodged against one of our facilities for a violation occurring during the time period before we acquired the facility, we may have indemnification rights against the seller of the facility to us. In each of our acquisitions, we have negotiated customary indemnification and hold harmless provisions for any damages we may incur in these areas.

Managed Care and Other Private Insurers

Managed care providers, including health maintenance organizations, preferred provider organizations, other private insurance companies and employers, are organizations that provide insurance coverage and a network of healthcare providers to members for a fixed monthly premium. To attract additional volume, most of our hospitals offer discounts from established charges or prospective payment systems to these large group purchasers of healthcare services. These discount programs often limit our ability to increase charges in response to increasing costs. However, as part of our business strategy, we have been able to renegotiate payment rates on many of our managed care contracts to improve our operating margin. While we generally received annual average payment rate increases of 5 to 11 percent from non-governmental managed care payers during fiscal year 2009, there can be no assurance that we will continue to receive increases in the future and that patient volumes from these payers will not be adversely affected by rate negotiations. These contracts often contain exclusions, carve-outs, performance criteria and other provisions and guidelines that require our constant focus and attention. Patients who are members of managed care plans are not required to pay us for their healthcare services except for coinsurance and deductible portions of their plan coverage calculated after managed care discounts have been applied. While the majority of our admissions and revenues are generated from patients covered by managed care plans, the percentage may decrease in the future due to increased Medicare utilization associated with the aging U.S. population. We experienced a slight decrease in managed care utilization of inpatient days as a percentage of total inpatient days during the year ended June 30, 2009 compared to the year ended June 30, 2008.

Self-Pay Patients

Self-pay patients are patients who do not qualify for government programs payments, such as Medicare and Medicaid, who do not qualify for charity care under our guidelines and who do not have some form of private insurance. These patients are responsible for their own medical bills. We also include in our self-pay accounts those unpaid coinsurance and deductible amounts for which payment has been received from the primary payer.

Effective for service dates on or after April 1, 2009, as a result of a state mandate, we implemented a new uninsured discount policy for those patients receiving services in our Illinois hospitals who had no insurance coverage and who did not otherwise qualify for charity care under our guidelines. Under this policy, we apply an uninsured discount (calculated as a standard percentage of gross charges) at the time of patient billing and include this discount as a reduction to patient service revenues. These discounts were approximately $11.7 million for the year ended June 30, 2009. We implemented this policy for most of our remaining facilities effective July 1, 2009 and expect to implement it at all of our facilities by the end of our fiscal year 2010.

A significant portion of our self-pay patients are admitted through our hospitals' emergency departments and often require high-acuity treatment. High-acuity treatment is more costly to provide and, therefore, results in higher billings, which are the least collectible of all accounts. We believe self-pay patient volumes and revenues have been impacted during the last two years due to a combination of broad economic factors, including reductions in state Medicaid budgets, increasing numbers of individuals and employers who choose not to purchase insurance and an increased burden of coinsurance and deductibles to be made by patients instead of insurers.

Self-pay accounts pose significant collectibility problems. At June 30, 2009, approximately 24.5% of our accounts receivable, prior to the allowance for doubtful accounts, contractual allowances and the charity care allowance, was comprised of self-pay accounts. The majority of our provision for doubtful accounts relates to self-pay patients. While our combined allowances for doubtful accounts, uninsured discounts and charity care cover over 96% of our self-pay receivables, we remain vulnerable to further increased self-pay utilization. We are taking multiple actions in an effort to mitigate the effect on us of the high number of uninsured patients and the related

economic impact. These initiatives include conducting detailed reviews of intake procedures in hospitals facing the greatest pressures and applying these intake best practices to all of our hospitals. We developed hospital-specific reports detailing collection rates by type of patient to help the hospital management teams better identify areas of vulnerability and opportunities for improvement. Also, we completely redesigned our self-pay collection workflows, enhanced technology and improved staff training in an effort to increase collections.

We do not pursue collection of amounts due from uninsured patients that qualify for charity care under our guidelines (currently those uninsured patients whose incomes are equal to or less than 200% of the current federal poverty guidelines set forth by the Department of Health and Human Services). We exclude charity care accounts from revenues when we determine that the account meets our charity care guidelines. We provide expanded discounts from billed charges and alternative payment structures for uninsured patients who do not qualify for charity care but meet certain other minimum income guidelines, primarily those uninsured patients with incomes between 200% and 500% of the federal poverty guidelines. During our fiscal years ended June 30, 2007, 2008 and 2009, we deducted $86.1 million, $86.1 million and $91.8 million of charity care from gross charges, respectively.

Other Reimbursement Regulatory and Legislative Changes

Other regulatory and legislative actions that impact or may have a future impact on Medicare or Medicaid reimbursement are set forth below.

- CMS Medicare Value-Based Purchasing Program Report – Congress, through DRA 2005, authorized the Secretary of Health and Human Services to develop a plan to implement value-based purchasing ("VBP"). In November 2007, CMS issued a report to Congress with its plan to implement a VBP program that would transform Medicare from a passive payer of claims to an active purchaser of care. Under this proposal, its VBP program would make a portion of hospital payments contingent on actual performance under specified standards rather than simply on the hospital's reporting data for those measures. We can not predict what action Congress will ultimately take regarding implementation of a VBP program at this time.

- Medicare regulation of serious medical errors – In an effort to encourage hospitals to improve quality of care, the Medicare program and certain state Medicaid programs have taken steps to withhold payments to hospitals for treatment provided to patients whose conditions were caused by serious medical error. Effective October 1, 2008, Medicare will no longer pay hospitals for the additional costs of care resulting from eight medical events such as patient falls, objects left inside patients during surgery, pressure ulcers, and certain types of infections. Certain states have established policies or proposed legislation to prohibit hospitals from charging or receiving payments from their Medicaid programs for highly preventable adverse medical events (often called "never events"), which were developed by the National Quality Forum. Never events include wrong-site surgery, serious medication errors, discharging a baby to the wrong mother, etc.

- SCHIP Extension Act of 2007 – The State Children's Health Insurance Program ("SCHIP") provides health insurance coverage for poor children. SCHIP is jointly funded by the federal government and state governments but is administered and designed by the states. SCHIP provided a capped amount of funds to states on a matching basis through September 30, 2007, when it expired. SCHIP funding was extended through March 31, 2009 by a law signed in December 2007. President Obama signed the State Children's Insurance Program bill in February 2009, which extends SCHIP by 4.5 years and expands the program to an additional 4.5 million children.

- The American Recovery and Reinvestment Act of 2009 – In February 2009, President Obama signed the American Recovery and Reinvestment Act of 2009 into law. The $787 billion economic stimulus plan includes certain measures affecting medical providers including: $21 billion in health insurance assistance that includes COBRA continuation coverage for unemployed workers; a freeze until September 30, 2009 of the final rule phasing out Medicare IME capital payments; $86.7 billion for a temporary (27-month) increase in the rate at which the federal government matches states' Medicaid expenditures and a 2.5% increase in the states' fiscal year 2009 and 2010 DSH payments (with 2010's 2.5% increase being above the new 2009 payment), but will revert to 100% of the annual DSH allotments under current law after 2010; and $31 billion in new spending on health information technology, most of which is for incentive

payments to physicians and hospitals and $2 billion for health information technology grants.

We can not predict what impact these measures will have on our future results of operations or cash flows at this time.

Government Regulation and Other Factors

Overview

All participants in the healthcare industry are required to comply with extensive government regulation at the federal, state and local levels. In addition, these laws, rules and regulations are extremely complex and the healthcare industry has had the benefit of little or no regulatory or judicial interpretation of many of them. Although we believe we are in compliance in all material respects with such laws, rules and regulations, if a determination is made that we were in material violation of such laws, rules or regulations, our business, financial condition or results of operations could be materially adversely affected. 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 their ability to participate in the Medicare and Medicaid programs.

Licensing, Certification and Accreditation

Healthcare facility construction and operation is subject to federal, state and local regulations relating to the adequacy of medical care, equipment, personnel, operating policies and procedures, fire prevention, rate-setting and compliance with building codes and environmental protection laws. Our facilities also are subject to periodic inspection by governmental and other authorities to assure continued compliance with the various standards necessary for licensing and accreditation. We believe that all of our operating healthcare facilities are properly licensed under appropriate state healthcare laws.

All of our operating hospitals are certified under the Medicare program and are accredited by The Joint Commission (formerly, known as The Joint Commission on Accreditation of Healthcare Organizations), the effect of which is to permit the facilities to participate in the Medicare and Medicaid programs. If any facility loses its accreditation by The Joint Commission, or otherwise loses its certification under the Medicare program, then the facility will be unable to receive reimbursement from the Medicare and Medicaid programs. We intend to conduct our operations in compliance with current applicable federal, state, local and independent review body regulations and standards. The requirements for licensure, certification and accreditation are subject to change and, in order to remain qualified, we may need to make changes in our facilities, equipment, personnel and services.

Certificates of Need

In some states, the construction of new facilities, acquisition of existing facilities or addition of new beds or services may be subject to review by state regulatory agencies under a Certificate of Need program. Illinois and Massachusetts are the only states in which we currently operate that require approval under a Certificate of Need program. These laws generally require appropriate state agency determination of public need and approval prior to the addition of beds or services or other capital expenditures. Failure to obtain necessary state approval can result in the inability to expand facilities, add services, acquire a facility or change ownership. Further, violation of such laws may result in the imposition of civil sanctions or the revocation of a facility's license.

Utilization Review

Federal law contains numerous provisions designed to ensure that services rendered by hospitals to Medicare and Medicaid patients meet professionally recognized standards and are medically necessary and that claims for reimbursement are properly filed. These provisions include a requirement that a sampling of admissions of Medicare and Medicaid patients be reviewed by quality improvement organizations that analyze the appropriateness of Medicare and Medicaid patient admissions and discharges, quality of care provided, validity of diagnosis related group classifications and appropriateness of cases of extraordinary length of stay or cost. Quality improvement organizations may deny payment for services provided, assess fines and recommend to the Department of Health and Human Services that a provider not in substantial compliance with the standards of the quality improvement

organization be excluded from participation in the Medicare program. Most non-governmental managed care organizations also require utilization review.

Federal Healthcare Program Statutes and Regulations

Participation in any federal healthcare program, such as the Medicare and Medicaid programs, is regulated heavily by statute and regulation. If a hospital provider fails to substantially comply with the numerous conditions of participation in the Medicare or Medicaid program or performs specific prohibited acts, the hospital's participation in the Medicare program may be terminated or civil or criminal penalties may be imposed upon it under provisions of the Social Security Act and other statutes.

Anti-Kickback Statute

A section of the Social Security Act known as the federal Anti-Kickback Statute prohibits providers and others from soliciting, receiving, offering or paying, directly or indirectly, any remuneration with the intent of generating referrals or orders for services or items covered by a federal healthcare program. Violation of this statute is a felony, including criminal penalties of imprisonment or criminal fines up to $25,000 for each violation, but it also includes civil money penalties of up to $50,000 per violation, damages up to three times the total amount of the improper payment to the referral source and exclusion from participation in Medicare, Medicaid or other federal healthcare programs.

The Office of the Inspector General of the Department of Health and Human Services (the "OIG") has published final safe harbor regulations that outline categories of activities that are deemed protected from prosecution under the Anti-Kickback Statute. Currently there are safe harbors for various activities, including the following: investment interests, space rental, equipment rental, practitioner recruitment, personal services and management contracts, sale of practice, referral services, warranties, discounts, employees, group purchasing organizations, waiver of beneficiary coinsurance and deductible amounts, managed care arrangements, obstetrical malpractice insurance subsidies, investments in group practices, ambulatory surgery centers and referral agreements for specialty services.

The fact that conduct or a business arrangement does not fall within a safe harbor does not automatically render the conduct or business arrangement illegal under the Anti-Kickback Statute. The conduct or business arrangement, however, does increase the risk of scrutiny by government enforcement authorities. We may be less willing than some of our competitors to take actions or enter into business arrangements that do not clearly satisfy the safe harbors. As a result, this unwillingness may put us at a competitive disadvantage.

The OIG, among other regulatory agencies, is responsible for identifying and eliminating fraud, abuse and waste. The OIG carries out this mission through a nationwide program of audits, investigations and inspections. In order to provide guidance to healthcare providers, the OIG has from time to time issued "fraud alerts" that, although they do not have the force of law, identify features of a transaction that may indicate that the transaction could violate the Anti-Kickback Statute or other federal healthcare laws. The OIG has identified several incentive arrangements as potential violations, including:

- 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;
- guarantees that 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 or a physician's continuing education courses;

- coverage on the hospital's group health insurance plans at an inappropriately low cost to the physician;

- rental of space in physician offices, at other than fair market value terms, by persons or entities to which physicians refer;

- 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

- "gain sharing," the practice of giving physicians a share of any reduction in a hospital's costs for patient care attributable in part to the physician's efforts.

Also, the OIG has encouraged persons having information about hospitals who offer the above types of incentives to physicians to report such information to the OIG.

The OIG also issues "Special Advisory Bulletins" as a means of providing guidance to healthcare providers. These bulletins, along with other "fraud alerts", have focused on certain arrangements between physicians and providers that could be subject to heightened scrutiny by government enforcement authorities, including, "suspect" joint ventures where physicians may become investors with the provider in a newly formed joint venture entity where the investors refer their patients to this new entity, and are paid by the entity in the form of "profit distributions." These subject joint ventures may be intended not so much to raise investment capital legitimately to start a business, but to lock up a stream of referrals from the physician investors and to compensate them indirectly for these referrals. Because physician investors can benefit financially from their referrals, unnecessary procedures and tests may be ordered or performed, resulting in unnecessary Medicare expenditures.

Similarly, in a Special Advisory Bulletin issued in April 2003, the OIG focused on "questionable" contractual arrangements where a healthcare provider in one line of business (the "Owner") expands into a related healthcare business by contracting with an existing provider of a related item or service (the "Manager/Supplier") to provide the new item or service to the Owner's existing patient population, including federal healthcare program patients (so called "suspect Contractual Joint Ventures"). The Manager/Supplier not only manages the new line of business, but may also supply it with inventory, employees, space, billing, and other services. In other words, the Owner contracts out substantially the entire operation of the related line of business to the Manager/Supplier – otherwise a potential competitor – receiving in return the profits of the business as remuneration for its federal program referrals. The Bulletin lists the following features of these "questionable" contractual relationships. First, the Owner expands into a related line of business, which is dependent on referrals from, or other business generated by, the Owner's existing business. Second, the Owner neither operates the new business itself nor commits substantial financial, capital or human resources to the venture. Instead, it contracts out substantially all the operations of the new business. The Manager/Supplier typically agrees to provide not only management services, but also a range of other services, such as the inventory necessary to run the business, office and healthcare personnel, billing support, and space. Third, the Manager/Supplier is an established provider of the same services as the Owner's new line of business. In other words, absent the contractual arrangement, the Manager/Supplier would be a competitor of the new line of business, providing items and services in its own right, billing insurers and patients in its own name, and collecting reimbursement. Fourth, the Owner and the Manager/Supplier share in the economic benefit of the Owner's new business. The Manager/Supplier takes its share in the form of payments under the various contracts with the Owner; the Owner receives its share in the form of the residual profit from the new business. Fifth, aggregate payments to the Manager/Supplier typically vary with the value or volume of business generated for the new business by the Owner. We monitor carefully our contracts with other healthcare providers and attempt to not allow our facilities to enter into these suspect Contractual Joint Ventures.

In addition to issuing fraud alerts and Special Advisory Bulletins, the OIG from time to time issues compliance program guidance for certain types of healthcare providers. In January 2005, the OIG published a Supplemental

Compliance Guidance for Hospitals, supplementing its 1998 guidance for the hospital industry. In the supplemental guidance, the OIG identifies a number of risk areas under federal fraud and abuse statutes and regulations. These areas of risk include compensation arrangements with physicians, recruitment arrangements with physicians and joint venture relationships with physicians.

We have a variety of financial relationships with physicians who refer patients to our hospitals. As of June 30, 2009, physicians owned interests in two of our free-standing surgery centers in California and seven of our diagnostic imaging centers in Texas. We may sell ownership interests in certain other of our facilities to physicians and other qualified investors in the future. We also have contracts with physicians providing for a variety of financial arrangements, including employment contracts, leases and professional service agreements. We have provided financial incentives to recruit physicians to relocate to communities served by our hospitals, including income and collection guarantees and reimbursement of relocation costs, and will continue to provide recruitment packages in the future. Although we have established policies and procedures to ensure that our arrangements with physicians comply with current law and applicable regulations, we cannot assure you that regulatory authorities that enforce these laws will not determine that some of these arrangements violate the Anti-Kickback Statute or other applicable laws. An adverse determination could subject us to liabilities under the Social Security Act, including criminal penalties, civil monetary penalties and exclusion from participation in Medicare, Medicaid or other federal healthcare programs, any of which could have a material adverse effect in our business, financial condition or results of operations.

Other Fraud and Abuse Provisions

The Social Security Act also imposes criminal and civil penalties for submitting false claims to Medicare and Medicaid. False claims include, but are not limited to, billing for services not rendered, misrepresenting actual services rendered in order to obtain higher reimbursement and cost report fraud. Like the Anti-Kickback Statute, these provisions are very broad. Further, the Social Security Act contains civil penalties for conduct including improper coding and billing for unnecessary goods and services. Careful and accurate preparation and submission of claims for reimbursement must be performed in order to avoid liability.

The Health Insurance Portability and Accountability Act of 1996 broadened the scope of the fraud and abuse laws by adding several criminal provisions for healthcare fraud offenses that apply to all health benefit programs. This Act also created new enforcement mechanisms to combat fraud and abuse, including the Medicaid Integrity Program and an incentive program under which individuals can receive up to $1,000 for providing information on Medicare fraud and abuse that leads to the recovery of at least $100 of Medicare funds. In addition, federal enforcement officials now have the ability to exclude from Medicare and Medicaid any investors, officers and managing employees associated with business entities that have committed healthcare fraud. Additionally, this Act establishes a violation for the payment of inducements to Medicare or Medicaid beneficiaries in order to influence those beneficiaries to order or receive services from a particular provider or practitioner.

Some of these provisions, including the federal Civil Monetary Penalty Law, require a lower burden of proof than other fraud and abuse laws, including the Anti-kickback Statute. Civil monetary penalties that may be imposed under the federal Civil Monetary Penalty Law range from $10,000 to $50,000 per act, and in some cases may result in penalties of up to three times the remuneration offered, paid, solicited or received. In addition, a violator may be subject to exclusion from federal and state healthcare programs. Federal and state governments increasingly use the federal Civil Monetary Penalty Law, especially where they believe they cannot meet the higher burden of proof requirements under the Anti-kickback Statute.

The Stark Law

The Social Security Act also includes a provision commonly known as the "Stark Law." This law prohibits physicians from referring Medicare and (to an extent) Medicaid patients to entities with which they or any of their immediate family members have a financial relationship for the provision of certain designated health services that are reimbursable by Medicare or Medicaid, including inpatient and outpatient hospital services. The law also prohibits the entity from billing the Medicare program for any items or services that stem from a prohibited referral. Sanctions for violating the Stark Law include denial of payment, refunding amounts received for services provided pursuant to prohibited referrals, civil money penalties up to $15,000 per item or service improperly billed and

exclusion from the federal healthcare programs. The statute also provides for a penalty of up to $100,000 for a circumvention scheme. There are a number of exceptions to the self-referral prohibition, including an exception for a physician's ownership interest in an entire hospital as opposed to an ownership interest in a hospital department although pending legislation in Congress would substantially restrict this "entire hospital" exception. There are also exceptions for many of the customary financial arrangements between physicians and providers, including employment contracts, leases, professional services agreements, non-cash gifts having an annual value of no more than $355 in calendar 2009 and recruitment agreements. Unlike safe harbors under the Anti-kickback Statute with which compliance is voluntary, an arrangement must comply with every requirement of a Stark Law exception or the arrangement is in violation of the Stark Law.

CMS has issued three phases of final regulations implementing the Stark Law, which became effective on January 4, 2002, July 26, 2004 and December 4, 2007, respectively, and which created several additional exceptions and many technical changes and nuanced details. Also, as part of its annual physician fee schedule update, on July 2, 2007, CMS released a number of proposed and potentially far-reaching changes to the Stark Law regulations apparently resulting from CMS's frustration with what it perceived as a growing number of hospital/physician joint venture arrangements that permitted physicians to profit from their referrals of ancillary services, while side-stepping or working around existing Stark Law restrictions. On July 31, 2008, CMS issued the final hospital inpatient prospective payment system rule for federal fiscal year 2009 which, in part, finalized and responded to public comments regarding some of its July 2007 proposed major changes to the Stark Law regulations to undermine many common hospital/physician joint venture models. The most far-reaching of the changes made in this final July 2008 rule will effectively prohibit, as of a delayed effective date of October 1, 2009, both "under arrangements" ventures between a hospital and any of its physicians and unit-of-service-based "per click" compensation and percentage-based compensation in office space and equipment leases between a hospital and its physicians. We have examined all of our "under arrangements" ventures and space and equipment leases with physicians to identify those arrangements which potentially violate these new Stark regulations, and we are in the process of restructuring or terminating non-conforming arrangements so identified prior to October 1, 2009.

Because the Stark Law and its implementing regulations are relatively new, we do not always have the benefit of significant regulatory or judicial interpretation of this law and its regulations. We attempt to structure our relationships to meet an exception to the Stark Law, but the regulations implementing the exceptions are detailed and complex, and we cannot assure that every relationship complies fully with the Stark Law. In addition, in the July 2008 final Stark rule CMS indicated that it will continue to enact further regulations tightening aspects of the Stark Law that it perceives allow for Medicare program abuse, especially those regulations that still permit physicians to profit from their referrals of ancillary services. There can be no assurance that the arrangements entered into by us and our facilities with physicians will be found to be in compliance with the Stark Law, as it ultimately may be implemented or interpreted.

Similar State Laws, etc.

Many of the states in which we operate also have adopted laws that prohibit payments to physicians in exchange for referrals similar to the federal Anti-Kickback Statute or that otherwise prohibit fraud and abuse activities. Many states also have passed self-referral legislation, similar to the Stark Law, prohibiting the referral of patients to entities with which the physician has a financial relationship. Often these state laws are broad in scope and they may apply regardless of the source of payment for care. These statutes typically provide criminal and civil penalties, as well as loss of licensure. Little precedent exists for the interpretation or enforcement of these state laws.

Certain Implications of these Fraud and Abuse Laws or New Laws

Our operations could be adversely affected by the failure of our arrangements to comply with the Anti-Kickback Statute, the Stark Law, billing laws and regulations, current state laws or other legislation or regulations in these areas adopted in the future. We are unable to predict whether other legislation or regulations at the federal or state level in any of these areas will be adopted, what form such legislation or regulations may take or how they may impact our operations. We are continuing to enter into new financial arrangements with physicians and other providers in a manner structured to comply in all material respects with these laws. We cannot assure you, however, that governmental officials responsible for enforcing these laws will not assert that we are in violation of them or

that such statutes or regulations ultimately will be interpreted by the courts in a manner consistent with our interpretation.

The Federal False Claims Act and Similar Laws

Another trend affecting the healthcare industry today is the increased use of the federal False Claims Act, and, in particular, actions being brought by individuals on the government's behalf under the False Claims Act's "*qui tam*" or whistleblower provisions. Whistleblower provisions allow private individuals to bring actions on behalf of the government alleging that the defendant has defrauded the federal government. If the government intervenes in the action and prevails, the party filing the initial complaint may share in any settlement or judgment. If the government does not intervene in the action, the whistleblower plaintiff may pursue the action independently, and may receive a larger share of any settlement or judgment. When a private party brings a *qui tam* action under the False Claims Act, the defendant generally will not be made aware of the lawsuit until the government makes a determination whether it will intervene.

When a defendant is determined by a court of law to be liable under the False Claims Act, the defendant must pay three times the actual damages sustained by the government, plus mandatory civil penalties of between $5,500 to $11,000 for each separate false claim. Settlements entered into prior to litigation usually involve a less severe calculation of damages. There are many potential bases for liability under the False Claims Act. Although liability often arises when an entity knowingly submits a false claim for reimbursement to the federal government, the False Claims Act defines the term "knowingly" broadly. Thus, simple negligence will not give rise to liability under the False Claims Act, but submitting a claim with reckless disregard to its truth or falsity can constitute "knowingly" submitting a false claim and result in liability. In some cases, whistleblowers or the federal government have taken the position that providers who allegedly have violated other statutes, such as the Anti-Kickback Statute or the Stark Law, have thereby submitted false claims under the False Claims Act.

A number of states, including states in which we operate, have adopted their own false claims provisions as well as their own whistleblower provisions whereby a private party may file a civil lawsuit in state court. From time to time, companies in the healthcare industry, including ours, may be subject to actions under the False Claims Act or similar state laws.

Provisions in the Deficit Reduction Act of 2005 ("DRA") that went into effect on January 1, 2007 give states significant financial incentives to enact false claims laws modeled on the federal False Claims Act. Additionally, the DRA requires every entity that receives annual payments of at least $5 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 health care providers. We have complied with the written policy requirements.

Corporate Practice of Medicine and Fee Splitting

The states in which we operate have laws that prohibit unlicensed persons or business entities, including corporations, from employing physicians or laws that prohibit certain 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 that may violate these restrictions. These statutes vary from state to state, are often vague and seldom have been interpreted by the courts or regulatory agencies. Although we exercise care to structure our arrangements with healthcare providers to comply with the relevant state law, and believe these arrangements comply with applicable laws in all material respects, we cannot assure you that governmental officials responsible for enforcing these laws will not assert that we, or transactions in which we are involved, are in violation of such laws, or that such laws ultimately will be interpreted by the courts in a manner consistent with our interpretations.

The Health Insurance Portability and Accountability Act of 1996

The Administrative Simplification Provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") require the use of uniform electronic data transmission standards for healthcare claims and

payment transactions submitted or received electronically. These provisions are intended to encourage electronic commerce in the healthcare industry. The Department of Health and Human Services ("HHS") has issued regulations implementing the HIPAA Administrative Simplification Provisions and compliance with these regulations is mandatory for our facilities. In January 2009, CMS published a final rule regarding updated standard code sets for certain diagnoses and procedures known as ICD-10 code sets and related changes to the formats used for certain electronic transactions. While use of the ICD-10 code sets is not mandatory until October 1, 2013, we will be modifying our payment systems and processes to prepare for the implementation. In addition, HIPAA requires that each provider use a National Provider Identifier. While use of the ICD-10 code sets will require significant administrative changes, we believe that the cost of compliance with these regulations has not had and is not expected to have a material, adverse effect on our business, financial position or results of operations.

The privacy and security regulations promulgated pursuant to HIPAA extensively regulate the use and disclosure of individually identifiable health information and require covered entities, including our hospitals and health plans, to implement administrative, physical and technical safeguards to protect the security of such information. Recently, the American Recovery and Reinvestment Act of 2009 ("ARRA") broadened the scope of the HIPAA privacy and security regulations. Among other things, the ARRA provides that HHS must issue regulations requiring covered entities to report certain security breaches to individuals affected by the breach and, in some cases, to HHS or to the public via a website. This reporting obligation will apply broadly to breaches involving unsecured protected health information and will become effective 30 days from the date HHS issues these regulations. In addition, the ARRA extends the application of certain provisions of the security and privacy regulations to business associates (entities that handle identifiable health information on behalf of covered entities) and subjects business associates to civil and criminal penalties for violation of the regulations.

Violations of the HIPAA privacy and security regulations may result in civil and criminal penalties, and the ARRA has strengthened the enforcement provisions of HIPAA, which may result in increased enforcement activity. Under the ARRA, HHS is required to conduct periodic compliance audits of covered entities and their business associates. The ARRA broadens the applicability of the criminal penalty provisions to employees of covered entities and requires HHS to impose penalties for violations resulting from willful neglect. The ARRA also significantly increases the amount of the civil penalties, with penalties of up to $50,000 per violation for a maximum civil penalty of $1,500,000 in a calendar year for violations of the same requirement. In addition, the ARRA authorizes state attorneys general to bring civil actions seeking either injunction or damages in response to violations of HIPAA privacy and security regulations that threaten the privacy of state residents.

In addition, we remain subject to any state laws that relate to privacy or the reporting of security breaches that are more restrictive than the regulations issued under HIPAA and the requirements of the ARRA. For example, various state laws and regulations may require us to notify affected individuals in the event of a data breach involving certain individually identifiable health or financial information. In addition, the Federal Trade Commission has issued regulations requiring health providers and health plans to implement by May 1, 2009 written identity theft prevention programs to detect, prevent, and mitigate identity theft in connection with certain accounts. We have complied with these new Federal Trade Commission regulations requiring identity theft prevention programs in all of our hospitals and health plans.

Compliance with these standards has and will continue to require significant commitment and action by us and significant costs. We have appointed members of our management team to direct our compliance with these standards. Implementation has and will continue to require us to engage in extensive preparation and make significant expenditures. At this time we have appointed a corporate privacy officer and a privacy officer at each of our facilities, prepared privacy policies, trained our workforce on these policies and entered into business associate agreements with the appropriate vendors. However, failure by us or third parties on which we rely, including payers, to resolve HIPAA-related implementation or operational issues could have a material adverse effect on our results of operations and our ability to provide healthcare services. Consequently, we can give you no assurance that issues related to the full implementation of, or our operations under, HIPAA will not have a material adverse effect on our financial condition or future results of operations.

Conversion Legislation

Many states have enacted laws affecting the conversion or sale of not-for-profit hospitals. These laws generally include provisions relating to attorney general approval, advance notification and community involvement. In addition, attorneys general in states without specific conversion legislation may exercise authority over these transactions based upon existing law. In many states, there has been an increased interest in the oversight of not-for-profit conversions. The adoption of conversion legislation and the increased review of not-for-profit hospital conversions may increase the cost and difficulty or prevent the completion of transactions with or acquisitions of not-for-profit organizations in various states.

The Emergency Medical Treatment and Active Labor Act

The Federal Emergency Medical Treatment and Active Labor Act ("EMTALA") was adopted by Congress in response to reports of a widespread hospital emergency room practice of "patient dumping." At the time of the enactment, patient dumping was considered to have occurred when a hospital capable of providing the needed care sent a patient to another facility or simply turned the patient away based on such patient's inability to pay for his or her care. The law imposes requirements upon physicians, hospitals and other facilities that provide emergency medical services. Such requirements pertain to what care must be provided to anyone who comes to such facilities seeking care before they may be transferred to another facility or otherwise denied care. The government broadly interprets the law to cover situations in which patients do not actually present to a hospital's emergency department, but present to a hospital-based clinic that treats emergency medical conditions on an urgent basis or are transported in a hospital-owned ambulance, subject to certain exceptions. EMTALA does not generally apply to patients admitted for inpatient services. Sanctions for violations of this statute include termination of a hospital's Medicare provider agreement, exclusion of a physician from participation in Medicare and Medicaid programs and civil monetary penalties. In addition, the law creates private civil remedies that enable an individual who suffers personal harm as a direct result of a violation of the law, and a medical facility that suffers a financial loss as a direct result of another participating hospital's violation of the law, to sue the offending hospital for damages and equitable relief. Although we believe that our practices are in substantial compliance with the law, we cannot assure you that governmental officials responsible for enforcing the law will not assert from time to time that our facilities are in violation of this statute.

Antitrust Laws

The federal government and most states have enacted antitrust laws that prohibit certain types of conduct deemed to be anti-competitive. These laws prohibit price fixing, agreements to fix wages, concerted refusal to deal, market monopolization, price discrimination, tying arrangements, acquisitions of competitors and other practices that have, or may have, an adverse effect on competition. Violations of federal or state antitrust laws can result in various sanctions, including criminal and civil penalties. Antitrust enforcement in the healthcare industry is currently a priority of the Federal Trade Commission. We believe we are in compliance with such federal and state laws, but there can be no assurance that a review of our practices by courts or regulatory authorities will not result in a determination that could adversely affect our operations.

Healthcare Reform

The healthcare industry, as one of the largest industries in the United States, continues to attract much legislative interest and public attention. The Obama administration has stated as its top domestic priority its desire to reform the U.S. healthcare system with the goal of providing affordable, accessible healthcare for all Americans while slowing the growth of healthcare costs. This priority was demonstrated in February 2009, when President Obama released a federal budget proposal to Congress that includes plans to expand coverage to more Americans, but also to reduce Medicare and Medicaid spending over ten years by $316.0 billion in the form of reduced subsidies to Medicare Advantage health plans, cuts in payments to hospitals with high readmission rates and bundled payments for post-acute services during the 30 days following inpatient stays and value-based purchasing savings by linking a portion of Medicare payments to hospitals to performance on specific quality measures. To implement their version of President Obama's reform plans, in July 2009 four of the five Congressional committees working on healthcare reform approved some version of reform legislation. In the House of Representatives, all three committees working on the legislation (the Committees on Ways and Means, Energy and Commerce and Education

and Labor) passed different versions of the same bill under which the principal provisions were as follows: (1) for individuals not currently covered, a new healthcare exchange will be established where they can select from a menu of healthcare options: either a new "public health insurance option" or a plan offered by private insurers; (2) the legislation will provide for portable, secure health care plans, with standardized and comprehensive healthcare benefits, ending denials of care based on pre-existing conditions and capping out-of-pocket expenses; (3) the federal government will provide affordability credits, available on a sliding scale for low- and middle-income individuals and families, to make premiums affordable and reduce cost-sharing; and (4) the legislation imposes both an individual and employer mandate: individuals would be required to obtain and maintain health insurance coverage or be subject to a penalty of 2.5% of modified adjusted gross income above certain specified levels; employers may choose to fund 72.5% of an individual employee's premium cost (65% for families) or contribute an amount ranging from 2% to 8% of the employer's payroll, with small businesses (payroll below $250,000) being exempt from the employer mandate. In the House Energy and Commerce Committee several key provisions of the legislation were changed to reduce its costs, to increase to $500,000 in payroll (from $250,000) the threshold at which small businesses would be required to offer health insurance and to permit providers to negotiate payment rates for the federally-administered "public option" health insurance plan rather than linking payments to Medicare rates. During the Congressional recess in August 2009, the three House committees worked to meld the bills into one final version for consideration by the entire House of Representatives as early as September 2009. In the Senate, its Committee on Health, Education, Labor and Pensions approved its version of healthcare reform legislation on July 15, 2009 which is similar to, but less extensive in benefits than, the House version. Meanwhile, during August 2009 the Senate Committee on Finance continued its efforts to negotiate a bipartisan agreement on healthcare reform legislation and that committee is not expected to vote upon its healthcare reform bill until at least September 2009, when Congress returns from its August recess. One of the most significant differences in the legislation produced by the Senate Finance Committee is likely to be the establishment of state and/or regional health insurance cooperatives in lieu of a federally-administered "public option" to compete with private health insurance plans. The health cooperatives would be privately-administered, non-profit entities managed by a board of directors comprised of cooperative members. The Senate Finance Committee is also developing additional tax proposals such as taxing healthcare benefits under the most generous plans, as well as Medicare and Medicaid reductions, to offset the cost of the legislation. Furthermore, unlike the proposals passed by the four other House and Senate committees, it is anticipated that the Senate Finance Committee package will likely not include a requirement that employers must offer health insurance coverage to employees and their families. Once passed by the Senate Finance Committee, the two Senate committees will need to merge the two bills into one final version for consideration by the entire Senate, potentially in September or October 2009.

Also, many states have enacted or are considering enacting measures designed to reduce their Medicaid expenditures. States have also adopted, or are considering, legislation designed to reduce coverage and program eligibility and/or impose additional taxes on hospitals to help finance or expand states' Medicaid systems. Also, many states, including the states in which we operate, have applied for and been granted federal waivers from current Medicaid regulations to allow them to serve some or all of their Medicaid participants through managed care providers.

We are unable to predict the future course of federal or state healthcare legislation. Further changes in the law or regulatory framework that reduce our revenues or increase our costs could have a material adverse effect on our business, financial condition or results of operations.

Healthcare Industry Investigations

Significant media and public attention has focused in recent years on the hospital industry. In recent years, increased attention has been paid to hospitals with high Medicare outlier payments and to recruitment arrangements with physicians. Further, there are numerous ongoing federal and state investigations regarding multiple issues. These investigations have targeted hospital companies as well as their executives and managers. Like other hospital companies, we have substantial Medicare, Medicaid and other governmental billings and we engage in various arrangements with physicians, which could result in scrutiny of our operations. We continue to monitor these and all other aspects of our business and have developed a compliance program to assist us in gaining comfort that our business practices are consistent with both legal principles and current industry standards. However, because the law in this area is complex and constantly evolving, we cannot assure you that government investigations will not result in interpretations that are inconsistent with industry practices, including ours. In public statements surrounding

current investigations, governmental authorities have taken positions on a number of issues, including some for which little official interpretation previously has been available, that appear to be inconsistent with practices that have been common within the industry and that previously have not been challenged in this manner. In some instances, government investigations that have in the past been conducted under the civil provisions of federal law may now be conducted as criminal investigations.

Many current healthcare investigations are national initiatives in which federal agencies target an entire segment of the healthcare industry. One example is the federal government's initiative regarding hospital providers' improper requests for separate payments for services rendered to a patient on an outpatient basis within three days prior to the patient's admission to the hospital, where reimbursement for such services is included as part of the reimbursement for services furnished during an inpatient stay. In particular, the government has targeted all hospital providers to ensure conformity with this reimbursement rule. The federal government also has undertaken a national investigative initiative targeting the billing of claims for inpatient services related to bacterial pneumonia, as the government has found that many hospital providers have attempted to bill for pneumonia cases under more complex and higher reimbursed diagnosis related groups codes. Further, the federal government continues to investigate Medicare overpayments to prospective payment hospitals that incorrectly report transfers of patients to other prospective payment system hospitals as discharges. We are aware that prior to our acquisition of them, several of our hospitals were contacted in relation to certain government investigations relating to their operations. Although we take the position that, under the terms of the acquisition agreements, the prior owners of these hospitals retained any liability resulting from these government investigations, we cannot assure you that the prior owners' resolution of these matters or failure to resolve these matters, in the event that any resolution was deemed necessary, will not have a material adverse effect on our operations. Further, under the federal False Claims Act, private parties have the right to bring *"qui tam"* whistleblower lawsuits against companies that submit false claims for payments to the government. Some states have adopted similar state whistleblower and false claims provisions.

In addition to national enforcement initiatives, federal and state investigations commonly relate to a wide variety of routine healthcare operations such as: cost reporting and billing practices; financial arrangements with referral sources; physician recruitment activities; physician joint ventures; and hospital charges and collection practices for self-pay patients. We engage in many of these routine healthcare operations and other activities that could be the subject of governmental investigations or inquiries from time to time. For example, we have significant Medicare and Medicaid billings, we have numerous financial arrangements with physicians who are referral sources to our hospitals and we have joint venture arrangements involving physician investors.

While we are not currently aware of any material investigation of us under federal or state health care laws or regulations, it is possible that governmental entities may conduct investigations at facilities operated by us and that such investigations could result in significant penalties to us, as well as adverse publicity. It is also possible that our executives and managers, many of whom have worked at other healthcare companies that are or may become the subject of federal and state investigations and private litigation, could be included in governmental investigations or named as defendants in private litigation. The positions taken by authorities in any future investigations of us, our executives or managers or other healthcare providers and the liabilities or penalties that may be imposed could have a material adverse effect on our business, financial condition and results of operations.

Health Plan Regulatory Matters

Our health plans are subject to state and federal laws and regulations. CMS has the right to audit our health plans to determine the plans' compliance with such standards. In addition, AHCCCS has the right to audit PHP to determine PHP's compliance with such standards. Also, PHP is required to file periodic reports with AHCCCS, meet certain financial viability standards, provide its enrollees with certain mandated benefits and meet certain quality assurance and improvement requirements. Our health plans also have to comply with the standardized formats for electronic transmissions and privacy and security standards set forth in the Administrative Simplifications Provisions of HIPAA. Our health plans have implemented the necessary policies and procedures to comply with the final federal regulations on these matters and were in compliance with them by their deadlines.

The Anti-Kickback Statute has been interpreted to prohibit the payment, solicitation, offering or receipt of any form of remuneration in return for the referral of federal health program patients or any item or service that is reimbursed, in whole or in part, by any federal healthcare program. Similar statutes have been adopted in Illinois and

Arizona that apply regardless of the source of reimbursement. The Department of Health and Human Services has adopted safe harbor regulations specifying certain relationships and activities that are deemed not to violate the Anti-Kickback Statute which specifically relate to managed care including:

- waivers by health maintenance organizations of Medicare and Medicaid beneficiaries' obligations to pay cost-sharing amounts or to provide other incentives in order to attract Medicare and Medicaid enrollees;
- certain discounts offered to prepaid health plans by contracting providers;
- certain price reductions offered to eligible managed care organizations; and
- certain price reductions offered by contractors with substantial financial risk to managed care organizations.

We believe that the incentives offered by our health plans to their enrollees and the discounts they receive contracting with healthcare providers satisfy the requirements of the safe harbor regulations. However, the failure to satisfy each criterion of the applicable safe harbor does not mean that the arrangement constitutes a violation of the law; rather, the safe harbor regulations provide that an arrangement which does not fit within a safe harbor must be analyzed on the basis of its specific facts and circumstances. We believe that our health plans' arrangements comply in all material respects with the federal Anti-Kickback Statute and similar state statutes.

Environmental Matters

We are subject to various federal, state and local laws and regulations relating to environmental protection. Our hospitals are not highly regulated under environmental laws because we do not engage in any industrial activities at those locations. The principal environmental requirements and concerns applicable to our operations relate to:

- the proper handling and disposal of hazardous and low level medical radioactive waste;
- ownership or historical use of underground and above-ground storage tanks;
- management of impacts from leaks of hydraulic fluid or oil associated with elevators, chiller units or incinerators;
- appropriate management of asbestos-containing materials present or likely to be present at some locations; and
- the potential acquisition of, or maintenance of air emission permits for, boilers or other equipment.

We do not expect our compliance with environmental laws and regulations to have a material effect on us. We may also be subject to requirements related to the remediation of substances that have been released into the environment at properties owned or operated by us or at properties where substances were sent for off-site treatment or disposal. These remediation requirements may be imposed without regard to fault and whether or not we owned or operated the property at the time that the relevant releases or discharges occurred. Liability for environmental remediation can be substantial.

Item 1A. Risk Factors.

If any of the following events discussed in the following risks were to occur, our business, results of operations, financial condition, cash flows or prospects could be materially adversely affected. Additional risks and uncertainties not presently known, or currently deemed immaterial by us, may also constrain our business and operations.

Risks Relating to our Capital Structure

Our high level of debt and significant leverage may adversely affect our operations and our ability to grow and otherwise execute our business strategy.

We have a substantial amount of debt. As of June 30, 2009, we had $1,551.6 million of outstanding debt, excluding letters of credit and guarantees. This represented 72.5% of our total capitalization as of June 30, 2009. The amount of our outstanding indebtedness is large compared to the net book value of our assets, and we have significant repayment obligations under our outstanding indebtedness.

Our substantial indebtedness could:

- limit our ability to obtain additional financing to fund future capital expenditures, working capital, acquisitions or other needs;
- increase our vulnerability to general adverse economic, market and industry conditions and limit our flexibility in planning for, or reacting to, these conditions;
- make us vulnerable to increases in interest rates since $316.4 million (as of September 1, 2009) and an additional $450.0 million (after the expiration of our interest rate swap agreement on March 31, 2010) of our borrowings under our senior credit facilities are, and additional borrowings may be, at variable interest rates;
- our flexibility to adjust to changing market conditions and ability to withstand competitive pressures could be limited, and we may be more vulnerable to a downturn in general economic or industry conditions or be unable to carry out capital spending that is necessary or important to our growth strategy and our efforts to improve operating margins;
- limit our ability to use operating cash in other areas of our business because we must use a substantial portion of these funds to make principal and interest payments; and
- limit our ability to compete with others who are not as highly-leveraged.

Our ability to make scheduled payments of principal and interest or to satisfy our other debt obligations, to refinance our indebtedness or to fund capital expenditures will depend on our future operating performance. Prevailing economic conditions (including interest rates) and financial, business and other factors, many of which are beyond our control, will also affect our ability to meet these needs. We may not be able to generate sufficient cash flows from operations or realize anticipated revenue growth or operating improvements, or obtain future borrowings in an amount sufficient to enable us to pay our debt, or to fund our other liquidity needs. We may need to refinance all or a portion of our debt on or before maturity. We may not be able to refinance any of our debt when needed on commercially reasonable terms or at all.

Despite our current significant leverage, we may still be able to incur substantially more debt. This could further exacerbate the risks that we and our subsidiaries face.

We and our subsidiaries may be able to incur substantial additional indebtedness in the future. The terms of the indentures and the senior credit facilities do not fully prohibit us or our subsidiaries from doing so. Our revolving credit facility provides commitments of up to $250.0 million (not giving effect to any outstanding letters of credit, which would reduce the amount available under our revolving credit facility), of which $218.8 million was available for future borrowings as of September 1, 2009. In addition, upon the occurrence of certain events, we may request an incremental term loan facility or facilities be added to our current senior credit facilities in an amount not to exceed $300.0 million in the aggregate, subject to receipt of commitments by existing lenders or other financing institutions and to the satisfaction of certain other conditions. We may in the future borrow all available amounts under the revolving credit facility, under the incremental term loan facility and in addition, we may borrow substantial additional indebtedness in the future under new debt agreements. If new debt is added to our current debt levels, the related risks that we and our subsidiaries now face could intensify.

Operating and financial restrictions in our debt agreements limit our operational and financial flexibility.

The senior credit facilities and the indentures under which $575.0 million aggregate principal amount of our 9.0% senior subordinated notes due 2014 and $216.0 million aggregate principal amount of our 11.25% senior discount notes due 2015 were issued (collectively, the "Public Notes") contain a number of significant covenants that, among other things, restrict our ability to:

- incur additional indebtedness or issue preferred stock;
- pay dividends on or make other distributions or repurchase our capital stock or make other restricted payments;
- make investments;
- enter into certain transactions with affiliates;
- limit dividends or other payments by restricted subsidiaries to our restricted subsidiaries;
- create liens on *pari passu* or subordinated indebtedness without securing the Public Notes;
- designate our subsidiaries as unrestricted subsidiaries; and
- sell certain assets or merge with or into other companies or otherwise dispose of all or substantially all of our assets.

In addition, under the senior credit facilities, we are required to satisfy and maintain specified financial ratios and tests. Events beyond our control may affect our ability to comply with those provisions, and we may not be able to meet those ratios and tests. The breach of any of these covenants would result in a default under the senior credit facilities. In the event of default, the lenders could elect to declare all amounts borrowed under the senior credit facilities, together with accrued interest, to be due and payable and could proceed against the collateral securing that indebtedness. Borrowings under the senior credit facilities are senior in right of payment to the Public Notes. If any of our indebtedness were to be accelerated, our assets may not be sufficient to repay in full that indebtedness and the Public Notes.

Our capital expenditure and acquisition strategies require substantial capital resources. The building of new hospitals and the operations of our existing hospitals and newly acquired hospitals require ongoing capital expenditures for construction, renovation, expansion and the addition of medical equipment and technology. More specifically, we may in the future be contractually obligated to make significant capital expenditures relating to the facilities we acquire. Also, construction costs to build new hospitals are substantial and continue to increase. Our debt agreements may restrict our ability to incur additional indebtedness to fund these expenditures.

A breach of any of the restrictions or covenants in our debt agreements could cause a cross-default under other debt agreements. A significant portion of our indebtedness then may become immediately due and payable. We are not certain whether we would have, or be able to obtain, sufficient funds to make these accelerated payments. If any senior debt is accelerated, our assets may not be sufficient to repay in full such indebtedness and our other indebtedness.

We may not be able to generate sufficient cash to service all of our indebtedness and 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 certain financial, business and other factors beyond our control. We may not be able to 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. In addition, the indentures governing the Public Notes allow us to make significant dividend payments, investments and other restricted payments. Our making these payments could decrease available cash and adversely affect our ability to make principal and interest payments on our indebtedness.

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, seek additional capital or seek to restructure or refinance our indebtedness. These alternative measures may not be successful and may not permit us to meet our scheduled debt service obligations. In the absence of such operating results and resources, we could face substantial liquidity problems and might be required to sell material assets or operations to attempt to meet our debt service and other obligations. The

senior credit facilities and the indentures restrict our ability to use the proceeds from asset sales. We may not be able to consummate those asset sales to raise capital or sell assets at prices that we believe are fair and proceeds that we do receive may not be adequate to meet any debt service obligations then due.

Tightened credit markets and continued economic deterioration may prevent us from servicing our current debt or refinancing, replacing or otherwise obtaining a new revolving loan facility to replace our facility expiring in September 2010 or obtaining the necessary funds to repay a significant portion of our debt that will mature during September 2011.

We are a highly leveraged company. As of June 30, 2009, we had $1,551.6 million of outstanding indebtedness. Of this amount, $766.4 million of term loans mature in September 2011. Additionally, we have a $250.0 million ($218.8 million net of borrowing capacity reductions for our outstanding letters of credit) revolving loan facility that expires in September 2010. The tightened credit markets have especially impacted the ability of highly leveraged companies, like us, to access sources of liquidity on similar terms or pricing as currently in place, or at all. Our inability to replace our revolving credit facility in September 2010 may limit our ability to competitively manage our current operations, make capital expenditures, make required principal and interest repayments under our debt agreements or complete acquisitions to grow our business. If prevailing instability in the credit and financial markets continues, we may be unable to refinance or repay our outstanding $766.4 million term debt due in September 2011. We also make significant cash interest payments on our outstanding $575.0 million 9.0% senior subordinated notes and will be required to make cash interest payments on our $216.0 million 11.25% senior discount notes beginning in April 2010. Should current economic conditions worsen, our operating cash flows may be materially adversely impacted, which could make it more difficult for us to make these cash interest payments. If we were unable to make scheduled interest or principal payments on our debt, we would be in default and, as a result:

- Our debt holders could declare all outstanding principal and interest to be due and payable;
- Our secured debt lenders could terminate their commitments and commence foreclosure proceedings against our assets; and
- We could be forced into bankruptcy or liquidation.

We also face the risk of non-compliance with the debt covenants under our senior secured credit agreement, including the total leverage ratio limit, which decreased to 4.50x from 5.00x for the test period ending March 31, 2009. While we are currently in compliance with all of our debt covenants, future violations of any of these covenants without cure would result in a debt default as described above.

An increase in interest rates would increase the cost of servicing our debt and could reduce our profitability.

A significant portion of the borrowings under our Senior Credit Facilities bear interest at variable rates. As a result, an increase in interest rates, whether because of an increase in market interest rates or an increase in our own cost of borrowing, would increase the cost of servicing our debt and could materially reduce our profitability. The impact of such an increase would be more significant than it would be for some other companies because of our substantial debt. For a discussion of how we manage our exposure to changes in interest rates through the use of interest rate swap agreements on certain portions of our outstanding debt, see "Item 7A. – Quantitave and Qualitative Disclosure About Market Risks."

We are controlled by a small number of stockholders and they may have conflicts of interest with us in the future.

We are controlled by our principal equity sponsors, and they have the ability to control our policies and operations. The interests of our principal equity sponsors may not in all cases be aligned with our interests. For example, our principal equity sponsors could cause us to make acquisitions, divestitures and other transactions that, in their judgment, could enhance their equity investment in us, even though such transactions might reduce cash flows or capital reserves available to fund our debt service obligations. Additionally, our controlling shareholders are in the business of making investments in companies and may from time to time acquire and hold interests in businesses that compete directly or indirectly with us. Accordingly, our principal equity sponsors may also pursue

acquisitions that may be complementary to our business, and as a result, those acquisition opportunities may not be available to us. So long as our principal equity sponsors continue to own a significant amount of our equity interests, even if such amount is less than 50%, they will continue to be able to strongly influence or effectively control our decisions.

Risks Related to our Business

If we are unable to enter into favorable contracts with managed care plans, our operating revenues may be reduced.

Our ability to negotiate favorable contracts with health maintenance organizations, insurers offering preferred provider arrangements and other managed care plans significantly affects the revenues and operating results of our hospitals. Revenues derived from health maintenance organizations, insurers offering preferred provider arrangements and other managed care plans, including managed Medicare and managed Medicaid plans, accounted for approximately 58% of our net patient revenues for the year ended June 30, 2009. Managed care organizations offering prepaid and discounted medical services packages represent an increasing portion of our admissions, a general trend in the industry which has limited hospital revenue growth nationwide and a trend that may continue. In addition, private payers are increasingly attempting to control healthcare costs through direct contracting with hospitals to provide services on a discounted basis, increased utilization review and greater enrollment in managed care programs such as health maintenance organizations and preferred provider organizations. Additionally, the trend towards consolidation among private managed care payers tends to increase their bargaining prices over fee structures. In most cases, we negotiate our managed care contracts annually as they come up for renewal at various times during the year. Our future success will depend, in part, on our ability to renew existing managed care contracts and enter into new managed care contracts on terms favorable to us. Other healthcare companies, including some with greater financial resources, greater geographic coverage or a wider range of services, may compete with us for these opportunities. If we are unable to contain costs through increased operational efficiencies or to obtain higher reimbursements and payments from managed care payers, our results of operations and cash flows will be materially adversely affected.

Our revenues may decline if federal or state programs reduce our Medicare or Medicaid payments or managed care companies reduce our reimbursements.

Approximately 56% of our net patient revenues for the year ended June 30, 2009 came from the Medicare and Medicaid programs, including Medicare and Medicaid managed plans. In recent years, federal and state governments have made significant changes in the Medicare and Medicaid programs. Some of those changes adversely affect the reimbursement we receive for certain services. In addition, due to budget deficits in many states, significant decreases in state funding for Medicaid programs have occurred or are being proposed.

On August 22, 2007, CMS issued a final rule for federal fiscal year 2008 for the hospital inpatient prospective payment system. This rule adopted a two-year implementation of MS-DRGs, a severity-adjusted DRG system. This change represented a refinement to the DRG system, and its impact on our revenues has not been significant. Realignments in the DRG system could impact the margins we receive for certain services.

DRG rates are updated and MS-DRG weights are recalibrated each federal fiscal year. The index used to update the market basket gives consideration to the inflation experienced by hospitals and entities outside the healthcare industry in purchasing goods and services. The annual Medicare regulatory update for federal fiscal year 2010 provides for a 2.1% market basket update for hospitals that submit certain quality patient care indicators and a 0.1% update for hospitals that do not submit this data. While we will endeavor to comply with all quality data submission requirements, our submissions may not be deemed timely or sufficient to entitle us to the full market basket adjustment for all our hospitals. Medicare payments to hospitals in federal fiscal year 2009 were reduced by 0.9% to eliminate what CMS estimates will be the effect of coding or classification changes as a result of hospitals implementing the MS-DRG system. After earlier proposing an increase in the "documentation and coding adjustment" to 1.9% for federal fiscal year 2010, on July 31, 2009 CMS announced that it had decided not to make any adjustment in federal fiscal year 2010 since it did not know whether federal fiscal year 2009 spending from documentation and coding is more or less than earlier projected. However, Congress has given CMS the ability to continue to retrospectively determine if the documentation and coding adjustment levels for federal fiscal years 2008

and 2009 were adequate to account for changes in payments not related to changes in case mix. If the levels are found to have been inadequate, CMS could impose an adjustment to payments for federal fiscal years 2011 and 2012. This evaluation of changes in case-mix based on actual claims data may yield a higher documentation and coding adjustment thereby potentially reducing our revenues and impacting our results of operations in ways that cannot be quantified at this time. Additionally, Medicare payments to hospitals are subject to a number of other adjustments, and the actual impact on payments to specific hospitals may vary. In some cases, commercial third-party payers and other payers such as some state Medicaid programs rely on all or portions of the Medicare DRG system to determine payment rates. The change from traditional Medicare DRGs to MS-DRGs could adversely impact those payment rates if any other payers adopt MS-DRGs.

The federal government and many states have recently adopted or are currently considering reducing the level of Medicaid funding (including upper payment limits) or program eligibility that could adversely affect future levels of Medicaid reimbursement received by our hospitals. Since states must operate with balanced budgets and since the Medicaid program is often a state's largest program, a number of states have adopted, or are considering adopting, legislation designed to reduce their Medicaid expenditures. DRA 2005 includes federal Medicaid cuts of approximately $4.8 billion over five years. Additionally, on May 29, 2007, CMS published a final rule entitled "Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership" which is estimated to reduce federal Medicaid funding from $12 to $20 billion over five years. Congress enacted two moratoria in respect of this rule that delayed six of seven proposed Medicaid regulations in this final CMS rule until July 1, 2009. On June 30, 2009, three more of the Medicaid regulations that had been under a congressional moratorium set to expire July 1, 2009 were officially rescinded all or in part by CMS, and CMS also delayed until June 30, 2010 the enforcement of the fourth of the six regulations. As a result of these changes in implementing the final rule, the impact on us of the final rule can not be quantified. States have also adopted, or are considering adopting, legislation designed to reduce coverage and program eligibility, enroll Medicaid recipients in managed care programs and/or impose additional taxes on hospitals to help finance or expand the states' Medicaid systems. Future legislation or other changes in the administration or interpretation of government health programs could have a material adverse effect on our financial position and results of operations.

Our ability to negotiate favorable contracts with managed care plans significantly affects the revenues and operating results of most of our hospitals. Managed care payers increasingly are demanding discounted fee structures, and the trend toward consolidation among managed care plans tends to increase their bargaining power over fee structures. Reductions in price increases or the amounts received from managed care plans could have a material adverse effect on our financial position and results of operations.

In recent years, both the Medicare program and several large managed care companies have changed our reimbursement to link some of their payments, especially their annual increases in payments, to performance of quality of care measures. We expect this trend to "pay-for-performance" to increase in the future. If we are unable to meet these performance measures, our results of operations and cash flow will be materially adversely affected.

We conduct business in a heavily regulated industry, and changes in regulations or violations of regulations may result in increased costs or sanctions that could reduce our revenues and profitability.

The healthcare industry is subject to extensive federal, state and local laws and regulations relating to licensing, the conduct of operations, the ownership of facilities, the addition of facilities and services, financial arrangements with physicians and other referral sources, confidentiality, maintenance and security issues associated with medical records, billing for services and prices for services. If a determination were made that we were in material violation of such laws or regulations, our operations and financial results could be materially adversely affected.

In many instances, the industry does not have the benefit of significant regulatory or judicial interpretations of these laws and regulations. This is particularly true in the case of Medicare and Medicaid statute codified under section 1128B(b) of the Social Security Act and known as the "Anti-Kickback Statute." This law prohibits providers and other person or entities from soliciting, receiving, offering or paying, directly or indirectly, any remuneration with the intent to generate referrals of orders for services or items reimbursable under Medicare, Medicaid and other federal healthcare programs. As authorized by Congress, the United States Department of Health and Human Services has issued regulations which describe some of the conduct and business relationships immune from prosecution under the Anti-Kickback Statute. The fact that a given business arrangement does not fall within one of

these "safe harbor" provisions does not render the arrangement illegal, but business arrangements of healthcare service providers that fail to satisfy the applicable safe harbor criteria risk increased scrutiny by enforcement authorities.

Some of the financial arrangements that our facilities maintain with physicians do not meet all of the requirements for safe harbor protection. The regulatory authorities that enforce the Anti-Kickback Statute may in the future determine that one or more of these arrangements violate the Anti-Kickback Statute or other federal or state laws. A determination that a facility has violated the Anti-Kickback Statute or other federal laws could subject us to liability under the Social Security Act, including criminal and civil penalties, as well as exclusion of the facility from participation in government programs such as Medicare and Medicaid or other federal healthcare programs.

In addition, the portion of the Social Security Act commonly known as the "Stark Law" prohibits physicians from referring Medicare and (to an extent) Medicaid patients to providers of certain "designated health services" if the physician or a member of his or her immediate family has an ownership or investment interest in, or compensation arrangement with, that provider. In addition, the provider in such arrangements is prohibited from billing for all of the designated health services referred by the physician. Many of the services furnished by our facilities are "designated health services" for Stark Law purposes. There are multiple exceptions to the Stark Law, among others, for physicians maintaining an ownership interest in an entire hospital or having a compensation relationship with the facility as a result of employment agreements, leases, physician recruitment and certain other arrangements. However, each of these exceptions applies only if detailed conditions are met. An arrangement subject to the Stark Law must qualify for an exception in order for the services to be lawfully referred by the physician and billed by the provider.

CMS has issued three phases of final regulations implementing the Stark Law. Phases I and II became effective in January 2002 and July 2004, respectively, and Phase III became effective in December 2007. While these regulations help clarify the requirements of the exceptions to the Stark Law, it is unclear how the government will interpret many of these exceptions for enforcement purposes. In addition, in July 2007 CMS proposed far-reaching changes to the regulations implementing the Stark Law that would further restrict the types of arrangements that hospitals and physicians may enter, including additional restrictions on certain leases, percentage compensation arrangements, and agreements under which a hospital purchases services under arrangements. On July 31, 2008, CMS issued a final rule which, in part, finalized and responded to public comments regarding some of its July 2007 proposed major changes to the Stark Law regulations to undermine many common hospital/physician joint venture models. The most far-reaching of the changes made in this final July 2008 rule will effectively prohibit, as of a delayed effective date of October 1, 2009, both "under arrangements" ventures between a hospital and any of its physicians and unit-of-service-based "per click" compensation and percentage-based compensation in office space and equipment leases between a hospital and its physicians. We have examined all of our "under arrangements" ventures and space and equipment leases with physicians to identify those arrangements which potentially violate these new Stark regulations, and we are in the process of restructuring or terminating non-conforming arrangements so identified prior to October 1, 2009. Because the Stark Law and its implementing regulations are relatively new, we do not always have the benefit of significant regulatory or judicial interpretation of this law and its regulations. We attempt to structure our relationships to meet an exception to the Stark Law, but the regulations implementing the exceptions are detailed and complex, and we cannot assure that every relationship complies fully with the Stark Law. In addition, in the July 2008 final Stark rule CMS indicated that it will continue to enact further regulations tightening aspects of the Stark Law that it perceives allow for Medicare program abuse, especially those regulations that still permit physicians to profit from their referrals of ancillary services. We cannot assure you that the arrangements entered into by our hospitals with physicians will be found to be in compliance with the Stark Law, as it ultimately may be implemented or interpreted.

Additionally, if we violate the Anti-kickback Statute or Stark Law, or if we improperly bill for our services, we may be found to violate the False Claims Act, either under a suit brought by the government or by a private person under a *qui tam*, or "whistleblower," suit.

If we fail to comply with the Anti-kickback Statute, the Stark Law, the False Claims Act or other applicable laws and regulations, or if we fail to maintain an effective corporate compliance program, we could be subjected to liabilities, including civil penalties (including the loss of our licenses to operate one or more facilities), exclusion of one or more facilities from participation in the Medicare, Medicaid and other federal and state health care programs

and, for violations of certain laws and regulations, criminal penalties. See Item 1, "Business — Governmental Regulation and Other Factors."

All of the states in which we operate have adopted or have considered adopting similar anti-kickback and physician self-referral legislation, some of which extends beyond the scope of the federal law to prohibit the payment or receipt of remuneration for the referral of patients and physician self-referrals, regardless of the source of payment for the care. Little precedent exists for the interpretation or enforcement of these laws. Both federal and state government agencies have announced heightened and coordinated civil and criminal enforcement efforts.

Government officials responsible for enforcing healthcare laws could assert that one or more of our facilities, or any of the transactions in which we are involved, are in violation of the Anti-Kickback Statute or the Stark Law and related state law exceptions. It is also possible that the courts could ultimately interpret these laws in a manner that is different from our interpretations. Moreover, other healthcare companies, alleged to have violated these laws, have paid significant sums to settle such allegations and entered into "corporate integrity agreements" because of concern that the government might exercise its authority to exclude those providers from governmental payment programs (Medicare, Medicaid, TRICARE). A determination that one or more of our facilities has violated these laws, or the public announcement that we are being investigated for possible violations of these laws, could have a material adverse effect on our business, financial condition, results of operations or prospects, and our business reputation could suffer significantly.

Illinois and Massachusetts require governmental determinations of need ("Certificates of Need") prior to the purchase of major medical equipment or the construction, expansion, closure, sale or change of control of healthcare facilities. We believe our facilities have obtained appropriate certificates wherever applicable. However, if a determination were made that we were in material violation of such laws, our operations and financial results could be materially adversely affected. The governmental determinations, embodied in Certificates of Need, can also affect our facilities' ability to add bed capacity or important services. We cannot predict whether we will be able to obtain required Certificates of Need in the future. A failure to obtain any required Certificates of Need may impair our ability to operate the affected facility profitably.

The laws, rules and regulations described above are complex and subject to interpretation. If we are in violation of any of these laws, rules or regulations, or if further changes in the regulatory framework occur, our results of operations could be significantly harmed. For a more detailed discussion of the laws, rules and regulations described above, see Item 1, "Business – Government Regulation and Other Factors."

Some of our hospitals will be required to submit to CMS information on their relationships with physicians and this submission could subject such hospitals and us to liability.

CMS announced in 2007 that it intends to collect information on ownership, investment and compensation arrangements with physicians from 500 (pre-selected) hospitals by requiring these hospitals to submit to CMS Disclosure of Financial Relationship Reports ("DFRR") from each selected hospital. CMS also indicated that at least 10 of our hospitals will be among these 500 hospitals required to submit a DFRR because these 10 hospitals did not respond to CMS' voluntary survey instrument on this topic purportedly submitted to these hospitals via email by CMS in 2006. CMS intends to use this data to determine whether these hospitals were in compliance with the Stark Law and implementing regulations during the reporting period (currently expected to be the cost reporting periods of these hospitals ending in 2006), and CMS has indicated it may share this information with other government agencies and with Congressional committees. Many of these agencies have not previously analyzed this information and have the authority to bring enforcement actions against the hospitals. However, in July 2008 CMS announced that, based on its further review and expected further public comments on this matter, CMS may decide in the future to decrease (but not increase) the number of hospitals to which it will send the DFRR below the 500 hospitals originally designated.

Once a hospital receives this request for a DFRR, the hospital will have 60 days to compile a significant amount of information relating to its financial relationships with physicians. The hospital may be subject to civil monetary penalties of up to $10,000 per day if it is unable to assemble and report this information within the required timeframe or if CMS or any other government agency determines that the submission is inaccurate or incomplete.

The hospital may be the subject of investigations or enforcement actions if a government agency determines that any of the information indicates a potential violation of law.

Also, while in 2007 CMS had announced that it was contemplating proposing a regular financial disclosure process that would apply in the future to all Medicare participating hospitals, in July 2008 CMS announced that, based upon public comments previously received, it was not adopting a regular reporting or disclosure process at that time, and, thus, CMS said the DFRR will initially be used as a one-time collection effort. However, CMS also said in July 2008 that, depending on the information received from the initial DFRR process and other factors, it may propose future rulemaking to use the DFRR or some other instrument as a periodic or regular collection instrument. Thus, even if one of our hospitals does not receive the DFRR survey as part of the initial up to 500 selected hospitals, we expect that all of our hospitals will possibly have to report similar information to CMS in the future.

The DFRR and its supporting documentation are currently under review by the Office of Management and Budget and have not yet been released. Depending on the final format of the DFRR, responding hospitals may be subject to substantial penalties as a result of enforcement actions brought by government agencies and whistleblowers acting pursuant to the False Claims Act and similar state laws, based on such allegations like failure to respond within required deadlines, that the response is inaccurate or contains incomplete information or that the response indicates a potential violation of the Stark Law or other requirements.

Any governmental investigation or enforcement action which results from the DFRR process could materially adversely affect the results of our operations.

Providers in the healthcare industry have been the subject of federal and state investigations, whistleblower lawsuits and class action litigation, and we may become subject to investigations, whistleblower lawsuits or class action litigation in the future.

Both federal and state government agencies have heightened and coordinated civil and criminal enforcement efforts as part of numerous ongoing investigations of hospital companies, as well as their executives and managers. These investigations relate to a wide variety of topics, including:

- cost reporting and billing practices;
- laboratory and home healthcare services;
- physician ownership of, and joint ventures with, hospitals;
- physician recruitment activities; and
- other financial arrangements with referral sources

In addition, the federal False Claims Act permits private parties to bring *qui tam*, or whistleblower, lawsuits against companies. Whistleblower provisions allow private individuals to bring actions on behalf of the government alleging that the defendant has defrauded the federal government. Because *qui tam* lawsuits are filed under seal, we could be named in one or more such lawsuits of which we are not aware. Defendants determined to be liable under the False Claims Act may be required to pay three times the actual damages sustained by the government, plus mandatory civil penalties of between $5,500 and $11,000 for each separate false claim. Typically, each fraudulent bill submitted by a provider is considered a separate false claim, and thus the penalties under false claims may be substantial. Liability arises when an entity knowingly submits a false claim for reimbursement to the federal government. In some cases, whistleblowers or the federal government have taken the position that providers who allegedly have violated other statutes and have submitted claims to a governmental payer during the time period they allegedly violated these other statutes, have thereby submitted false claims under the False Claims Act. Some states have adopted similar whistleblower and false claims provisions.

The Office of the Inspector General of the Department of Health and Human Services and the Department of Justice have, from time to time, established national enforcement initiatives that focus on specific billing practices or other suspected areas of abuse. Initiatives include a focus on hospital billing for outpatient charges associated with inpatient services, as well as hospital laboratory billing practices. As a result of these regulations and initiatives, some of our activities could become the subject of governmental investigations or inquiries. For example, we have significant Medicare and Medicaid billings, we provide some durable medical equipment and home healthcare

services, and we have joint venture arrangements involving physician investors. We also have a variety of other financial arrangements with physicians and other potential referral sources including recruitment arrangements and leases. In addition, our executives and managers, many of whom have worked at other healthcare companies that are or may become the subject of federal and state investigations and private litigation, could be included in governmental investigations or named as defendants in private litigation. We are aware that several of our hospitals or their related healthcare operations were and may still be under investigation in connection with activities conducted prior to our acquisition of them. Under the terms of our various acquisition agreements, the prior owners of our hospitals are responsible for any liabilities arising from pre-closing violations. The prior owners' resolution of these matters or failure to resolve these matters, in the event that any resolution was deemed necessary, may have a material adverse effect on our business, financial condition or results of operations. Any investigations of us, our executives, managers, facilities or operations could result in significant liabilities or penalties to us, as well as adverse publicity.

We maintain a voluntary compliance program to address health regulatory and other compliance requirements. This program includes initial and periodic ethics and compliance training and effectiveness reviews, a toll-free hotline for employees to report, without fear of retaliation, any suspected legal or ethical violations, annual "fraud and abuse" audits to look at all of our financial relationships with physicians and other referral sources and annual "coding audits" to make sure our hospitals bill the proper service codes in respect of obtaining payment from the Medicare and Medicaid programs.

As an element of our corporate compliance program and our internal compliance audits, from time to time we make voluntary disclosures and repayments to the Medicare and Medicaid programs and/or to the federal and/or state regulators for these programs in the ordinary course of business. At the current time, we know of no active investigations by any of these programs or regulators in respect of our disclosures or repayments. All of these voluntary actions on our part could lead to an investigation by the regulators to determine whether any of our facilities have violated the Stark Law, the Anti-Kickback Statute, the False Claims Act or similar state law. Either an investigation or initiation of administrative or judicial actions could result in a public announcement of possible violations of the Stark Law, the Anti-Kickback Statute or the False Claims Act or similar state law. Such determination or announcements could have a material adverse effect on our business, financial condition, results of operations or prospects, and our business reputation could suffer significantly.

Additionally, several hospital companies have in recent years been named defendants in class action litigation alleging, among other things, that their charge structures are fraudulent and, under state law, unfair or deceptive practices, insofar as those hospitals charge insurers lower rates than those charged to uninsured patients. We cannot assure you that we will not be named as a defendant in litigation of this type. Furthermore, the outcome of these suits may affect the industry standard for charity care policies and any response we take may have a material adverse effect on our financial results.

In June 2006 we and two other hospital systems operating in San Antonio, Texas had a putative class action lawsuit brought against all of us alleging that we and the other defendants has conspired with each other and with other unidentified San Antonio area hospitals to depress the compensation levels of registered nurses employed at the competing hospitals within the San Antonio area by engaging in certain activities that violated the federal antitrust laws. See "Item 3- Legal Proceedings" for further discussion of this litigation. On the same day that this litigation was brought against us and two other hospital systems in San Antonio, substantially similar class action litigation was brought against multiple hospitals in three other cities.

Competition from other hospitals or healthcare providers (especially specialty hospitals) may reduce our patient volumes and profitability.

The healthcare business is highly competitive and competition among hospitals and other healthcare providers for patients has intensified in recent years. Generally, other hospitals in the local communities served by most of our hospitals provide services similar to those offered by our hospitals. In addition, we believe the number of freestanding specialty hospitals and surgery and diagnostic centers in the geographic areas in which we operate has increased significantly in recent years. As a result, most of our hospitals operate in an increasingly competitive environment. Some of the hospitals that compete with our hospitals are owned by governmental agencies or not-for-profit corporations supported by endowments and charitable contributions and can finance capital expenditures and

operations on a tax-exempt basis. Increasingly, we are facing competition from physician-owned specialty hospitals and freestanding surgery centers that compete for market share in high margin services and for quality physicians and personnel. If ambulatory surgery centers are better able to compete in this environment than our hospitals, our hospitals may experience a decline in patient volume, and we may experience a decrease in margin, even if those patients use our ambulatory surgery centers. Further, if our competitors are better able to attract patients, recruit physicians, expand services or obtain favorable managed care contracts at their facilities than our hospitals and ambulatory surgery centers, we may experience an overall decline in patient volume. See Item 1, "Business - Competition."

In 2005, CMS began making public performance data related to 10 quality measures that hospitals submit in connection with their Medicare reimbursement. In February 2006, federal legislation was enacted to expand and provide for the future expansion of the number of quality measures that must be reported. During federal fiscal year 2008, CMS required hospitals to report 30 measures of inpatient quality of care to avoid a 2% point reduction in their market basket update. During federal fiscal year 2009, CMS requires hospitals to report 43 inpatient quality measures to avoid a 2% point reduction in their market basket update. For federal fiscal year 2010, CMS will require hospitals to report 47 inpatient quality measures to avoid a 2% reduction in their market basket update. If any of our hospitals achieve poor results (or results that are lower than our competitors) on these quality measures, patient volumes could decline. Also, the additional quality measures and future trends toward clinical transparency may have an unanticipated impact on our competitive position and patient volumes.

PHP also faces competition within the Arizona markets that it serves. As in the case of our hospitals, some of our competitors in these markets are owned by governmental agencies or not-for-profit corporations that have greater financial resources than we do. The revenues we derive from PHP could significantly decrease if new plans operating under AHCCCS enter these markets or other existing AHCCCS plans increase their number of enrollees. Moreover, a failure to attract future enrollees may negatively impact our ability to maintain our profitability in these markets.

We may be subject to liabilities from claims brought against our facilities.

We operate in a highly regulated and litigious industry. As a result, various lawsuits, claims and legal and regulatory proceedings have been instituted or asserted against us, including those outside of the ordinary course of business like class actions and those in the ordinary course of business like malpractice lawsuits. Some of these actions may involve large claims as well as significant defense costs. (See "Item 3, "Legal Proceedings.")

We maintain professional and general liability insurance in amounts we believe are sufficient to cover claims arising out of the operations of our facilities. Some of the claims could exceed the scope of the coverage in effect or coverage of particular claims or damages could be denied.

The relatively high cost of professional liability insurance and, in some cases, the lack of availability of such insurance coverage, for physicians with privileges at our hospitals increases our risk of vicarious liability in cases where both our hospital and the uninsured or underinsured physician are named as co-defendants. As a result, we are subject to greater self-insured risk and may be required to fund claims out of our operating cash flows to a greater extent than during fiscal year 2009. We cannot assure you that we will be able to continue to obtain insurance coverage in the future or that such insurance coverage, if it is available, will be available on acceptable terms.

While we cannot predict the likelihood of future claims or inquiries, we expect that new matters may be initiated against us from time to time. Moreover, the results of current claims, lawsuits and investigations cannot be predicted, and it is possible that the ultimate resolution of these matters, individually or in the aggregate, may have a material adverse effect on our business (both in the near and long term), financial position, results of operations or cash flows.

Our hospitals face a growth in uncompensated care as the result of the inability of uninsured patients to pay for healthcare services and difficulties in collecting patient portions of insured accounts.

Like others in the hospital industry, we have experienced an increase in uncompensated care. Our combined provision for doubtful accounts and charity care deductions as a percentage of patient service revenues increased

from 12.0% during fiscal 2007 to 12.5% during fiscal 2008 and decreased to 12.0% during fiscal 2009. Our self pay discharges as a percentage of total discharges have not fluctuated significantly during our past three fiscal years. Our hospitals remain at risk for increases in uncompensated care as a result of price increases, the continuing trend of increases in coinsurance and deductible portions of managed care accounts and increases in uninsured patients as a result of potential state Medicaid funding cuts or general economic weakness. Although we continue to seek ways of improving point of service collection efforts and implementing appropriate payment plans with our patients, if we continue to experience growth in self-pay volumes and revenues, our results of operations could be materially adversely affected. Further, our ability to improve collections for self-pay patients may be limited by regulatory and investigatory initiatives, including private lawsuits directed at hospital charges and collection practices for uninsured and underinsured patients.

Our performance depends on our ability to recruit and retain quality physicians.

Physicians generally direct the majority of hospital admissions. Thus, the success of our hospitals depends in part on the following factors:

- the number and quality of the physicians on the medical staffs of our hospitals;
- the admitting practices of those physicians; and
- the maintenance of good relations with those physicians.

Most physicians at our hospitals also have admitting privileges at other hospitals. Our efforts to attract and retain physicians are affected by our managed care contracting relationships, national shortages in some specialties, such as anesthesiology and radiology, the adequacy of our support personnel, the condition of our facilities and medical equipment, the availability of suitable medical office space and federal and state laws and regulations prohibiting financial relationships that may have the effect of inducing patient referrals. If facilities are not staffed with adequate support personnel or technologically advanced equipment that meets the needs of patients, physicians may be discouraged from referring patients to our facilities, which could adversely affect our profitability.

In an effort to meet community needs in the markets in which we operate, we have implemented a strategy to employ physicians both in primary care and in certain specialties. As of June 30, 2009, we employed approximately 290 practicing physicians, excluding residents. The deployment of a physician employment strategy includes increased salary costs, physician integration risks and difficulties associated with physician practice management. While we believe this strategy is consistent with industry trends, we cannot be assured of the long-term success of such a strategy.

We may be unable to achieve our acquisition and growth strategies and we may have difficulty acquiring not-for-profit hospitals due to regulatory scrutiny.

An important element of our business strategy is expansion by acquiring hospitals in our existing and in new urban and suburban markets and by entering into partnerships or affiliations with other healthcare service providers. The competition to acquire hospitals is significant, including competition from healthcare companies with greater financial resources than ours. We may not be able to make suitable acquisitions on favorable terms. We may have difficulty obtaining financing, if necessary, for such acquisitions on satisfactory terms. We sometimes agree not to sell an acquired hospital for some period of time (currently no longer than 10 years) after purchasing it and/or grant the seller a right of first refusal to purchase the hospital if we agree to sell it to a third party. In addition, we may not be able to effectively integrate any acquired facilities with our operations. Even if we continue to acquire additional facilities and/or enter into partnerships or affiliations with other healthcare service providers, federal and state regulatory agencies may constrain our ability to grow.

Additionally, many states, including some where we have hospitals and others where we may in the future attempt to 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 focus primarily on the appropriate valuation of the assets divested and the use of the sale proceeds by the not-for-profit seller. These review and approval processes can add time to the consummation of an acquisition of a not-for profit hospital, and future actions on the state level could seriously

delay or even prevent future acquisitions of not-for-profit hospitals. Furthermore, as a condition to approving an acquisition, the attorney general of the state in which the hospital is located may require us to maintain specific services, such as emergency departments, or to continue to provide specific levels of charity care, which may affect our decision to acquire or the terms upon which we acquire one of these hospitals.

Difficulties with integrating our acquisitions may disrupt our ongoing operations.

We may not be able to profitably or effectively integrate the operations of, or otherwise achieve the intended benefits from, any acquisitions we make or partnerships or affiliations we may form. The process of integrating acquired hospitals may require a disproportionate amount of management's time and attention, potentially distracting management from its day-to-day responsibilities. This process may be even more difficult in the case of hospitals we may acquire out of bankruptcy or otherwise in financial distress. In addition, poor integration of acquired facilities could cause interruptions to our business activities, including those of the acquired facilities. As a result, we may incur significant costs related to acquiring or integrating these facilities and may not realize the anticipated benefits.

Moreover, acquired businesses may have unknown or contingent liabilities, including liabilities for failure to comply with healthcare laws and regulations. We could in the future become liable for past activities of acquired businesses and these liabilities could be material.

The cost of our malpractice insurance and the malpractice insurance of physicians who practice at our facilities remains volatile. Successful malpractice or tort claims asserted against us, our physicians or our employees could materially adversely affect our financial condition and profitability.

Physicians, hospitals and other healthcare providers are subject to legal actions alleging malpractice, product liability or related legal theories. Many of these actions involve large monetary claims and significant defense costs. Hospitals and physicians have typically maintained a special type of insurance (commonly called malpractice or professional liability insurance) to protect against the costs of these types of legal actions. We created a captive insurance subsidiary on June 1, 2002, to assume a substantial portion of the professional and general liability risks of our facilities. For claims incurred during the period June 1, 2002 to May 31, 2006, we maintained all of our professional and general liability insurance through this captive insurance subsidiary in respect of losses up to $10.0 million per occurrence. For claims incurred from June 1, 2006 to June 30, 2009, we self-insured the first $9.0 million per occurrence, and our captive subsidiary insured the next $1.0 million per occurrence. We have also purchased an umbrella excess policy for professional and general liability insurance for the period July 1, 2009 to June 30, 2010 with unrelated commercial carriers. This policy covers losses in excess of $10.0 million per occurrence up to $75.0 million, but is limited to total annual payments of $65.0 million in the aggregate. While our premium prices have declined during the past few years, the total cost of professional and general liability insurance remains sensitive to the volume and severity of cases reported. There is no guarantee that excess insurance coverage will continue to be available in the future at a cost allowing us to maintain adequate levels of such insurance. Moreover, due to the increased retention limits insured by us and our captive subsidiary, if actual payments of claims materially exceed our projected estimates of malpractice claims, our financial condition could be materially adversely affected.

Physicians' professional liability insurance costs in certain markets have dramatically increased to the point where some physicians are either choosing to retire early or leave those markets. If physician professional liability insurance costs continue to escalate in markets in which we operate, some physicians may choose not to practice at our facilities, which could reduce our patient volumes and revenues. Our hospitals may also incur a greater percentage of the amounts paid to claimants if physicians are unable to obtain adequate malpractice coverage since we are often sued in the same malpractice suits brought against physicians on our medical staffs who are not employed by us.

We anticipate employing over 160 additional physicians during our fiscal year 2010. Such a significant increase in employed physicians could significantly increase our professional and general liability risks and related costs in future periods since for employed physicians there is no insurance coverage from unaffiliated insurance companies.

We are subject to uncertainties regarding healthcare reform that could materially and adversely affect our business.

In recent years, an increasing number of legislative initiatives have been introduced or proposed in Congress and in state legislatures that would result in major changes in the healthcare system, either nationally or at the state level. Among the proposals that have been introduced in recent years are price controls on hospitals, insurance market reforms to increase the availability of group health insurance to small businesses, requirements that all businesses offer health insurance coverage to their employees and the creation of a government health insurance plan or plans that would cover all citizens and increase payments by beneficiaries. Also, the Obama administration has stated as its top domestic priority its desire to reform the U.S. healthcare system with the goal of providing affordable, accessible healthcare for all Americans. In July 2009 four of the five Congressional committees working on healthcare reform approved some version of reform legislation. In the House of Representatives, all three committees working on the legislation (the Committees on Ways and Means, Energy and Commerce and Education and Labor) passed different versions of the same extensive reform bill under which, for individuals not currently covered, a new healthcare exchange will be established where they can select either a new "public health insurance option" or a plan offered by private insurers. During the Congressional recess in August 2009, the three House committees worked to meld the bills into one final version for consideration by the entire House of Representatives as early as September 2009. In the Senate, its Committee on Health, Education, Labor and Pensions approved its version of healthcare reform legislation on July 15, 2009 which is similar to, but less extensive in benefits than, the House version. Meanwhile, during August 2009 the Senate Committee on Finance continued its efforts to negotiate a bipartisan agreement on healthcare reform legislation and that committee is not expected to vote upon its healthcare reform bill until at least September 2009. One of the most significant differences in the legislation produced by the Senate Finance Committee is likely to be the establishment of state and/or regional health insurance cooperatives in lieu of a federally-administered "public option" to compete with private health insurance plans. Once passed by the Senate Finance Committee, the two Senate committees will need to merge the two bills into one final version for consideration by the entire Senate, potentially in September or October 2009. Also, many states have enacted or are considering enacting measures designed to reduce their Medicaid expenditures. States have also adopted, or are considering, legislation designed to reduce coverage and program eligibility, enroll Medicaid recipients in managed care programs and/or impose additional taxes on hospitals to help finance or expand states' Medicaid systems. We cannot predict whether any of the above proposals or any other proposals will be adopted, and if adopted, we cannot assure you that the implementation of these reforms will not have a material adverse effect on our business, financial position or results of operations.

Our facilities are concentrated in a small number of regions. If any one of the regions in which we operate experiences a regulatory change, economic downturn or other material change, our overall business results may suffer.

Among our operations as of June 30, 2009, five hospitals and various related healthcare businesses were located in San Antonio, Texas; five hospitals and related healthcare businesses were located in metropolitan Phoenix, Arizona; two hospitals and related healthcare businesses were located in metropolitan Chicago, Illinois; and three hospitals and related healthcare businesses were located in Massachusetts.

For the year ended June 30, 2009, our total revenues were generated as follows:

	Year Ended June 30, 2009
San Antonio	29.6 %
Phoenix Health Plan and Abrazo Advantage Health Plan	19.3
Massachusetts	18.3
Metropolitan Phoenix, excluding Phoenix Health Plan and Abrazo Advantage Health Plan	17.9
Metropolitan Chicago (1)	14.6
Other	0.3
	100.0 %

(1) Includes MacNeal Health Providers.

Any material change in the current demographic, economic, competitive or regulatory conditions in any of these regions could adversely affect our overall business results because of the significance of our operations in each of these regions to our overall operating performance. Moreover, due to the concentration of our revenues in only four regions, our business is less diversified and, accordingly, is subject to greater regional risk than that of some of our larger competitors.

If we are unable to control our healthcare costs at Phoenix Health Plan and Abrazo Advantage Health Plan, if the health plans should lose their governmental contracts or if budgetary cuts reduce the scope of Medicaid or dual-eligibility coverage, our profitability may be adversely affected.

For the year ended June 30, 2009, PHP generated approximately 18.1% of our total revenues. PHP derives substantially all of its revenues through a contract with AHCCCS. AHCCCS pays capitated rates to PHP, and PHP subcontracts with physicians, hospitals and other healthcare providers to provide services to its enrollees. If we fail to effectively manage our healthcare costs, these costs may exceed the payments we receive. Many factors can cause actual healthcare costs to exceed the capitated rates paid by AHCCCS, including:

- our ability to contract with cost-effective healthcare providers;
- the increased cost of individual healthcare services;
- the type and number of individual healthcare services delivered; and
- the occurrence of catastrophes, epidemics or other unforeseen occurrences

Our current contract with AHCCCS began October 1, 2008 and expires September 30, 2011. This contract is terminable without cause on 90 days' written notice from AHCCCS or for cause upon written notice from AHCCCS if we fail to comply with any term or condition of the contract or fail to take corrective action as required to comply with the terms of the contract. AHCCCS may also terminate the contract with PHP in the event of unavailability of state or federal funding. If our AHCCCS contract is terminated, our profitability would be adversely affected by the loss of these revenues and cash flows. Also, should the scope of the Medicaid program be reduced as a result of state budgetary cuts or other political factors, our results of operations could be adversely affected.

For the year ended June 30, 2009, AAHP generated 1.2% of our total revenues. AAHP began providing healthcare coverage to Medicare and Medicaid dual-eligible enrollees on January 1, 2006. Most of AAHP's members were formerly enrolled in PHP. AAHP's contract with CMS went into effect on January 1, 2006, for a term of one year, with a provision for successive one year renewals, and has currently been renewed through December 31, 2009. If we fail to effectively manage AAHP's healthcare costs, these costs may exceed the payments we receive.

We are dependent on our senior management team and local management personnel, and the loss of the services of one or more of our senior management team or key local management personnel could have a material adverse effect on our business.

The success of our business is largely dependent upon the services and management experience of our senior management team, which includes Charles N. Martin, Jr., our Chairman and Chief Executive Officer; Kent H. Wallace, our President and Chief Operating Officer; Keith B. Pitts, our Vice Chairman, Phillip W. Roe, our Executive Vice President, Chief Financial Officer and Treasurer; and Joseph D. Moore, Executive Vice President. In addition, we depend on our ability to attract and retain local managers at our hospitals and related facilities, on the ability of our senior officers and key employees to manage growth successfully and on our ability to attract and retain skilled employees. We do not maintain key man life insurance policies on any of our officers. If we were to lose any of our senior management team or members of our local management teams, or if we are unable to attract other necessary personnel in the future, it could have a material adverse effect on our business, financial condition and results of operations. If we were to lose the services of one or more members of our senior management team or a significant portion of our hospital management staff at one or more of our hospitals, we would likely experience a significant disruption in our operations and failure of the affected hospitals to adhere to their respective business plans.

Controls designed to reduce inpatient services may reduce our revenues.

Controls imposed by Medicare and commercial third-party payers designed to reduce admissions and lengths of stay, commonly referred to as "utilization review," have affected and are expected to continue to affect our facilities. Utilization review entails the review of the admission and course of treatment of a patient by managed care plans. Inpatient utilization, average lengths of stay and occupancy rates continue to be negatively affected by payer-required preadmission authorization and utilization review and by payer pressures to maximize outpatient and alternative healthcare delivery services for less acutely ill patients. Efforts to impose more stringent cost controls are expected to continue. Although we are unable to predict the effect these changes will have on our operations, significant limits on the scope of services reimbursed and on reimbursement rates and fees could have a material, adverse effect on our business, financial position and results of operations.

If we fail to continually enhance our hospitals with the most recent technological advances in diagnostic and surgical equipment, our ability to maintain and expand our markets will be adversely affected.

Technological advances with respect to computed axial tomography (CT), magnetic resonance imaging (MRI) and positron emission tomography (PET) equipment, as well as other equipment used in our facilities, are continually evolving. In an effort to compete with other healthcare providers, we must constantly evaluate our equipment needs and upgrade equipment as a result of technological improvements. Such equipment costs typically range from $1.0 million to $3.0 million, exclusive of construction or build-out costs.

Our hospitals face competition for staffing especially as a result of the national shortage of nurses and the increased imposition on us of nurse-staffing ratios, which has in the past and may in the future increase our labor costs and materially reduce our profitability.

We compete with other healthcare providers in recruiting and retaining qualified management and staff personnel responsible for the day-to-day operations of each of our hospitals, including most significantly nurses and other non-physician healthcare professionals. In the healthcare industry generally, including in our markets, the national shortage of nurses and other medical support personnel has become a significant operating issue. This shortage has caused us in the past and may require us in the future to increase wages and benefits to recruit and retain nurses and other medical support personnel or to hire more expensive temporary personnel. We have voluntarily raised on several occasions in the past, and expect to raise in the future, wages for our nurses and other medical support personnel.

In addition, union-mandated or state-mandated nurse-staffing ratios significantly affect not only labor costs, but may also cause us to limit patient admissions with a corresponding adverse effect on revenues if we are unable to hire the appropriate number of nurses to meet the required ratios. While we do not currently operate in any states with mandated nurse-staffing ratios, the states in which we operate could adopt mandatory nurse-staffing ratios at any time. In those instances where our nurses are unionized, it is our experience that new union contracts often impose significant new additional staffing ratios by contract on our hospitals. This was the case with the increased staffing ratios imposed on us in our union contract with our nurses at Saint Vincent Hospital in Worcester, Massachusetts negotiated in 2007.

Congress is currently considering a bill called the Employee Free Choice Act of 2009 ("EFCA") which organized labor, a major supporter of the Obama administration, has called its number one legislative objective. EFCA would amend the National Labor Relations Act to establish a procedure whereby the National Labor Relations Board would certify a union as the bargaining representative of employees, without a NLRB-supervised secret ballot election, if a majority of unit employees signs valid union authorization cards (the "card-check provision"). Additionally, under EFCA, parties that are unable to reach a first contract within 90 days of collective bargaining could refer the dispute to mediation by the Federal Mediation and Conciliation Service. If the Service is unable to bring the parties to agreement within 30 days, the dispute then would be referred to binding arbitration. Also, the bill would provide for increased penalties for labor law violations by employers. In July 2009, due to intense opposition from the business community, alternative draft legislation became public dropping the card-check provision, but putting in its place new provisions making it easier for employees to organize including provisions to require shorter unionization campaigns, faster elections and limitations on employer-sponsored anti-unionization

meetings which employees are required to attend. This legislation, if passed, would make it easier for our nurses or other groups of hospital employees to unionize, which could materially increase our labor costs.

If our labor costs continue to increase, we may not be able to raise our payer reimbursement levels to offset these increased costs, including the significantly increased costs that we will incur for wage increases and nurse-staffing ratios under our new union contract with our nurses at Saint Vincent Hospital. Because substantially all of our net patient revenues consist of payments based on fixed or negotiated rates, our ability to pass along increased labor costs is materially constrained. Our failure to recruit and retain qualified management, nurses and other medical support personnel, or to control our labor costs, could have a material adverse effect on our profitability.

The current economic recession, along with difficult and volatile conditions in the capital and credit markets, could materially adversely affect our financial position, results of operations or cash flows, and we are unsure whether these conditions will improve in the near future.

The United States economy is currently in a period of recession and global credit markets remain volatile. Declining consumer confidence and increased unemployment have increased concerns of prolonged economic weakness. While certain healthcare spending is considered non-discretionary and may not be significantly impacted by economic downturns, other types of healthcare spending may be significantly adversely impacted by such conditions. When patients are experiencing personal financial difficulties or have concerns about general economic conditions, they may choose to defer or forego elective surgeries and other non-emergent procedures, which are generally more profitable lines of business for hospitals. We are unable to determine the specific impact of the current economic conditions on our business at this time, but we believe that further deterioration or a prolonged period of recession will have an adverse impact on our operations. Other risk factors discussed in this report describe some significant risks that may be magnified by the current economic conditions such as the following:

- Our concentration of operations in a small number of regions, and the impact of economic downturns in those communities. To the extent the communities in and around San Antonio, Texas; Phoenix, Arizona; Chicago, Illinois or certain communities in Massachusetts experience a greater degree of economic weakness than average, the adverse impact on our operations could be magnified.

- Our revenues may decline if federal or state programs reduce our Medicare or Medicaid payments or managed care companies (including managed Medicare and managed Medicaid payers) reduce our reimbursement. Current economic conditions have accelerated and increased the budget deficits for most states, including those in which we operate. These budgetary pressures may result in healthcare payment reductions under state Medicaid plans or reduced benefits to participants in those plans. Also, governmental, managed Medicare or managed Medicaid payers may defer payments to us to conserve cash. Managed care companies may also seek to reduce payment rates or limit payment rate increases to hospitals in response to reductions in enrolled participants.

- Our hospitals face a growth in uncompensated care as the result of the inability of uninsured patients to pay for healthcare services and difficulties in collecting patient portions of insured accounts. Higher unemployment, Medicaid benefit reductions and employer efforts to reduce employee healthcare costs may increase our exposure to uncollectible accounts for uninsured patients or those patients with higher co-pay and deductible limits.

- We believe our operating cash and remaining borrowing capacity is sufficient to run our business and fund our growth initiatives. However, under extreme market conditions, there can be no assurance that such funds will be available to us on favorable terms or at all. Most of our cash and borrowing capacity under our revolving credit facility is held with a limited number of financial institutions, which could increase our liquidity risk if one or more of those institutions become financially strained or are no longer able to operate.

We are unable to predict if the condition of the United States economy, the local economies in the communities we serve or global credit conditions will improve in the near future or when such improvements may occur.

Compliance with section 404 of the Sarbanes-Oxley Act may negatively impact our results of operations and failure to comply may subject us to regulatory scrutiny and a loss of investors' confidence in our internal control over financial reporting.

Section 404 of the Sarbanes-Oxley Act of 2002 (the "404 Act") requires us to perform an evaluation of our internal control over financial reporting and file management's attestation with our annual report. The 404 Act also requires our independent auditors to opine on our internal control over financial reporting beginning with our fiscal year ending June 30, 2010. We have evaluated, tested and implemented internal controls over financial reporting to enable management to report on such internal controls under the 404 Act. However, we can not assure you that the conclusions reached in our June 30, 2010 management report will be the same as those reached by our independent auditors in its report. Failure on our part to comply with the 404 Act may subject us to regulatory scrutiny and a loss of public confidence in our internal control over financial reporting.

A failure of our information systems would adversely affect our ability to properly manage our operations.

We rely on our advanced information systems and our ability to successfully use these systems in our operations. These systems are essential to the following areas of our business operations, among others:

- patient accounting, including billing and collection of patient service revenues;
- financial, accounting, reporting and payroll;
- coding and compliance;
- laboratory, radiology and pharmacy systems;
- remote physician access to patient data;
- negotiating, pricing and administering managed care contracts; and
- monitoring quality of care.

If we are unable to use these systems effectively, we may experience delays in collection of patient service revenues and may not be able to properly manage our operations or oversee the compliance with laws or regulations.

Difficulties with current construction projects or new construction projects such as additional hospitals or major expansion projects may involve significant capital expenditures that could have an adverse impact on our liquidity.

We may decide to construct an additional hospital or hospitals in the future or construct additional major expansion projects to existing hospitals in order to achieve our growth objectives. Our ability to complete construction of new hospitals or new expansion projects on budget and on schedule would depend on a number of factors, including, but not limited to:

- our ability to control construction costs;
- the failure of general contractors or subcontractors to perform under their contracts;
- adverse weather conditions;
- shortages of labor or materials;
- our ability to obtain necessary licensing and other required governmental authorizations; and
- other unforeseen problems and delays.

As a result of these and other factors, we cannot assure you that we will not experience increased construction costs on our construction projects or that we will be able to construct our current or any future construction projects as originally planned. In addition, our current and any future major construction projects would involve a significant commitment of capital with no revenues associated with the projects during construction, which also could have a future adverse impact on our liquidity.

If the costs for construction materials and labor continue to rise, such increased costs could have an adverse impact on the return on investment relating to our expansion projects.

The cost of construction materials and labor has significantly increased over the past years as a result of global and domestic events. We have experienced significant increases in the cost of steel due to the demand in China for

such materials and an increase in the cost of lumber due to multiple factors. Increases in oil and gas prices have increased costs for oil-based products and for transporting materials to job sites. As we continue to invest in modern technologies, emergency rooms and operating room expansions, we expend large sums of cash generated from operating activities. We evaluate the financial viability of such projects based on whether the projected cash flow return on investment exceeds our cost of capital. Such returns may not be achieved if the cost of construction continues to rise significantly or anticipated volumes do not materialize.

State efforts to regulate the construction or expansion of hospitals could impair our ability to operate and expand our operations.

Some states require healthcare providers to obtain prior approval, known as certificates of need, for:

- the purchase, construction or expansion of healthcare facilities;
- capital expenditures exceeding a prescribed amount; or
- changes in services or bed capacity.

In giving approval, these states consider the need for additional or expanded healthcare facilities or services. Illinois and Massachusetts are the only states in which we currently own hospitals that have certificate of need laws. The failure to obtain any required certificate of need could impair our ability to operate or expand operations in these states.

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

Blackstone acquired our predecessor company during fiscal 2005. We recorded a significant portion of the purchase price as goodwill. At June 30, 2009, we had approximately $692.1 million of goodwill recorded on our financial statements. We expect to recover the carrying value of this goodwill through our future cash flows. On an ongoing basis, we evaluate, based on the fair value of our reporting units, whether the carrying value of our goodwill is impaired. During fiscal 2007, we recorded a $123.8 million ($110.5 million, net of tax benefit) impairment charge to goodwill to reduce the carrying values of our Chicago hospitals to their fair values. If the carrying value of our goodwill is further impaired, we may incur an additional material non-cash charge to earnings.

Additional Risk Factors

See the additional risks related to our business in "Item 7 – Management's Discussion and Analysis of Financial Conditions and Results of Operations – General Trends" which are incorporated by reference in this Item 1A as if fully set forth herein.

Available Information

We currently voluntarily file certain reports with the Securities and Exchange Commission ("SEC"), including annual reports on Form 10-K and quarterly reports on Form 10-Q. The public may read and copy any materials we file with the SEC at the SEC's Public Reference Room at 100 F Street, N.E., Washington, DC 20549. The public may obtain information on the operation of the Public Reference Room by calling the SEC at 1-800-SEC-0330. We are an electronic filer and the SEC maintains an Internet site at http://www.sec.gov that contains the reports and other information we file electronically. Our Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q, Current Reports on Form 8-K and amendments to those reports are also available free of charge on our internet website at www.vanguardhealth.com under "Investor Relations-SEC Filings-SEC Filings on the Edgar Database" as soon as reasonably practicable after such reports are electronically filed with or furnished to the SEC. Please note that our website address is provided as an inactive textual reference only. Also, the information provided on our website is not part of this report, and is therefore not incorporated by reference unless such information is specifically referenced elsewhere in this report.

Item 1B. Unresolved Staff Comments.

Not applicable.

Item 2. Properties.

A listing of our owned acute hospitals is included in Item 1 of this report under the caption "Business-Our Facilities". We also own or lease space for outpatient service facilities complementary to our hospitals and own and operate a limited number of medical office buildings (some of which are joint ventures) associated with our hospitals that are occupied primarily by physicians who practice at our hospitals. The most significant of these complementary outpatient healthcare facilities are two surgery centers in Orange County, California, five diagnostic imaging centers in metropolitan Phoenix, Arizona and a 50% interest in seven diagnostic imaging centers in San Antonio, Texas. Most of these outpatient facilities are in leased facilities, and the diagnostic imaging centers in San Antonio are owned and operated in joint ventures where we have minority partners.

As of June 30, 2009, we leased approximately 53,200 square feet of office space at 20 Burton Hills Boulevard, Nashville, Tennessee, for our corporate headquarters.

Our headquarters, hospitals and other facilities are suitable for their respective uses and are, in general, adequate for our present needs. Our obligations under our senior credit facilities are secured by a pledge of substantially all of our assets, including first priority mortgages on each of our hospitals. Also, our properties are subject to various federal, state and local statutes and ordinances regulating their operation. Management does not believe that compliance with such statutes and ordinances will materially affect our financial position or results from operations.

Item 3. Legal Proceedings.

We operate in a highly regulated and litigious industry. As a result, various lawsuits, claims and legal and regulatory proceedings have been instituted or asserted against us. While we cannot predict the likelihood of future claims or inquiries, we expect that new matters may be initiated against us from time to time. The results of claims, lawsuits and investigations cannot be predicted, and it is possible that the ultimate resolution of these matters, individually or in the aggregate, may have a material adverse effect on our business (both in the near and long term), financial position, results of operations or cash flows. We recognize that, where appropriate, our interests may be best served by resolving certain matters without litigation. If non-litigated resolution is not possible or appropriate with respect to a particular matter, we will continue to defend ourselves vigorously.

Currently pending and recently settled legal proceedings and investigations that are not in the ordinary course of business are set forth below. Where specific amounts are sought in any pending legal proceeding, those amounts are disclosed. For all other matters, where the possible loss or range of loss is reasonably estimable, an estimate is provided. Where no estimate is provided, the possible amount of loss is not reasonably estimable at this time. We record reserves for claims and lawsuits when they are probable and reasonably estimable. For matters where the likelihood or extent of a loss is not probable or cannot be reasonably estimated, we have not recognized in our consolidated financial statements all potential liabilities that may result. We undertake no obligation to update the following disclosures for any new developments.

Sherman Act Antitrust Class Action Litigation – Maderazo, et al v. VHS San Antonio Partners, L.P. d/b/a Baptist Health Systems, et al, Case No. 5:06cv00535 (United States District Court, Western District of Texas, San Antonio Division, filed June 20, 2006 and amended August 29, 2006)

On June 20, 2006, a federal antitrust class action suit was filed in San Antonio, Texas against our Baptist Health System subsidiary in San Antonio, Texas and two other large hospital systems in San Antonio. In the complaint, plaintiffs allege that the three hospital system defendants conspired with each other and with other unidentified San Antonio area hospitals to depress the compensation levels of registered nurses employed at the conspiring hospitals within the San Antonio area by engaging in certain activities that violated the federal antitrust laws. The complaint alleges two separate claims. The first count asserts that the defendant hospitals violated Section 1 of the federal Sherman Act, which prohibits agreements that unreasonably restrain competition, by conspiring to depress nurses' compensation. The second count alleges that the defendant hospital systems also violated Section 1 of the Sherman Act by participating in wage, salary and benefits surveys for the purpose, and having the effect, of depressing registered nurses' compensation or limiting competition for nurses based on their compensation. The class on whose behalf the plaintiffs filed the complaint is alleged to comprise all registered nurses employed by the defendant hospitals since June 20, 2002. The suit seeks unspecified damages, trebling of this damage amount pursuant to

federal law, interest, costs and attorneys fees. From 2006 through April 2008 we and the plaintiffs worked on producing documents to each other relating to, and supplying legal briefs to the court in respect of, the issue of whether the court will certify a class in this suit. In April 2008 the case was stayed by the judge pending his ruling on plaintiffs' motion for class certification. We believe that the allegations contained within this putative class action suit are without merit, and we have vigorously worked to defeat class certification. If a class is certified, we will continue to defend vigorously against the litigation.

On the same date that this suit was filed against us in federal district court in San Antonio, the same attorneys filed three other substantially similar putative class action lawsuits in federal district courts in Chicago, Illinois, Albany, New York and Memphis, Tennessee against some of the hospitals in those cities (none of such hospitals being owned by us). The attorneys representing the plaintiffs in all four of these cases said in June 2006 that they may file similar complaints in other jurisdictions and in December 2006 they brought a substantially similar class action lawsuit against various hospitals in the Detroit, Michigan metropolitan area. Since representatives of the Service Employees International Union joined plaintiffs' attorneys in announcing the filing of all four complaints on June 20, 2006, and as has been reported in the media, we believe that SEIU's involvement in these actions appears to be part of a corporate campaign to attempt to organize nurses in these cities, including San Antonio. The nurses in our hospitals in San Antonio are currently not members of any union.

Claims in the ordinary course of business.

We are also subject to claims and lawsuits arising in the ordinary course of business, including potential claims related to care and treatment provided at our hospitals and outpatient services facilities. Although the results of these claims and lawsuits cannot be predicted with certainty, we believe that the ultimate resolution of these ordinary course claims and lawsuits will not have a material adverse effect on our business, financial condition or results of operations.

Item 4. Submission of Matters to a Vote of Security Holders.

No matters were submitted to a vote of stockholders during the fourth quarter ended June 30, 2009, except that the holders of 100% of our outstanding common stock approved Amendment 6 to our 2004 Stock Incentive Plan pursuant to a written consent dated May 5, 2009. This Amendment increased the total number of our shares which may be issued under the Plan from 101,117 to 105,611.

PART II

Item 5. Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities.

There is no established public trading market for our common stock. At September 1, 2009, there were five holders of record of our common stock. These holders are VHS Holdings LLC and four investment funds affiliated with Blackstone.

We have not declared or paid any dividends on our common stock in our two most recent fiscal years. We intend to retain all current and foreseeable future earnings to support operations and finance expansion. Our senior secured credit facility and the indentures governing our long-term indebtedness restrict our ability to pay cash dividends on our common stock.

There were no unregistered sales of our equity securities during the quarter ended June 30, 2009.

Information regarding our equity compensation plans is set forth in this report under "Item 12 – Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters – Equity Compensation Plan Information", which information is incorporated herein by reference.

Item 6. Selected Financial Data.

The following table sets forth our selected historical financial and operating data for, or as of the end of, each of the five years ended June 30, 2009 (including the predecessor and successor periods). The selected historical financial data as of and for the combined predecessor and successor year ended June 30, 2005 and the years ended June 30, 2006, 2007, 2008 and 2009 were derived from our audited consolidated financial statements that have been audited by Ernst & Young LLP, an independent registered public accounting firm. Dispositions completed during fiscal 2007 have been excluded from all periods presented. See "Executive Overview" included in "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations." This table should be read in conjunction with the consolidated financial statements and notes thereto.

	Combined Basis Year Ended June 30, 2005	Year Ended June 30, 2006	Year Ended June 30, 2007	Year ended June 30, 2008	Year ended June 30, 2009	Predecessor July 1, 2004 through September 22, 2004	Successor September 23, 2004 through June 30, 2005
			(Dollars in millions, except Operating Data)				
Statement of Operations Data:							
Total revenues	$ 2,037.3	$ 2,418.6	$ 2,580.7	$ 2,790.7	$ 3,199.7	$ 397.9	$ 1,639.4
Costs and expenses:							
Salaries and benefits (includes stock compensation of $97.4, $1.7, $1.2, $2.5, $4.4, $96.7 and $0.7, respectively)	909.2	991.4	1,067.9	1,152.7	1,240.1	248.2	661.0
Supplies	336.8	394.1	421.8	434.5	456.3	63.7	273.1
Health plan claims expense	237.2	270.3	297.0	328.2	525.6	55.0	182.2
Provision for doubtful accounts	133.0	156.8	175.2	205.6	210.8	27.8	105.2
Other operating expenses	288.8	353.0	375.0	405.8	468.9	57.3	231.5
Depreciation and amortization	75.7	100.3	118.6	131.0	130.6	16.0	59.7
Interest, net	82.3	103.8	123.8	122.1	111.6	9.0	73.3
Debt extinguishment costs	62.2	0.1	—	—	—	62.2	—
Minority interests	(0.3)	2.6	2.6	3.0	3.2	(0.5)	0.2
Merger expenses	23.3	—	—	—	—	23.1	0.2
Impairment loss	—	—	123.8	—	6.2	—	—
Other expenses	3.6	6.5	0.2	6.5	2.7	0.4	3.2
Subtotal	2,151.8	2,378.9	2,705.9	2,789.4	3,156.0	562.2	1,589.6
Income (loss) from continuing operations before income taxes	(114.5)	39.7	(125.2)	1.3	43.7	(164.3)	49.8
Income tax expense (benefit)	(34.7)	17.8	(11.6)	1.7	16.0	(52.2)	17.5
Income (loss) from continuing operations	(79.8)	21.9	(113.6)	(0.4)	27.7	(112.1)	32.3
Income (loss) from discontinued operations, net of taxes	1.7	(9.0)	(19.1)	(0.3)	0.9	1.4	0.3
Net income (loss)	(78.1)	12.9	(132.7)	(0.7)	28.6	(110.7)	32.6
Preferred dividends	(1.0)	—	—	—	—	(1.0)	—
Net income (loss) attributable to common stockholders	$ (79.1)	$ 12.9	$ (132.7)	$ (0.7)	$ 28.6	$ (111.7)	$ 32.6
Balance Sheet Data:							
Assets	$ 2,471.7	$ 2,650.5	$ 2,538.1	$ 2,582.3	$ 2,731.1		$ 2,471.7
Long-term debt, including current portion	1,357.1	1,519.2	1,528.7	1,537.5	1,551.6		1,357.1
Working capital	77.7	193.0	156.4	217.8	251.6		77.7
Other Financial Data:							
Capital expenditures	$ 224.2	$ 275.5	$ 164.3	$ 121.6	$ 132.1	$ 27.1	$ 197.1
Cash provided by operating activities	201.8	149.3	123.3	173.1	308.2	78.8	123.0
Cash used in investing activities	(324.3)	(245.4)	(118.5)	(143.8)	(133.6)	(50.0)	(274.3)
Cash provided by (used in) financing activities	151.6	140.5	(8.3)	(7.8)	(8.0)	(20.0)	171.6
Operating Data-continuing operations: (unaudited)							
Number of hospitals at end of period	15	15	15	15	15		
Number of licensed beds at end of period (a)	3,907	3,937	4,143	4,181	4,135		
Discharges (b)	147,798	162,446	166,873	169,668	167,880		
Adjusted discharges - hospitals (c)	231,322	261,056	264,698	270,076	274,767		
Adjusted discharges (d)	278,255	303,696	278,820	284,680	289,997		
Net revenue per adjusted discharge – hospitals (e)	$ 6,859	$ 7,319	$ 7,766	$ 8,110	$ 8,623		
Net revenue per adjusted discharge (f)	$ 6,817	$ 7,353	$ 7,690	$ 8,059	$ 8,517		
Patient days (g)	623,333	701,307	721,832	734,838	709,952		
Average length of stay (days) (h)	4.2	4.3	4.3	4.3	4.2		
Inpatient surgeries (i)	33,424	36,606	37,227	37,538	37,970		
Outpatient surgeries (j)	67,944	76,437	76,606	73,339	76,378		
Emergency room visits (k)	504,172	554,250	572,946	588,246	605,729		
Occupancy rate (l)	48.5%	49.2%	48.2%	48.0%	47.0%		
Average daily census (m)	1,708	1,921	1,978	2,008	1,945		
Member lives (n)	146,700	146,200	145,600	149,600	218,700		
Health plan claims expense percentage (o)	71.1%	72.1%	74.0%	72.9%	77.5%		

(a) Licensed beds are those beds for which a facility has been granted approval to operate from the applicable state licensing agency.

(b) Discharges represent the total number of patients discharged (in the facility for a period in excess of 23 hours) from our hospitals and is used by management and certain investors as a general measure of inpatient volumes.

(c) Adjusted discharges-hospitals is used by management and certain investors as a general measure of combined hospital inpatient and outpatient volumes. Adjusted discharges-hospitals is computed by multiplying discharges by the sum of gross hospital inpatient and gross hospital outpatient revenues and then dividing the result by gross hospital inpatient revenues. This computation enables management to assess hospital volumes by a combined measure of hospital inpatient and outpatient utilization.

(d) Adjusted discharges is used by management and certain investors as a general measure of consolidated inpatient and outpatient volumes. Adjusted discharges is computed by multiplying discharges by the sum of gross inpatient revenues and gross outpatient revenues and then dividing the result by gross inpatient revenues.

(e) Net revenue per adjusted discharge-hospitals is calculated by dividing hospital net patient revenues by adjusted discharges-hospitals and measures the average net payment expected to be received for a patient's stay in the hospital.

(f) Net revenue per adjusted discharge is calculated by dividing net patient revenues by adjusted discharges and measures the average net payment expected to be received for an episode of service provided to a patient.

(g) Patient days represent the number of days (calculated as overnight stays) our beds were occupied by patients during the periods.

(h) Average length of stay represents the average number of days an admitted patient stays in our hospitals.

(i) Inpatient surgeries represent the number of surgeries performed in our hospitals where overnight stays are necessary.

(j) Outpatient surgeries represent the number of surgeries performed at hospitals or ambulatory surgery centers on an outpatient basis (patient overnight stay not necessary).

(k) Emergency room visits represent the number of patient visits to a hospital or freestanding emergency room where treatment is received, regardless of whether an overnight stay is subsequently required.

(l) Occupancy rate represents the percentage of hospital licensed beds occupied by patients. Occupancy rate provides a measure of the utilization of inpatient rooms.

(m) Average daily census represents the average number of patients in our hospitals each day during our ownership.

(n) Member lives represent the total number of enrollees in PHP, AAHP and MHP as of the end of the respective period.

(o) Health plan claims expense percentage is calculated by dividing health plan claims expense by premium revenues.

Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations.

You should read the following discussion together with our historical financial statements and related notes included elsewhere herein and the information set forth under "Item 6. Selected Financial Data." The discussion contains forward-looking statements that involve risks and uncertainties. For additional information regarding some of the risks and uncertainties that affect our business and the industry in which we operate, please read "Item 1A. - Risk Factors" included elsewhere herein. Our actual results may differ materially from those estimated or projected in any of these forward-looking statements.

Executive Overview

As of June 30, 2009, we owned and operated 15 hospitals with a total of 4,135 licensed beds, and related outpatient service facilities complementary to the hospitals in San Antonio, Texas; metropolitan Phoenix, Arizona; metropolitan Chicago, Illinois; and Massachusetts, and two surgery centers in Orange County, California. As of June 30, 2009, we also owned three health plans as set forth in the following table.

Health Plan	Location	Membership
Phoenix Health Plan ("PHP") – managed Medicaid	Arizona	176,200
Abrazo Advantage Health Plan ("AAHP") – managed Medicare and Dual Eligible	Arizona	2,800
MacNeal Health Providers ("MHP") – capitated outpatient and physician services	Illinois	39,700
		218,700

Our objective is to help communities achieve health for life by delivering an ideal patient-centered experience in a highly reliable environment of care. We plan to grow our business by improving quality of care, expanding services and strengthening the financial performance of our existing operations and selectively acquiring other hospitals where we see an opportunity to improve operating performance and profitability.

Operating Environment

We believe that the operating environment for hospital operators continues to evolve, which presents both challenges and opportunities for us. In order to remain competitive in the markets we serve, we must transform our operating strategies to not only accommodate changing environmental factors but to make them operating advantages for us relative to our peers. These factors will require continued focus on quality of care initiatives. As consumers become more involved in their healthcare decisions, we believe perceived quality of care will become an even greater factor in determining where physicians choose to practice and where patients choose to receive care. In the following paragraphs we discuss both current challenges and future challenges that we face and our strategies to proactively address them.

Pay for Performance Reimbursement

Many payers, including Medicare and several large managed care organizations, currently require hospital providers to report certain quality measures in order to receive the full amount of payment increases that were awarded automatically in the past. For federal fiscal year 2010, Medicare expanded the number of quality measures to be reported to 47 compared to 43 during federal fiscal year 2009. Many large managed care organizations have developed quality measurement criteria that are similar to or even more stringent than these Medicare requirements. While current Medicare guidelines and contracts with most managed care payers provide for reimbursement based upon the reporting of quality measures, we believe it is only a matter of time until all significant payers utilize the quality measures themselves to determine reimbursement rates for hospital services. In order to meet these requirements, we must deliver an ideal patient-centered experience. This will require us to engage our nurses and partner with physicians to drive our quality of care strategies, invest in and to upgrade our information technology systems to monitor clinical quality indicators and to make all of our processes more efficient.

Physician Alignment

Our ability to attract skilled physicians to our hospitals is critical to our success. Coordination of care and alignment of care strategies between hospitals and physicians will become more critical as reimbursement becomes more episode-based. We have adopted several significant physician recruitment goals with primary emphasis on recruiting physicians specializing in family practice, internal medicine, obstetrics and gynecology, cardiology, neurology, orthopedics and inpatient hospital care (hospitalists). To provide our patients access to the appropriate physician resources, we recruited approximately 150 physicians to the communities served by our hospitals during the year ended June 30, 2009 through employment agreements, relocation agreements or physician practice acquisitions. We have invested heavily in the infrastructure necessary to coordinate our physician alignment strategies and manage our physician operations. Our hospitalist strategy is a key element in coordination of patient-centered care. The costs associated with recruiting, integrating and managing such a large number of new physicians will have a negative impact on our operating results and cash flows in the short term. However, we expect to realize improved clinical quality and service expansion capabilities from this initiative that will positively impact our operating results over the long-term.

Cost pressures

In order to demonstrate a highly reliable environment of care, we must hire and retain nurses who share our ideals and beliefs and who have access to the training necessary to implement our clinical quality initiatives. While the national nursing shortage has abated somewhat during the past year, the nursing workforce remains volatile. As a result, we expect continuing pressures on nursing salaries and benefits. These pressures include higher than normal base wage increases, demands for flexible working hours and other increased benefits and higher nurse to patient ratios necessary to improve quality of care. Inflationary pressures and technological advancements continue to drive supplies costs higher. We have implemented multiple supply chain initiatives including consolidation of low-priced vendors, establishment of value analysis teams and coordination of care efforts with physicians to reduce physician preference items.

Potential Healthcare Reform

The increase in the number of individuals and families without healthcare coverage has heightened debate about whether and how to implement comprehensive reform of the United States healthcare system. The Obama administration has made healthcare reform its primary domestic agenda item, and Congress is currently considering multiple plans on how to change the healthcare system and how to fund those changes. Generally, President Obama and most members of Congress believe that the current healthcare system is too inefficient and leaves too many individuals without healthcare coverage. Much of the current healthcare reform debate includes the following considerations: whether a public insurance option should be established; the impact to private insurance companies; the impact to consumer choice of healthcare services; the impact to small businesses; and the impact of funding alternatives including personal tax rate increases, business surcharges, service provider assessments and increasing the federal deficit. We are not able to predict whether healthcare reform will be implemented, what provisions a potential reform plan may include or what impact these developments may have on our future operating results or cash flows at this time.

Implementation of our Clinical Quality Initiatives

The integral component of each of the challenge areas previously discussed is quality of care. We have implemented many of our expanded clinical quality initiatives and are in the process of implementing several others. These initiatives include monthly review of the current 43 CMS quality indicators, rapid response teams, mock Joint Commission surveys, hourly nursing rounds, our nurse leadership professional practice model, alignment of hospital management incentive compensation with quality performance indicators and the formation of Physician Advisory Councils at our hospitals to align the quality goals of our hospitals with those of the physicians who practice in our hospitals.

Revenue/Volume Trends

Our revenues depend upon inpatient occupancy levels, outpatient procedures performed at our facilities, the ancillary services and therapy programs ordered by physicians and provided to patients and our ability to successfully negotiate appropriate payment rates for these services with third party payers.

Sources of Revenues

The primary sources of our revenues include various managed care payers including managed Medicare and managed Medicaid programs, the traditional Medicare program, various state Medicaid programs, commercial health plans and the patients themselves. We are typically paid much less than our gross charges regardless of the payer source. Refer to "Item 1. Business – "Sources of Revenues" section of this report for a comprehensive discussion of these payers, how they reimburse us for our services provided and the risks we face with regard to potential reimbursement changes.

The following table sets forth the percentages of net patient revenues by payer for the years ended June 30, 2007, 2008 and 2009.

	Year ended June 30,		
	2007	2008	2009
Medicare	26.4%	26.2%	25.3%
Medicaid	8.6%	7.6%	7.8%
Managed Medicare	12.8%	14.0%	14.1%
Managed Medicaid	7.5%	7.5%	8.9%
Managed care	32.0%	35.0%	34.8%
Self pay	9.7%	8.6%	8.2%
Other	3.0%	1.1%	0.9%
Total	100.0%	100.0%	100.0%

Volumes by Payer

During the year ended June 30, 2009, we experienced a 1.1% decrease in discharges compared to the prior year. During the year ended June 30, 2009, we experienced a 1.7% increase in hospital adjusted discharges compared to the prior year. The following table provides details of discharges by payer for the years ended June 30, 2007, 2008 and 2009.

	Year ended June 30,					
	2007		2008		2009	
Medicare	46,452	27.8%	47,040	27.7%	45,516	27.1%
Medicaid	22,518	13.5%	20,195	11.9%	17,068	10.2%
Managed Medicare	23,339	14.0%	26,040	15.3%	26,925	16.0%
Managed Medicaid	18,579	11.1%	19,893	11.7%	23,185	13.8%
Managed care	48,481	29.1%	50,040	29.5%	48,977	29.2%
Self pay	6,181	3.7%	5,854	3.5%	5,650	3.4%
Other	1,323	0.8%	606	0.4%	559	0.3%
Total	166,873	100.0%	169,668	100.0%	167,880	100.0%

Impact of Current Economic Environment

We continue to experience limited volume growth due to stagnant demand for inpatient healthcare services and increased competition for available patients. The current economic recession has negatively impacted many industries. While many healthcare services are considered non-discretionary in nature, certain services including elective procedures and other non-emergent services may be deferred or canceled by patients when they are suffering personal financial hardship or have a negative outlook on the general economy. Increases in unemployment often result in a higher number of uninsured patients, and employer cost reduction programs may result in a higher level of co-pays and deductible limits for patients. Governmental payers and managed care payers may reduce reimbursement paid to hospitals and other healthcare providers to address budget shortfalls or enrollment declines. We are unable to determine the specific impact of the economic recession on our results of operations and cash flows, but we believe a prolonged or more severe economic recession during the remainder of 2009 and into 2010 will have an adverse impact on our revenues whether in the form of payer mix shifts from managed care to uninsured or Medicaid, additional charity care, lower patient volumes, lower collection rates of patient co-pay and deductible balances or a combination of such factors. We expect our volumes to improve more significantly over the long-term as a result of our quality of care and service expansion initiatives and other market-specific strategies, especially as more individuals in the markets we serve reach ages where hospital services become more prevalent. However, we have no way to estimate when the economy may improve or when we will realize the benefits of our long-term strategies.

Payer Reimbursement Trends

In addition to the volume factors described above, patient mix, acuity factors and pricing trends affect our patient service revenues. Net patient revenue per adjusted hospital discharge was $8,110 and $8,623 for the years ended June 30, 2008 and 2009, respectively. This increase reflects improved reimbursement for services provided under negotiated managed care contracts and increased revenues earned from the Texas upper payment limit ("UPL") program and the Illinois provider tax assessment ("PTA") program further described below. However, due to consolidation of managed care plans and federal and state efforts to decrease Medicare and Medicaid spending, our ability to recognize improved reimbursement above or equal to rates recognized in previous periods is becoming more difficult. We cannot assure you that future reimbursement rates, even if improved, will sufficiently cover potential increases in the cost of providing healthcare services to our patients.

During fiscal 2007 we were approved to receive payments under the Bexar County, Texas UPL Medicaid program. UPL programs allow private hospitals to enter into indigent care affiliation agreements with governmental entities. Within the parameters of these programs, private hospitals expand charity care services to indigent patients and alleviate expenses for the governmental entity. The governmental entity is then able to utilize its tax revenue to fund the Medicaid program for private hospitals. CMS began reviewing the operations of this private hospital UPL program after the State of Texas made the first payments in April 2007. It is customary for CMS to review Medicaid UPL payment programs. In October 2007, the State of Texas halted all funding of its private hospital UPL programs due to the deferral by CMS of certain federal Medicaid payments to the State of Texas. In August 2008, CMS completed its review and the state lifted its moratorium on payments under this UPL program. Payments received under the Texas UPL program increased income before taxes by $0.2 million and $19.5 million during the years ended June 30, 2008 and 2009, respectively.

During our third quarter of fiscal 2009, the federal government approved federal matching funds for the Illinois PTA program. This program enables the state of Illinois to increase funding for its state Medicaid plan. Hospitals providing services to Medicaid enrollees receive funds directly from the state and then repay a portion of these proceeds to the state in the form of a provider tax assessment. We received $24.9 million of cash from this program during the year ended June 30, 2009, all of which increased revenues and $13.4 million of which was subsequently paid to the state in the form of a provider tax assessment and is included in non-income taxes in our consolidated statement of operations for the year ended June 30, 2009. The PTA program increased income before taxes by $11.5 million during the year ended June 30, 2009.

Accounts Receivable Collection Risks Leading to Increased Bad Debts

Similar to others in the hospital industry, we have a significant amount of self-pay receivables (including self-pay after primary), and collecting these receivables is difficult and may become more difficult if economic conditions worsen. The following table provides a summary of our accounts receivable payer class mix as of June 30, 2007, 2008 and 2009.

June 30, 2007	0-90 days	91-180 days	Over 180 days	Total
Medicare	15.0%	0.6%	0.6%	16.2%
Medicaid	7.5%	2.0%	1.0%	10.5%
Managed Medicare	7.6%	0.7%	0.6%	8.9%
Managed Medicaid	5.3%	0.6%	0.7%	6.6%
Managed Care	25.1%	2.7%	1.6%	29.4%
Self-Pay[1]	10.2%	8.0%	1.7%	19.9%
Self-Pay after primary[2]	1.8%	2.8%	1.1%	5.7%
Other	1.8%	0.6%	0.4%	2.8%
Total	74.3%	18.0%	7.7%	100.0%

June 30, 2008	0-90 days	91-180 days	Over 180 days	Total
Medicare	15.3%	0.6%	0.4%	16.3%
Medicaid	8.0%	2.2%	1.3%	11.5%
Managed Medicare	8.5%	0.6%	0.5%	9.6%
Managed Medicaid	5.6%	0.4%	0.3%	6.3%
Managed Care	25.8%	2.6%	1.9%	30.3%
Self-Pay[1]	9.3%	7.6%	1.1%	18.0%
Self-Pay after primary[2]	1.9%	2.6%	1.0%	5.5%
Other	1.6%	0.5%	0.4%	2.5%
Total	76.0%	17.1%	6.9%	100.0%

June 30, 2009	0-90 days	91-180 days	Over 180 days	Total
Medicare	15.6%	0.3%	0.3%	16.2%
Medicaid	6.7%	0.9%	1.0%	8.6%
Managed Medicare	10.0%	0.5%	0.3%	10.8%
Managed Medicaid	7.1%	0.5%	0.5%	8.1%
Managed Care	25.1%	2.3%	1.5%	28.9%
Self-Pay[1]	9.7%	8.1%	0.8%	18.6%
Self-Pay after primary[2]	2.1%	2.9%	0.9%	5.9%
Other	1.8%	0.6%	0.5%	2.9%
Total	78.1%	16.1%	5.8%	100.0%

(1) Includes uninsured only.
(2) Includes patient co-insurance and deductible amounts after payment has been received from the primary payer.

Our combined allowances for doubtful accounts, self-pay discounts and charity care covered 96.3% and 96.5% of combined self-pay and self-pay after primary accounts receivable as of June 30, 2008 and 2009, respectively.

The volume of self-pay accounts receivable remains sensitive to a combination of factors including price increases, acuity of services, higher levels of patient deductibles and co-insurance under managed care plans, economic factors and the increased difficulties of uninsured patients who do not qualify for charity care programs to pay for escalating healthcare costs. We have implemented policies and procedures designed to expedite upfront cash collections and promote repayment plans from our patients. However, we believe bad debts will remain a significant risk for us and the rest of the hospital industry in the near term.

Governmental and Managed Care Payer Reimbursement

Healthcare spending comprises a significant portion of total spending in the United States and has been growing at annual rates that exceed inflation, wage growth and gross national product. There is considerable pressure on governmental payers, managed Medicare/Medicaid payers and commercial managed care payers to control costs by either reducing or limiting increases in reimbursement to healthcare providers or limiting benefits to enrollees. The current economic recession has magnified these pressures. Lower than expected tax collections due to higher unemployment and depressed consumer spending have resulted in budget shortfalls for most states, including those in which we operate. Additionally, the demand for Medicaid coverage has increased due to job losses that have left many individuals without health insurance. To balance their budgets, many states, either directly or through their managed Medicaid programs, may enact healthcare spending cuts or defer cash payments to healthcare providers, since raising taxes is not a popular option during recessionary cycles. Further, the tightened credit markets have complicated the states' efforts to issue additional bonds to raise cash. During the year ended June 30, 2009, Medicaid and managed Medicaid programs accounted for approximately 17% of our net patient revenues. Managed care payers also face economic pressures during periods of economic weakness due to lower enrollment resulting from higher unemployment rates and the inability of individuals to afford private insurance coverage. These payers may respond to these challenges by reducing or limiting increases to healthcare provider reimbursement rates or reducing benefits to enrollees. During the year ended June 30, 2009, we recognized approximately 35% of our net patient revenues from managed care payers. If we do not receive increased payer reimbursement rates from governmental or managed care payers that cover the increasing cost of providing healthcare services to our patients or if governmental payers defer payments to our hospitals, our financial position, results of operations and cash flows could be materially adversely impacted.

Increased Costs of Compliance in a Heavily Regulated Industry

We conduct business in a heavily regulated industry. Accordingly, we maintain a comprehensive, company-wide compliance program to address healthcare regulatory and other compliance requirements. This compliance program includes, among other things, initial and periodic ethics and compliance training, a toll-free reporting hotline for employees, annual fraud and abuse audits and annual coding audits. The organizational structure of our compliance program includes oversight by our board of directors and a high-level corporate management compliance committee. Our Senior Vice President of Compliance and Ethics reports jointly to our Chairman and Chief Executive Officer and to our board of directors, serves as our Chief Compliance Officer and is charged with direct responsibility for the day-to-day management of our compliance program. We also have regional compliance officers in our markets that are 100% dedicated to compliance duties. The financial resources necessary for program oversight, internal enforcement and periodic improvements to our program continue to grow, especially when we add new features to our program or engage external resources to assist with these highly complex matters.

Premium Revenues

We recognize premium revenues from our three health plans, PHP, AAHP and MHP. PHP's membership increased to approximately 176,200 at June 30, 2009 compared to approximately 103,400 at June 30, 2008 primarily due to a new contract with Arizona Health Care Cost Containment System ("AHCCCS") that went into effect on October 1, 2008, as discussed below. Premium revenues from these three plans increased $227.8 million or 50.6% during the year ended June 30, 2009 compared to the prior year period.

In May 2008, PHP was awarded a new contract with AHCCCS effective for the three-year period beginning October 1, 2008 and ending September 30, 2011. AHCCCS has the option to renew the new contract, in whole or in part, for two additional one-year periods commencing on October 1, 2011 and on October 1, 2012. The new contract covers the three counties covered under the previous contract (Gila, Maricopa and Pinal) plus an additional six Arizona counties: Apache, Coconino, Mohave, Navajo, Pima and Yavapai. We experienced a significant increase in PHP membership and premium revenues during our second, third and fourth quarters of our fiscal year ended June 30, 2009 as a result of this new contract. The new contract utilizes a national episodic/diagnostic risk adjustment factor for non-reconciled enrollee risk groups, the calculation of which AHCCCS expects to finalize by September 30, 2009 and then apply retroactively to October 1, 2008, that was not part of PHP's previous AHCCCS contract. Our financial statements include an estimated reserve for the impact of this risk adjustment factor, and we will adjust the reserve as necessary once the calculation is finalized by AHCCCS. Given the State of Arizona's recent budget crisis and continued concerns about economic indicators during its 2010 fiscal year, AHCCCS could cut reimbursement rates, reduce enrollment, defer capitation payments, reduce or limit covered services or take other steps to reduce program expenditures including cancelling PHP's contract. Any of these actions could materially adversely impact our future results of operations, financial position or cash flows.

Critical Accounting Policies

Our consolidated financial statements have been prepared in accordance with accounting principles generally accepted in the United States. In preparing these financial statements, we make estimates and assumptions that affect the reported amounts of assets, liabilities, revenues and expenses included in the financial statements. Management bases its estimates on historical experience and other available information, the results of which form the basis of the estimates and assumptions. We consider the following accounting policies to be critical because they involve highly subjective and complex assumptions and assessments, are subject to a great degree of fluctuation period over period and are the most critical to our operating performance.

Revenues and Revenue Deductions

We recognize patient service revenues during the period the healthcare services are provided based upon estimated amounts due from payers. We record contractual adjustments to our gross charges to reflect expected reimbursement negotiated with or prescribed by third party payers. We estimate contractual adjustments and allowances based upon payment terms set forth in managed care health plan contracts and by federal and state regulations. For the majority of our patient service revenues, we apply contractual adjustments to patient accounts at the time of billing using specific payer contract terms entered into the accounts receivable systems, but in some cases we record an estimated allowance until payment is received. If our estimated contractual adjustments as a percentage of gross revenues were 1% higher for all insured accounts, our net revenues would have been reduced by approximately $79.0 million for the year ended June 30, 2009. We derive most of our patient service revenues from healthcare services provided to patients with Medicare (including managed Medicare plans) or managed care insurance coverage.

Services provided to Medicare patients are generally reimbursed at prospectively determined rates per diagnosis ("PPS"), while services provided to managed care patients are generally reimbursed based upon predetermined rates per diagnosis, per diem rates or discounted fee-for-service rates. Medicaid reimbursements vary by state. Other than Medicare, no individual payer represents more than 10% of our patient service revenues.

Medicare regulations and many of our managed care contracts are often complex and may include multiple reimbursement mechanisms for different types of services provided in our healthcare facilities. To obtain reimbursement for certain services under the Medicare program, we must submit annual cost reports and record estimates of amounts owed to or receivable from Medicare. These cost reports include complex calculations and estimates related to indirect medical education, disproportionate share payments, reimbursable Medicare bad debts and other items that are often subject to interpretation that could result in payments that differ from recorded estimates. We estimate amounts owed to or receivable from the Medicare program using the best information available and our interpretation of the applicable Medicare regulations. We include differences between original estimates and subsequent revisions to those estimates (including final cost report settlements) in our consolidated statements of operations in the period in which the revisions are made. Net adjustments for final third party settlements increased patient service revenues and income from continuing operations before income taxes by $6.3

million, $7.9 million and $8.0 million during the years ended June 30, 2007, 2008 and 2009, respectively. Additionally, updated regulations and contract negotiations with payers occur frequently, which necessitates continual review of revenue estimation processes by management. Management believes that future adjustments to its current third party settlement estimates will not materially impact our results of operations, cash flows or financial position.

Effective for service dates on or after April 1, 2009, as a result of a state mandate, we implemented a new uninsured discount policy for those patients receiving services in our Illinois hospitals who had no insurance coverage and who did not otherwise qualify for charity care under our guidelines. Under this policy, we apply an uninsured discount (calculated as a standard percentage of gross charges) at the time of patient billing and include this discount as a reduction to patient service revenues. These discounts were approximately $11.7 million for the year ended June 30, 2009. We implemented this policy for most of our remaining facilities effective July 1, 2009 and expect to implement it at all of our facilities by the end of our fiscal year 2010.

We do not pursue collection of amounts due from uninsured patients that qualify for charity care under our guidelines (currently those uninsured patients whose incomes are equal to or less than 200% of the current federal poverty guidelines set forth by the Department of Health and Human Services). We deduct charity care accounts from revenues when we determine that the account meets our charity care guidelines. We also provide discounts from billed charges and alternative payment structures for uninsured patients who do not qualify for charity care but meet certain other minimum income guidelines, primarily those uninsured patients with incomes between 200% and 500% of the federal poverty guidelines. During the past three fiscal years, a significant percentage of our charity care deductions represented services provided to undocumented aliens under the Section 1011 border funding reimbursement program. Border funding qualification has ended in Texas, and we expect that qualification will end sometime during our fiscal 2010 in Arizona and Illinois when funds appropriated to those states have been exhausted.

The following table provides a breakdown of our charity care deductions during the years ending June 30, 2007, 2008 and 2009, respectively (in millions).

	Year ended June 30,		
	2007	2008	2009
Total charity care deductions	$ 86.1	$ 86.1	$ 91.8
Border funding charity deductions, net of payments received	$ 19.4	$ 29.6	$ 34.9
Payments received for border funding accounts	$ 2.0	$ 3.8	$ 4.6

We record revenues related to the Illinois PTA program, as previously described, when the receipt of payment from the state entity is assured. For the Texas UPL program, as previously described, we recognize revenues that offset the expenses associated with the provision of charity care when the services are provided. We recognize federal match revenues under the Texas UPL program when payments are assured.

We earned premium revenues of $401.4 million, $450.2 million and $678.0 million during the years ended June 30, 2007, 2008 and 2009, respectively, from our health plans. Our health plans, PHP, AAHP and MHP, have agreements with AHCCCS, CMS and various health maintenance organizations ("HMOs"), respectively, to contract to provide medical services to subscribing participants. Under these agreements, our health plans receive monthly payments based on the number of HMO participants in MHP or the number and coverage type of enrollees in PHP and AAHP. Our health plans recognize the payments as revenues in the month in which members are entitled to healthcare services with the exception of AAHP Medicare Part D reinsurance premiums and low income subsidy cost sharing premiums that are recorded as a liability to fund future healthcare costs or else repaid to CMS.

Allowance for Doubtful Accounts and Provision for Doubtful Accounts

Our ability to collect the self-pay portions of our receivables is critical to our operating performance and cash flows. Our allowance for doubtful accounts was approximately 28.1% and 30.6% of accounts receivable, net of contractual discounts, as of June 30, 2008 and 2009, respectively. The primary collection risk relates to uninsured

patient accounts and patient accounts for which primary insurance has paid but patient deductibles or co-insurance portions remain outstanding.

We estimate our allowance for doubtful accounts using a standard policy that reserves all accounts aged greater than 365 days subsequent to discharge date plus percentages of uninsured accounts and self-pay after primary accounts less than 365 days old. We test our allowance for doubtful accounts policy quarterly using a hindsight calculation that utilizes write-off data for all payer classes during the previous twelve-month period to estimate the allowance for doubtful accounts at a point in time. We also supplement our analysis by comparing cash collections to net patient revenues and monitoring self-pay utilization. We adjust the standard percentages in our allowance for doubtful accounts reserve policy as necessary given changes in trends from these analyses. We most recently adjusted this reserve policy when we implemented our uninsured discount policy in Illinois. If our uninsured accounts receivable as of June 30, 2009 were 1% higher, our provision for doubtful accounts would have increased by $1.0 million. Significant changes in payer mix, business office operations, general economic conditions and healthcare coverage provided by federal or state governments or private insurers may have a significant impact on our estimates and significantly affect our liquidity, results of operations and cash flows.

Prior to the implementation of our new uninsured discount policy, we classified accounts pending Medicaid approval as Medicaid accounts in our accounts receivable aging report and recorded a contractual allowance for these accounts equal to the average Medicaid reimbursement rate for that specific state until qualification was confirmed at which time the account was netted in the aging. In the event an account did not successfully qualify for Medicaid coverage and did not meet our charity guidelines, the previously recorded Medicaid contractual adjustment remained a revenue deduction (similar to a self-pay discount), and the remaining net account balance was reclassified to uninsured status and subjected to our allowance for doubtful accounts policy. If accounts did not qualify for Medicaid coverage but did qualify as charity care, the contractual adjustments were reversed and the gross account balances was recorded as charity deductions.

Upon the implementation of our new uninsured discount policy, all uninsured accounts (including those pending Medicaid qualification) that do not qualify for charity care receive the standard uninsured discount. The balance of these accounts are subject to our allowance for doubtful accounts policy. For those accounts that subsequently qualify for Medicaid coverage, the uninsured discount is reversed and the account is reclassified to Medicaid accounts receivable with the appropriate contractual discount applied. Thus, the contractual allowance for Medicaid pending accounts is no longer necessary for those accounts subject to the uninsured discount policy. The following table provides the value of accounts pending Medicaid qualification, the balance successfully qualified for Medicaid coverage, the balance not qualified and transferred to uninsured status, the balance not qualified and transferred to charity and the percentage successfully qualified for Medicaid coverage during the respective fiscal years (dollars in millions).

	Fiscal Year June 30, 2008			Fiscal Year June 30, 2009		
	Accounts prior to uninsured discount policy	Accounts subject to uninsured discount policy	Total	Accounts prior to uninsured discount policy	Accounts subject to uninsured discount policy	Total
Medicaid pending accounts receivable balance	$ 12.5	$ –	$ 12.5	$ 12.5	$ 3.3	$ 15.8
Medicaid pending accounts successfully qualified	$ 22.5	$ –	$ 22.5	$ 23.5	$ –	$ 23.5
Medicaid pending accounts not qualified (uninsured)	$ 25.1	$ –	$ 25.1	$ 29.4	$ 0.2	$ 29.6
Medicaid pending accounts not qualified (charity)	$ 7.2	$ –	$ 7.2	$ 8.0	$ –	$ 8.0
Medicaid pending qualification success percentage			41%			39%

Because we require patient verification of coverage at the time of admission, reclassifications of Medicare or managed care accounts to self-pay, other than patient coinsurance or deductible amounts, occur infrequently and are not material to our financial statements. Additionally, the impact of these classification changes is further limited by our ability to identify any necessary classification changes prior to patient discharge or soon thereafter. Due to information system limitations, we are unable to quantify patient deductible and co-insurance receivables that are included in the primary payer classification in the accounts receivable aging report at any given point in time. When classification changes occur, the account balance remains aged from the patient discharge date.

Insurance Reserves

As of June 30, 2008, we maintained a self-insured medical plan for a limited number of our employees. Claims were accrued under the self-insured plan as the incidents that gave rise to them occurred. Unpaid claims accruals were based on the estimated ultimate cost of settlement, including claim settlement expenses, in accordance with an average lag time and historical experience. Effective July 1, 2008, we began covering all of our employees under a self-insured medical plan, which subjected us to significantly higher risks and reserve levels.

Due to the nature of our operating environment, we are subject to professional and general liability and workers compensation claims and related lawsuits in the ordinary course of business. For professional and general liability claims incurred from June 1, 2002 to May 31, 2006, our wholly owned captive subsidiary insured our professional and general liability risks at a $10.0 million retention level. For professional and general liability claims incurred subsequent to May 31, 2006 through June 30, 2009, we self-insured the first $9.0 million per claim, and the captive subsidiary insured the next $1.0 million per claim. We maintain excess coverage from independent third party insurers on a claims-made basis for individual claims exceeding $10.0 million up to $75.0 million, but limited to total annual payments of $65.0 million in the aggregate.

We insure our excess professional and general liability coverage under a retrospectively rated policy, and premiums under this policy are recorded at the minimum premium amount unless our claims experience leads us to believe that a higher premium applies. We self-insure our workers compensation claims up to $1.0 million per claim and purchase excess insurance coverage for claims exceeding $1.0 million.

The following tables summarize our employee health, professional and general liability and workers compensation reserve balances (including the current portions of such reserves) as of June 30, 2008 and 2009 and claims loss and claims payment information during the years ended June 30, 2007, 2008 and 2009.

	Employee Health	Professional and General Liability	Workers Compensation
		(in millions)	
Reserve balance:			
June 30, 2006	$ 1.6	$ 58.8	$ 15.3
June 30, 2007	$ 1.2	$ 64.6	$ 18.5
June 30, 2008	$ 1.5	$ 74.3	$ 18.8
June 30, 2009	$ 13.4	$ 92.9	$ 18.2
Current year provision for claims losses:			
Fiscal year 2007	$ 6.8	$ 24.7	$ 9.4
Fiscal year 2008	$ 7.3	$ 22.4	$ 7.6
Fiscal year 2009	$ 93.2	$ 22.2	$ 7.8
Adjustments to prior year claims losses:			
Fiscal year 2007	$ –	$ (4.5)	$ –
Fiscal year 2008	$ –	$ (0.6)	$ (2.3)
Fiscal year 2009	$ (0.6)	$ 13.4	$ (3.8)
Claims paid related to current year:			
Fiscal year 2007	$ 6.0	$ 0.2	$ 1.3
Fiscal year 2008	$ 5.8	$ 0.1	$ 1.0
Fiscal year 2009	$ 79.8	$ 0.3	$ 1.6
Claims paid related to prior years:			
Fiscal year 2007	$ 1.2	$ 14.2	$ 4.9
Fiscal year 2008	$ 1.2	$ 12.0	$ 4.0
Fiscal year 2009	$ 0.9	$ 16.7	$ 3.0

In developing our estimates of our reserves for employee health, professional and general liability and workers compensation claims, we utilize actuarial and certain case-specific information. Each reserve is comprised of

estimated indemnity and expense payments related to: 1) reported events ("case reserves") and 2) incurred but not reported ("IBNR") events as of the end of the period. Management uses information from its human resource and risk managers and its best judgment to estimate case reserves. Actuarial IBNR estimates are dependent on multiple variables including our risk exposures, our self-insurance limits, geographic locations in which we operate, the severity of our historical losses compared to industry averages and the reporting pattern of our historical losses compared to industry averages, among others. Most of these variables require judgment, and changes in these variables could result in significant period over period fluctuations in our estimates. We discount our workers compensation reserve using actuarial estimates of projected cash payments in future periods (approximately 5.0% for each of the past three fiscal years). We do not discount our professional and general liability reserve. We adjust these reserves from time to time as we receive updated information.

In April 2009, a jury awarded damages to the plaintiff in a professional liability case against one of our hospitals in the amount of approximately $14.9 million, which exceeded our captive subsidiary's $10.0 million self insured limit. Based upon this verdict, we increased our professional and general liability reserve by the excess of the verdict amount over our previously established case reserve estimate and recorded a receivable from our captive subsidiary's third party excess carrier for that portion exceeding $10.0 million. We then reduced this receivable by the additional premium due to the excess carrier under our retrospectively rated insurance policy for that particular policy year. These developments resulted in an increase to insurance expense of approximately $11.9 million during the year ended June 30, 2009. We appealed this verdict since most of the verdict represented non-economic damages like pain and suffering, but we can not predict whether or not the verdict will be reduced at this time.

Our best estimate of professional and general liability and workers compensation IBNR utilizes statistical confidence levels that are below 75%. Using a higher statistical confidence level, while not permitted under United States generally accepted accounting principles, would increase the estimated reserve. The following table illustrates the sensitivity of the reserve estimates at 75% and 90% confidence levels.

	Professional and General Liability	Workers Compensation
	(in millions)	
June 30, 2008 reserve:		
As reported	$ 74.3	$ 18.8
With 75% Confidence Level	$ 85.7	$ 21.5
With 90% Confidence Level	$ 97.2	$ 23.8
June 30, 2009 reserve:		
As reported	$ 92.9	$ 18.2
With 75% Confidence Level	$ 104.9	$ 21.2
With 90% Confidence Level	$ 116.9	$ 23.8

Our best estimate of employee health claims IBNR relies primarily upon payment lag data. If our estimate of the number of unpaid days of employee health claims expense changed by 5 days, our employee health IBNR estimate would change by approximately $1.3 million.

Health Plan Claims Reserves

During the years ended June 30, 2007, 2008 and 2009, medical claims expense was $297.0 million, $328.2 million and $525.6 million, respectively, primarily representing medical claims of PHP. Vanguard estimates PHP's reserve for medical claims using historical claims experience (including cost per member and payment lag time) and other actuarial data including number of enrollees and certain enrollee demographic information. The following table provides the health plan reserve balances as of June 30, 2008 and 2009 and health plan claims and payment information during the years ended June 30, 2007, 2008 and 2009, respectively (in millions).

	Year ended June 30,		
	2007	2008	2009
Health plan reserves, beginning of year	$ 46.6	$ 61.4	$ 51.1
Current year provision for health plan claims	293.9	329.7	525.5
Current year adjustments to prior year health plan claims	3.1	(1.5)	0.1
Program settlement, capitation and other activity	(9.7)	(24.2)	19.3
Claims paid related to current year	(231.2)	(268.4)	(424.6)
Claims paid related to prior years	(41.3)	(45.9)	(53.8)
Health plan reserves, end of year	$ 61.4	$ 51.1	$ 117.6

The increases in reserves, claims losses and claims payments from 2008 to 2009 were primarily due to the significant increase in enrollees during the current year period as a result of the new AHCCCS contract that went into effect on October 1, 2008. While management believes that its estimation methodology effectively captures trends in medical claims costs, actual payments could differ significantly from its estimates given changes in the healthcare cost structure or adverse experience. During the years ended June 30, 2007, 2008 and 2009, approximately $34.2 million, $31.2 million and $34.0 million, respectively, of accrued and paid claims for services provided to our health plan enrollees by our hospitals and our other healthcare facilities were eliminated in consolidation. Our operating results and cash flows could be materially affected by increased or decreased utilization of our healthcare facilities by enrollees in our health plans.

Income Taxes

We believe that our income tax provisions are accurate and supportable, but certain tax matters require interpretations of tax law that may be subject to future challenge and may not be upheld under tax audit. To reflect the possibility that all of our tax positions may not be sustained, we maintain tax reserves that are subject to adjustment as updated information becomes available or as circumstances change. We record the impact of tax reserve changes to our income tax provision in the period in which the additional information, including the progress of tax audits, is obtained.

We assess the realization of our deferred tax assets to determine whether an income tax valuation allowance is required. Based on all available evidence, both positive and negative, and the weight of that evidence to the extent such evidence can be objectively verified, we determine whether it is more likely than not that all or a portion of the deferred tax assets will be realized. The factors used in this determination include the following:

- Cumulative losses in recent years
- Income/losses expected in future years
- Unsettled circumstances that, if favorably resolved, would adversely affect future operations
- Availability, or lack thereof, of taxable income in prior carryback periods that would limit realization of tax benefits
- Carryforward period associated with the deferred tax assets and liabilities
- Prudent and feasible tax planning strategies

In addition, financial forecasts used in determining the need for or amount of federal and state valuation allowances are subject to changes in underlying assumptions and fluctuations in market conditions that could significantly alter our recoverability analysis and thus have a material adverse effect on our consolidated financial condition, results of operations or cash flows. Effective July 1, 2007, we adopted the provisions of FASB Interpretation No. 48, *Accounting for Uncertainty in Income Taxes – An Interpretation of FASB Statement No. 109* ("FIN 48"). The following table provides the detail comprising our FIN 48 net liability from the date of adoption through June 30, 2009 (in millions).

Reclassification from income taxes payable	$	0.3
Increase to non-current deferred tax assets		2.7
Cumulative impact of change recorded to retained earnings		(2.6)
Opening balance at July 1, 2007	$	0.4
Additions for tax provisions of prior years		0.2
Balance at June 30, 2008	$	0.6
Additions for tax positions of prior years		2.9
Reductions for tax positions of prior years		(0.3)
Balance at June 30, 2009	$	3.2

The provisions of FIN 48 allow for the classification election of interest on an underpayment of income taxes, when the tax law requires interest to be paid, and penalties, when a tax position does not meet the minimum statutory threshold to avoid payment of penalties, in income taxes, interest expense or another appropriate expense classification based on the accounting policy election of the entity. We elected to continue our historical practice of classifying interest and penalties as a component of income tax expense. All $3.2 million of the unrecognized tax benefits, if recognized, would impact the effective tax rate.

Long-Lived Assets and Goodwill

Long-lived assets, including property, plant and equipment and amortizable intangible assets, comprise a significant portion of our total assets. We evaluate the carrying value of long-lived assets when impairment indicators are present or when circumstances indicate that impairment may exist under the provisions of SFAS 144, *Accounting for the Impairment or Disposal of Long-Lived Assets*. When management believes impairment indicators may exist, projections of the undiscounted future cash flows associated with the use of and eventual disposition of long-lived assets held for use are prepared. If the projections indicate that the carrying values of the long-lived assets are not recoverable, we reduce the carrying values to fair value. In May 2009, we recorded a $6.2 million ($3.8 million net of taxes) impairment charge to write-down the value of a building that we currently lease to other healthcare service providers to fair value. For long-lived assets held for sale, we compare the carrying values to an estimate of fair value less selling costs to determine potential impairment. We test for impairment of long-lived assets at the lowest level for which cash flows are measurable. These impairment tests are heavily influenced by assumptions and estimates that are subject to change as additional information becomes available. Given the relatively few number of hospitals we own and the significant amounts of long-lived assets attributable to those hospitals, an impairment of the long-lived assets for even a single hospital could materially adversely impact our operating results or financial position.

Goodwill also represents a significant portion of our total assets. We review goodwill for impairment annually during our fourth fiscal quarter or more frequently if certain impairment indicators arise under the provisions of SFAS 142, *Goodwill and Other Intangible Assets*. We review goodwill at the reporting level unit, which is one level below an operating segment. We review the carrying value of the net assets of each reporting unit to the net present value of estimated discounted future cash flows of the reporting unit. If the carrying value exceeds the net present value of estimated discounted future cash flows, an impairment indicator exists and an estimate of the impairment loss is calculated. The fair value calculation includes multiple assumptions and estimates, including the projected cash flows and discount rates applied. Changes in these assumptions and estimates could result in goodwill impairment that could materially adversely impact our financial position or results of operations. In December 2006, we recorded a goodwill impairment charge in the amount of $123.8 million ($110.5 million, net of tax benefit) related to our Chicago hospitals.

We completed our annual goodwill impairment test during the fourth quarter of fiscal 2009 noting no impairment. However, we will continue to closely monitor the operations of our Chicago hospitals reporting unit, which has goodwill of approximately $43.0 million, due to the sensitivity of the projected operating results of this reporting unit to the goodwill impairment analysis. If projected future cash flows become less favorable than those

projected by management, an additional impairment charge relating to our Chicago hospitals may become necessary that could have a material adverse impact on our financial position and results of operations.

Selected Operating Statistics

The following table sets forth certain operating statistics for the periods indicated below.

	Year Ended June 30,		
	2007	2008	2009
Number of hospitals at end of period	15	15	15
Number of licensed beds at end of period	4,143	4,181	4,135
Discharges (a)	166,873	169,668	167,880
Adjusted discharges - hospitals (b)	264,698	270,076	274,767
Adjusted discharges (c)	278,820	284,680	289,997
Net revenue per adjusted discharge-hospitals (d)	$ 7,766	$ 8,110	$ 8,623
Net revenue per adjusted discharge (e)	$ 7,690	$ 8,059	$ 8,517
Patient days (f)	721,832	734,838	709,952
Average length of stay (days) (g)	4.3	4.3	4.2
Inpatient surgeries (h)	37,227	37,538	37,970
Outpatient surgeries (i)	76,606	73,339	76,378
Emergency room visits (j)	572,946	588,246	605,729
Occupancy rate (k)	48.2%	48.0%	47.0%
Member lives (l)	145,600	149,600	218,700
Health plan claims expense percentage (m)	74.0%	72.9%	77.5%

(a) Discharges represent the total number of patients discharged (in the facility for a period in excess of 23 hours) from our hospitals and is used by management and certain investors as a general measure of inpatient volumes.

(b) Adjusted discharges-hospitals is used by management and certain investors as a general measure of combined hospital inpatient and hospital outpatient volumes. Adjusted discharges-hospitals is computed by multiplying discharges by the sum of gross hospital inpatient revenues and gross hospital outpatient revenues and then dividing the result by gross hospital inpatient revenues.

(c) Adjusted discharges is used by management and certain investors as a general measure of consolidated inpatient and outpatient volumes. Adjusted discharges is computed by multiplying discharges by the sum of gross inpatient revenues and gross outpatient revenues and then dividing the result by gross inpatient revenues.

(d) Net revenue per adjusted discharge-hospitals is calculated by dividing net hospital patient revenues by adjusted discharge-hospitals and measures the average net payment expected to be received for a patient's stay in the hospital.

(e) Net revenue per adjusted discharge is calculated by dividing net patient revenues by adjusted discharges and measures the average net payment expected to be received for an episode of service provided to a patient.

(f) Patient days represent the number of days (calculated as overnight stays) our beds were occupied by patients during the periods.

(g) Average length of stay represents the average number of days an admitted patient stays in our hospitals.

(h) Inpatient surgeries represent the number of surgeries performed in our hospitals where overnight stays are necessary.

(i) Outpatient surgeries represent the number of surgeries performed at hospitals or ambulatory surgery centers on an outpatient basis (patient overnight stay not necessary).

(j) Emergency room visits represent the number of patient visits to a hospital emergency room where treatment is received, regardless of whether an overnight stay is subsequently required.

(k) Occupancy rate represents the percentage of hospital licensed beds occupied by patients. Occupancy rate provides a measure of the utilization of inpatient beds.

(l) Member lives represent the total number of enrollees in PHP, AAHP and MHP as of the end of the respective period.

(m) Health plan claims expense percentage is calculated by dividing health plan claims expense by premium revenues.

Results of Operations

The following tables present a summary of our operating results for the respective periods shown.

	Year Ended June 30,					
	2007		2008		2009	
	Amount	%	Amount	%	Amount	%
	(Dollars in millions)					
Patient service revenues	$ 2,179.3	84.4%	$ 2,340.5	83.9%	$ 2,521.7	78.8%
Premium revenues	401.4	15.6	450.2	16.1	678.0	21.2
Total revenues	2,580.7	100.0	2,790.7	100.0	3,199.7	100.0
Salaries and benefits (includes stock compensation of $1.2, $2.5 and $4.4 respectively)	1,067.9	41.4	1,152.7	41.3	1,240.1	38.7
Health plan claims expense	297.0	11.5	328.2	11.8	525.6	16.4
Supplies	421.8	16.4	434.5	15.5	456.3	14.3
Provision for doubtful accounts	175.2	6.8	205.6	7.4	210.8	6.6
Other operating expenses	375.0	14.5	405.8	14.5	468.9	14.6
Depreciation and amortization	118.6	4.6	131.0	4.7	130.6	4.1
Interest, net	123.8	4.8	122.1	4.4	111.6	3.5
Impairment loss	123.8	4.8	–	0.0	6.2	0.2
Other expenses	2.8	0.1	9.5	0.3	5.9	0.2
Income (loss) from continuing operations before income taxes	(125.2)	(4.9)	1.3	0.1	43.7	1.4
Income tax expense (benefit)	(11.6)	(0.5)	1.7	0.1	16.0	0.5
Income (loss) from continuing operations	(113.6)	(4.4)	(0.4)	0.0	27.7	0.9
Income (loss) from discontinued operations, net of taxes	(19.1)	(0.7)	(0.3)	0.0	0.9	0.0
Net income (loss)	$ (132.7)	(5.1)%	$ (0.7)	0.0%	$ 28.6	0.9%

Year Ended June 30, 2009 Compared to the Year Ended June 30, 2008

Revenues. Patient service revenues increased 7.7% year over year primarily as a result of a 5.7% increase in patient revenues per adjusted discharge and a 1.9% increase in adjusted discharges. Total outpatient volumes increased year over year, including a 3.0% and 4.1% increase in emergency room visits and outpatient surgeries, respectively. Our volumes by payer remained relatively consistent during both years. However, our combined Medicaid and managed Medicaid net revenues as a percentage of total net revenues increased to 16.7% during the current year compared to 15.1% during the prior year, primarily as a result of the increase in Texas UPL and Illinois PTA revenues previously discussed. The acuity level of our patients also increased year over year. However, during the current year, we continued to generate most of our admissions from emergency room visits and experieneed lower elective admissions. Patients often elect to defer elective procedures when general economic conditions are weak. We also face continued intense competition from other hospitals to recruit and retain the best physicians to practice in our facilities. Further improvement in our operating results will depend on our ability to increase elective inpatient and outpatient business to maintain a favorable payer mix. We believe our quality initiatives will be the catalyst for long-term revenue growth, especially given the forecasted population growth for most of the markets in which we operate. However, environmental factors outside our control, including patient demand, potential healthcare reform, deterioration of general economic conditions, payer pressures and increased competition could limit our future revenue growth.

Premium revenues increased $227.8 million or 50.6% during the current year as a result of higher enrollment at PHP compared to the prior year. PHP's new contract with AHCCCS began on October 1, 2008, and average enrollment increased from 101,435 during the prior year to 150,468 during the current year. PHP was awarded six new counties under the new contract in addition to the three counties served under the prior AHCCCS contract.

We continue to implement our quality of care initiatives and streamline our processes from admission to discharge to provide our patients effective healthcare solutions in an efficient manner. Part of this process includes identifying the optimal service line mix that both meets the needs of our patients and improves our operating results. The success of these objectives depends on our ability to engage our nursing workforce, recruit and retain physicians

who share our commitment to quality, strengthen the primary care infrastructure for our hospitals and complete capital improvements projects including advanced clinical systems in a timely manner.

Costs and Expenses. Total costs and expenses from continuing operations, exclusive of income taxes, were $3,156.0 million or 98.6% of total revenues during the current year, compared to 99.9% during the prior year. Salaries and benefits, supplies, health plan claims and provision for doubtful accounts represent the most significant of our normal costs and expenses and those typically subject to the greatest level of fluctuation period over period.

- **Salaries and benefits.** Salaries and benefits as a percentage of total revenues decreased to 38.7% during the current year from 41.3% during the prior year. This ratio was positively impacted by the significant increase in premium revenues, which utilize a much lower rate of salaries and benefits than acute care services, during the current year compared to the prior year and by the increase in Texas UPL and Illinois PTA revenues during the current year compared to the prior year. Salaries and benefits as a percentage of acute care segment revenues were 47.2% during the current year compared to 47.8% during the prior year, which improvement was primarily attributable to the Texas UPL and Illinois PTA revenues growth during the current year.

  These ratios were adversely impacted during the current year by our investments in physician services and quality initiatives. We continue to employ more physicians to support the communities our hospitals serve and have added significant corporate resources during the past year to manage and oversee the physician growth. Implementation of our quality initiatives have also resulted in additional labor costs associated with training staff to utilize new clinical quality systems and additional hospital and corporate resources to monitor and manage quality indicators. As of June 30, 2009, we had approximately 19,200 full-time and part-time employees compared to 18,500 as of June 30, 2008. Our contract labor expense as a percentage of patient service revenues decreased to 2.6% for the current year compared to 3.5% for the prior year. We have been successful in our nurse recruiting and retention initiatives during the current year, much of which we attribute to our commitment to delivering quality patient care. While the national nursing shortage has abated to some degree during the current year as a result of weakened economic conditions, shortages in certain pockets of the communities we serve still exist. We expect that our nurse leadership program will help mitigate this risk.

- **Supplies.** Supplies as a percentage of total revenues decreased to 14.3% during the current year compared to 15.5% during the prior year. Supplies as a percentage of patient service revenues decreased to 18.1% during the current year quarter compared to 18.6% during the prior year. The increase in Texas UPL and Illinois PTA revenues during the current year quarter accounted for approximately half of this improvement. Although the acuity of our services provided increased during the current year compared to the prior year, we were successful in limiting the ratio of supplies to patient service revenues by further implementing certain supply chain initiatives such as increased use of our group purchasing contract and pharmacy formulary management. Because our growth strategies include expansion of higher acuity services and due to inflationary pressures on medical supplies and pharmaceuticals, our ability to reduce this ratio in future periods may be limited.

- **Health plan claims.** Health plan claims expense as a percentage of premium revenues increased to 77.5% during the current year compared to 72.9% during the prior year. The new PHP contract resulted in a significant change in the mix of our AHCCCS enrollees with a significant increase in enrollees in geographic areas not previously served by PHP. As a result of the bid process for these new areas, the rates paid to providers in those six new counties and capitated payment rates received from AHCCCS for those counties were not necessarily the same as those applicable to the three counties previously served by PHP. Also, the additional PHP revenues diluted the impact of the third party administrator revenues at MHP that have no corresponding medical claims expense. We could experience changes in this ratio during upcoming quarters as we receive more PHP historical claims payment information, especially for the new counties where service began on October 1, 2008. During fiscal 2009, we accrued for the estimated amount payable to AHCCCS for the risk adjustment factor payment methodology that will be retroactively applied to October 1, 2008, which also caused the health plan claims expense as a percentage of premium revenues to increase during the current year.

Health plan claims expense represents the amounts paid by the health plans for healthcare services provided to their members, including an estimate of incurred but not yet reported claims that is determined based upon lag data and other actuarial assumptions. Revenues and expenses between the health plans and our hospitals and related outpatient service providers of approximately $34.0 million, or 6.1% of gross health plan claims expense, were eliminated in consolidation during the current year.

- **Provision for doubtful accounts**. The provision for doubtful accounts as a percentage of patient service revenues decreased to 8.4% during the current year from 8.8% during the prior year. On a combined basis, the provision for doubtful accounts, uninsured discounts and charity care deductions as a percentage of patient service revenues was 12.0% for both the current year and prior year periods. During the current year, our self-pay revenues as a percentage of net patient revenues decreased to 8.2% compared to 8.6% during the prior year. We have also experienced improved upfront cash collections and success in qualifying patients for coverage under Medicaid or similar programs. We utilized hindsight testing analysis, cash collections data and other metrics to conclude that our policies adequately provided for uncompensated care during the year ended June 30, 2009. Our combined allowances for doubtful accounts, uninsured discounts and charity care as of June 30, 2009 represented 96.5% of total self-pay accounts receivable compared to 96.3% as of June 30, 2008. We expect our bad debts ratios to remain sensitive to environmental factors including deteriorating economic conditions that could result in a greater number of uninsured patients and increased difficulty for patients to pay their co-payment and deductible balances.

Other operating expenses. Other operating expenses include, among others, purchased services, insurance, non-income taxes, rents and leases, repairs and maintenance and utilities. Other operating expenses as a percentage of total revenues increased to 14.6% during the current year compared to 14.5% during the prior year. Other operating expenses as a percentage of patient service revenues increased to 18.6% during the current year compared to 17.3% during the prior year. In April 2009, a jury awarded damages to the plaintiff in a professional liability case against one of our hospitals in the amount of approximately $14.9 million, which exceeded our captive insurance subsidiary's $10.0 million self-insured limit. Based upon this verdict, we recognized additional insurance expense of $11.9 million during the current year representing the amount necessary to reach our captive's self-insured limit plus additional premiums due to the third party excess coverage carrier under our retrospectively rated insurance policy with that carrier. Also, non-income taxes increased by $23.9 million during the current year primarily as a result of $13.4 million of Illinois PTA program cash receipts that were subsequently paid to the state in the form of a provider tax and higher premiums taxes related to the significant enrollment growth at PHP.

Other. Depreciation and amortization was flat year over year. Net interest decreased by $10.5 million during the current year primarily due to lower interest rates on the variable portion of our term debt. We incurred an impairment loss of $6.2 million ($3.8 million, net of taxes) during the current year resulting from the write-down of a non-hospital building to fair value.

Income taxes. Our effective tax rate was approximately 36.6% during the current year. Income taxes during the prior year were not significant.

Net income. Net income increased by $29.3 million during the current year compared to the prior year primarily due to improved operating results both from our acute care services and health plan segments.

Year Ended June 30, 2008 Compared to the Year Ended June 30, 2007

Revenues. Patient service revenues increased 7.4% year over year primarily as a result of a 4.8% increase in patient revenues per adjusted discharge and a 2.1% increase in adjusted discharges. Total outpatient volumes increased year over year, including a 2.7% increase in emergency room visits, although outpatient surgeries decreased year over year. We experienced positive year over year payer mix shifts highlighted by an increase in combined Medicare and managed Medicare volumes compared to a decrease in combined Medicaid and managed Medicaid volumes. The acuity level of our patients also increased year over year. However, we continued to generate most of our inpatient stays from emergency room visits and struggled to improve our elective admissions.

Premium revenues increased 12.2% during fiscal 2008 primarily as a result of a 5.7% in year over year annual membership at PHP and a capitation rate increase that went into effect for PHP as of October 1, 2007. PHP's membership increased as a result of a greater number of AHCCCS-eligible residents as a result of weakened general economic conditions and a greater allocation of the AHCCCS enrollees to PHP.

Costs and Expenses. Total costs and expenses, exclusive of income taxes and discontinued operations, were $2,789.4 million or 99.9% of total revenues during fiscal 2008 compared to 104.9% during fiscal 2007. Fiscal 2007 costs and expenses were negatively impacted by the $123.8 million impairment loss related to our Chicago hospitals. Salaries and benefits, supplies, medical claims and provision for doubtful accounts represent our most significant individual costs and expenses or those subject to the greatest level of fluctuation period over period.

- **Salaries and benefits.** Salaries and benefits as a percentage of total revenues were relatively flat period over period. Excluding the growth in our health plan operations, salaries and benefits would have increased to 42.0% during fiscal 2008 compared to the 41.4% during the prior year. The national nursing shortage, which was particularly prevalent in Phoenix, hindered our ability to fully manage salaries and benefits costs. Even with the nursing shortage in Phoenix, we made progress in stabilizing our nurse workforce in Phoenix to reduce contract labor utilization. We incurred a significant increase in period over period salaries and benefits costs in our Massachusetts hospitals primarily resulting from requirements set forth in our collective bargaining agreement ratified with the nurses union at St. Vincent Hospital.

- **Supplies.** Supplies as a percentage of total revenues decreased from 16.3% during fiscal 2007 to 15.5% during fiscal 2008. Supplies as a percentage of patient service revenues decreased to 18.6% during fiscal 2008 compared to 19.4% during fiscal 2007. Fiscal 2008 was the first full year that certain of our supply chain corporate initiatives were fully implemented. These initiatives included formulary refinements, standardization of commodities and supplies reprocessing and improved compliance with our group purchasing contract. Effective May 2008, we renewed our group purchasing contract with HealthTrust Purchasing Group for an additional five years.

- **Health plan claims expense.** Health plan claims expense as a percentage of premium revenues decreased from 74.0% during fiscal 2007 to 72.9% during fiscal 2008. Capitation revenues for our health plans increased at a greater rate year over year than did the utilization of medical services by our health plans' enrollees. Health plan claims expense represents the amounts paid by health plans for healthcare services provided to their members, including an estimate of incurred but not reported claims that is determined based upon lag data and other actuarial assumptions. Revenues and expenses between the health plans and our hospitals and related outpatient service providers of approximately $31.2 million, or 8.7% of gross health plan claims expense, were eliminated in consolidation during fiscal 2008 compared to $34.2 million or 10.3% of gross health plan claims expense during fiscal 2007.

- **Provision for doubtful accounts.** During fiscal 2008, the provision for doubtful accounts as a percentage of patient service revenues increased to 8.8% from 8.0% during fiscal 2007. During fiscal 2008, our self-pay discharges as a percentage of total discharges decreased to 3.5% from 3.7% during fiscal 2007. However, price increases at our hospitals and increased levels of patient co-insurance and deductibles under managed care plans increased our exposure to uncollectible revenues. The previously discussed change in our allowance for doubtful accounts policy during fiscal 2008 resulted in a higher provision for doubtful accounts as a percentage of patient service revenues during fiscal 2008 compared to fiscal 2007. Our provision for doubtful accounts as a percentage of patient service revenues is reduced by our policy of deducting charity accounts from revenues at the time in which those accounts meet our charity care guidelines. On a combined basis, the provision for doubtful accounts and charity care deductions as a percentage of patient service revenues increased to 12.5% during fiscal 2008 compared to 12.0% during fiscal 2007.

Other operating expenses. Other operating expenses include, among others, purchased services, insurance, non-income taxes, rents and leases, repairs and maintenance and utilities. Other operating expenses as a percentage of total revenues were flat year over year. We incurred higher physician recruiting costs, higher repairs and

maintenance costs related to the implementation of our clinical information systems in our hospitals and higher utilities costs during 2008 compared to 2007.

Other. Depreciation and amortization as a percentage of total revenues increased to 4.7% during fiscal 2008 compared to 4.6% during fiscal 2007 as a result of our capital improvement and expansion initiatives. Portions of our clinical quality systems were placed into service during fiscal 2008, and fiscal 2008 was the first full year in which all of our previous significant expansion projects in Phoenix and San Antonio had been fully in service. The decrease in net interest as a percentage of total revenues to 4.4% during fiscal 2008 compared to 4.8% during fiscal 2007 resulted primarily from the increase in total revenues during fiscal 2008 compared to fiscal 2007 without additional debt borrowings.

Income taxes. Income taxes were not significant during fiscal 2008. The effective tax rate for fiscal 2007 was 9.3% due to the majority of the impairment loss being nondeductible for tax purposes.

Discontinued operations. Our loss from discontinued operations was not significant during the fiscal year ended June 30, 2008 due to the winding down of operations at PMH compared to fiscal 2007 when PMH operated as an acute care hospital for the majority of the fiscal year.

Net loss. The $132.0 million year over year decrease in net loss resulted primarily from the improved operating results during fiscal 2008 and the after tax impact of the impairment loss recorded during fiscal 2007.

Liquidity and Capital Resources

Operating Activities

At June 30, 2009, we had working capital of $251.6 million, including cash and cash equivalents of $308.2 million. Working capital at June 30, 2008 was $217.8 million. Cash provided by operating activities increased $135.1 million during the year ended June 30, 2009 compared to the prior year. The increase in operating cash flows was primarily due to improved net cash collections of accounts receivable, the impact of the significant enrollee growth at PHP on capitation payments received from AHCCCS and the timing of claims payments made for new members, the timing of claims payments related to the expansion of our self-insured employee medical plan, the increase in net payments received under the Bexar County, Texas UPL program and the Illinois PTA program and improved operating results during the year ended June 30, 2009 compared to the prior year. Net accounts receivable days decreased by approximately 6 days to 45 days at June 30, 2009 compared to 51 days at June 30, 2008.

Investing Activities

Cash used in investing activities decreased from $143.8 million during the prior year to $133.6 million during the current year, primarily as a result of net $26.3 million purchases of auction rate securities during the prior year that we continued to hold during the current year. Capital expenditures increased $10.5 million during the current year compared to the prior year.

We anticipate spending a total of $180.0 million to $200.0 million in capital expenditures during fiscal 2010 This estimated range includes $71.0 million of replacement, regulatory or maintenance capital and $129.0 million of combined information technology upgrades and other discretionary initiatives. We could choose to defer or cancel most of the information technology and discretionary capital projects included in our fiscal year 2010 capital expenditures estimate should we need to conserve cash, avoid debt covenant violations or for other reasons. Any decision to defer or cancel such capital projects, while providing some short-term benefits, could have negative long-term implications to our operating results and cash flows.

We expect to fund our fiscal 2010 capital expenditures with cash on hand and cash flows from operations. We also have $218.8 million available under our revolving credit facility as of June 30, 2009. We believe our current capital expenditure program is sufficient to service, expand and improve our existing facilities to meet our quality objectives and growth strategies.

Financing Activities

Cash flows used in financing activities were flat year over year. As of June 30, 2009, we had outstanding $1,551.6 million in aggregate indebtedness. Our liquidity requirements are significant, primarily due to debt service requirements. The 9.0% Notes require semi-annual interest payments until their maturity in September 2014. The indenture related to the 9.0% Notes contains a customary restricted payments covenant that restricts certain of our cash payments, including repurchase or redemption prior to maturity of the 11.25% Notes. This covenant restriction does not apply to cash interest payments for the 11.25% Notes. However, at June 30, 2009, we would be able to expend up to approximately $143.0 million free of any such restrictions pursuant to the general restricted payment basket provisions set forth in this covenant. Through October 1, 2009, our interest expense on the 11.25% Notes consists solely of non-cash accretions of principal. Commencing April 1, 2010 through the maturity of the 11.25% Notes in September 2015, we will make semi-annual cash interest payments under the 11.25% Notes.

Our $766.4 million outstanding term loan borrowings bear interest at a rate equal to, at our option, a base rate plus 1.25% per annum or LIBOR plus 2.25% per annum and mature in September 2011. However, $450.0 million of our term loan borrowings are subject to a fixed interest rate under the terms of an interest rate swap agreement effective June 30, 2008 that expires March 31, 2010. We make quarterly principal payments on our outstanding term loan borrowings equal to one-fourth of one percent. Borrowings under our $250.0 million revolving credit facility, which matures in September 2010, would currently bear interest at a rate equal to, at our option, a base rate plus 1.0% per annum or LIBOR plus 2.0% per annum. These rates are subject to increase by up to 0.50% per annum should our leverage ratio exceed certain designated levels. We are required to pay a commitment fee to the lenders under the revolving credit facility in respect of the unutilized commitments thereunder at a rate equal to 0.50% per annum. We also pay customary letter of credit fees.

Debt Covenants

Our term loan facility and revolving credit facility contain a number of covenants that, among other things, restrict, subject to certain exceptions, our ability, and the ability of our subsidiaries, to sell assets, incur additional indebtedness or issue preferred stock, repay other indebtedness (including the 9.0% Notes and 11.25% Notes), pay dividends and distributions or repurchase our capital stock, create liens on assets, make investments, loans or advances, make certain acquisitions, engage in mergers or consolidations, enter into sale and leaseback transactions, engage in certain transactions with affiliates, amend certain material agreements governing our indebtedness, including the 9.0% Notes and 11.25% Notes, change the business conducted by our subsidiaries and enter into certain hedging agreements. In addition, the senior credit facilities require us to maintain the following financial covenants: a maximum total leverage ratio, a maximum senior leverage ratio, a minimum interest coverage ratio and a maximum capital expenditures limitation. As of June 30, 2009, our capital expenditures, as defined in the senior secured credit agreement, were below the maximum covenant amount, and we were in compliance with the other debt covenant ratios as defined in our senior secured credit agreement, as follows.

	Debt Covenant Ratio	Actual Ratio
Interest coverage ratio requirement	2.00x	3.56x
Total leverage ratio limit	4.50x	3.35x
Senior leverage ratio limit	3.50x	1.45x

While we are currently in compliance with all of our debt covenants, factors outside our control may make it more difficult for us to remain in compliance during future periods. These factors include a prolonged economic recession, a higher number of uninsured or underinsured patients and decreased governmental or managed care payer reimbursement, among others, any or all of which could negatively impact our results of operations and cash flows and cause us to violate one or more of these covenants. Violation of one or more of the covenants under our senior secured credit agreement could result in an immediate call of the outstanding principal amount of our term loans or the necessity of lender waivers with more onerous terms including adverse pricing or repayment provisions or more restrictive covenants.

Credit Ratings

The table below summarizes our credit ratings as of the date of this filing.

	Standard & Poor's	Moody's
Corporate credit rating	B	B2
9% Senior Subordinated Notes	CCC+	Caa1
11¼% Senior Discount Notes	CCC+	Caa1
Senior credit facilities	B+	Ba3

Our credit ratings are subject to periodic reviews by the ratings agencies. If our results of operations deteriorate either as a result of the current economic recession or other factors, any or all of our corporate ratings may be downgraded. A credit rating downgrade could further impede our ability to refinance all or a portion of our outstanding debt.

Capital Resources

We expect that cash on hand, cash generated from our operations and cash expected to be available to us under our revolving credit facility will be sufficient to meet our working capital needs, debt service requirements and planned capital expenditure programs during the next twelve months and into the foreseeable future prior to the maturity dates of our outstanding debt. However, we cannot assure you that our operations will generate sufficient cash or that future borrowings under our senior credit facilities will be available to enable us to meet these requirements, especially given the current diminished credit availability and general economic weakness.

Our $250.0 million revolving credit facility expires in September 2010, and we are not certain if we will be able to replace the revolving credit facility with favorable terms at such time given the current instability in the capital and credit markets and with the current uncertainty of when normal credit market liquidity conditions will return. Additionally, our financial position and cash flows could be materially adversely impacted should we be unable to access the current amounts available under our revolving credit facility due to default by one or more of the lenders. Our $766.4 million term debt under our term loan facility matures in September 2011. Our ability to refinance or obtain funds to repay this term debt could also be compromised if the current capital and credit markets do not improve.

We had $308.2 million of cash and cash equivalents as of June 30, 2009. We rely on available cash, cash flows generated by operations and available borrowing capacity under our revolving credit facility to fund our operations and capital expenditures. We invest our cash in accounts in high-quality financial institutions. We continually explore various options to increase the return on our invested cash while preserving our principal cash balances. However, the significant majority of our cash and cash equivalents are not federally-insured and could be at risk in the event of a collapse of those financial institutions.

At June 30, 2009, we held $21.6 million in total available for sale investments in auction rate securities ("ARS") backed by student loans, which are included in long-term investments in auction rate securities on our consolidated balance sheet due to inactivity in the primary ARS market during the past year. The par value of the ARS was $26.3 million as of June 30, 2009.

We also intend to continue to pursue acquisitions or partnering arrangements, either in existing markets or new markets, which fit our growth strategies. To finance such transactions, we might draw upon cash on hand, amounts available under our revolving credit facility or seek additional funding sources. We continually assess our capital needs and may seek additional financing, including debt or equity, as considered necessary to fund potential acquisitions, fund capital projects or for other corporate purposes. However, we may be unable to raise additional equity proceeds from Blackstone or other investors should we need to obtain cash for any of these purposes. Our future operating performance, ability to service our debt and ability to draw upon other sources of capital will be subject to future economic conditions and other business factors, many of which are beyond our control.

Obligations and Commitments

The following table reflects a summary of obligations and commitments outstanding with payment dates as of June 30, 2009.

	Payments due by period				
	Within 1 year	During Years 2-3	During Years 4-5	After 5 years	Total
Contractual Cash Obligations::		*(In millions)*			
Long-term debt (1)	$ 99.8	$ 935.0	$ 152.1	$ 853.3	$ 2,040.2
Operating leases (2)	30.4	48.1	32.2	42.3	153.0
Purchase obligations (2)	17.4	–	–	–	17.4
Health plan claims payable (3)	117.6	–	–	–	117.6
Estimated self-insurance liabilities (4)	47.8	39.0	22.9	14.8	124.5
Subtotal	$ 313.0	$ 1,022.1	$ 207.2	$ 910.4	$ 2,452.7

	Within 1 year	During Years 2-3	During Years 4-5	After 5 years	Total
Other Commitments:		*(In millions)*			
Construction and capital improvements (5)	$ 31.8	$ 1.3	$ –	$ –	$ 33.1
Guarantees of surety bonds (6)	40.0	–	–	–	40.0
Letters of credit (7)	–	31.2	–	–	31.2
Physician commitments (8)	4.4	–	–	–	4.4
FIN 48 net liability (9)	3.2	–	–	–	3.2
Subtotal	$ 79.4	$ 32.5	$ –	$ –	$ 111.9
Total obligations and commitments	$ 392.4	$ 1,054.6	$ 207.2	$ 910.4	$ 2,564.6

(1) Includes both principal and interest portions of outstanding debt. The interest portion of our debt assumes an approximate 5.0% rate over the remaining term of the debt.

(2) These obligations are not reflected in our consolidated balance sheets.

(3) Represents estimated payments to be made in future periods for healthcare costs incurred by enrollees in PHP, AAHP and MHP and is separately stated on our consolidated balance sheets.

(4) Includes the current and long-term portions of our professional and general liability, workers' compensation and employee health reserves.

(5) Represents our estimate of amounts we are committed to fund in future periods through executed agreements to complete projects included as construction in progress on our consolidated balance sheets.

(6) Represents performance bonds we have purchased related to health claims liabilities of PHP.

(7) Amounts relate primarily to instances in which we have letters of credit outstanding with the third party administrator of our self-insured workers' compensation program.

(8) Includes physician guarantee liabilities recognized in our consolidated balance sheets under the provisions of FSP 45-3, *Application of FASB Interpretation No. 45 to Minimum Revenue Guarantees Granted to a Business or Its Owners*, and liabilities for other fixed expenses under physician relocation agreements not yet paid.

(9) Represents expected future tax liabilities determined under the provisions of FIN 48.

Guarantees and Off Balance Sheet Arrangements

We are currently a party to a certain rent shortfall agreement with a certain unconsolidated entity. We also enter into physician income guarantees and service agreement guarantees and other guarantee arrangements, including parent-subsidiary guarantees, in the ordinary course of business. We have not engaged in any transaction or arrangement with an unconsolidated entity that is reasonably likely to materially affect liquidity.

Effects of Inflation and Changing Prices

Various federal, state and local laws have been enacted that, in certain cases, limit our ability to increase prices. Revenues for acute hospital services rendered to Medicare patients are established under the federal government's prospective payment system. We believe that hospital industry operating margins have been, and may continue to be, under significant pressure because of changes in payer mix and growth in operating expenses in excess of the increase in prospective payments under the Medicare program. In addition, as a result of increasing regulatory and competitive pressures, our ability to maintain operating margins through price increases to non-Medicare patients is limited.

Item 7A. Quantitative and Qualitative Disclosures About Market Risk.

We are subject to market risk from exposure to changes in interest rates based on our financing, investing, and cash management activities. As of June 30, 2009, we had in place $1,016.4 million of senior credit facilities bearing interest at variable rates at specified margins above either the agent bank's alternate base rate or its LIBOR rate. The senior credit facilities consist of $766.4 million in term loans maturing in September 2011 and a $250.0 million revolving credit facility maturing in September 2010 (of which $31.2 million of capacity was utilized by outstanding letters of credit as of June 30, 2009). Although changes in the alternate base rate or the LIBOR rate would affect the cost of funds borrowed in the future, we believe the effect, if any, of reasonably possible near-term changes in interest rates would not be material to our results of operations or cash flows. The variable interest rate risk is partially mitigated by the interest rate swap that became effective on June 30, 2008, as discussed below. As of June 30, 2009, the estimated fair values of our term debt, our 9.0% senior subordinated notes and our 11.25% senior discount notes were approximately $735.7 million, $547.7 million and $209.3 million, respectively.

Our $250.0 million revolving credit facility bears interest at the alternate base rate plus a margin ranging from 1.00%-1.50% per annum or the LIBOR rate plus a margin ranging from 2.00%-2.50% per annum, in each case dependent upon our leverage ratio. Our revolving credit facility matures in September 2010. Our $766.4 million in outstanding term loans bear interest at the alternate base rate plus a margin of 1.25% per annum or the LIBOR rate plus a margin of 2.25% per annum and mature in September 2011. The interest rate related to the unhedged term loans was approximately 2.6% as of June 30, 2009.

In April 2008, we entered into an interest rate swap agreement with Bank of America, N.A. (the counterparty) that became effective on June 30, 2008. Under this agreement and through March 31, 2009, we made or received quarterly net interest rate swap payments based upon the difference between the 90-day LIBOR rate and the swap fixed interest rate of 2.785% on a notional $450.0 million of our term debt. We accounted for this swap as a highly effective cash flow hedge with critical terms that substantially match the underlying term debt and measured any ineffectiveness using the hypothetical derivative method. In March 2009, we and the counterparty executed an amended swap agreement with the same terms and provisions as the original agreement except that after March 31, 2009, we will make or receive net interest payments based upon the difference between the 30-day LIBOR rate and the swap fixed interest rate of 2.5775%. As a result of this amended swap agreement, we de-designated our existing cash flow hedge and re-designated the amended swap agreement as a hedge of the remaining interest payments associated with $450.0 million of our outstanding term debt. As the forecasted transactions (i.e. the future interest payments under our outstanding term debt) are still probable of occurring, we did not immediately recognize the accumulated other comprehensive loss balance related to the de-designated swap in earnings. Based on our assessment, we determined this re-designated swap will be highly effective in offsetting the changes in cash flows related to the hedged risk. Upon the execution of the amended swap agreement, we began measuring hedge ineffectiveness by comparing the fair value of the original swap agreement to a new hypothetical derivative using the amended terms to determine if the underlying term debt has been overhedged. We determined that the hedge ineffectiveness was not significant as of June 30, 2009. The fair value of the interest rate swap as of June 30, 2009 was a liability for us of approximately $6.9 million ($4.3 million, net of taxes). We use derivatives such as interest rate swaps from time to time to manage our market risk associated with variable rate debt or similar derivatives for

fixed rate debt. We do not hold or issue derivative instruments for trading purposes and are not a party to any instruments with leverage features.

At June 30, 2009, we held $21.6 million in total available for sale investments in auction rate securities ("ARS") backed by student loans, which are included in long-term investments in auction rate securities on our consolidated balance sheet due to inactivity in the primary ARS market during the past year. The par value of the ARS was $26.3 million as of June 30, 2009. As of June 30, 2008, we had reflected the ARS as current marketable securities. We recorded a $0.6 million realized holding loss on $10.0 million of these marketable securities during the quarter ended September 30, 2008 as a result of a tender offer we received from the issuer of the ARS and accepted. However, the tender offer contained certain conditions that were not met by the December 2008 deadline, and the tender failed. Thus, we reclassified the $9.4 million of marketable securities to investments in auction rate securities, along with the other outstanding ARS, on our condensed consolidated balance sheet as of December 31, 2008. We also recorded temporary impairments totaling $4.1 million ($2.5 million, net of taxes) related to all $26.3 million par value ARS during the year ended June 30, 2009, which are included in accumulated other comprehensive income (loss) on our consolidated balance sheet as of June 30, 2009.

Our ARS were rated "AAA" by one or more major credit rating agencies at June 30, 2009 based on their most recent ratings update. The ratings take into account insurance policies guaranteeing both the principal and accrued interest of the investments. The U.S. government guarantees approximately 96%-98% of the principal and accrued interest on each investment in student loans under the Federal Family Education Loan Program or similar programs.

We will continue to monitor market conditions for this type of ARS to ensure that our classification and fair value estimate remain appropriate. Should market conditions in future periods warrant a reclassification or other than temporary impairment of our ARS, we do not believe our financial position, results of operations, cash flows or compliance with debt covenants would be materially impacted. We believe that we currently have adequate working capital to fund operations during the near future based on access to cash and cash equivalents, expected operating cash flows and availability under our revolving credit facility. We do not expect that our holding of the ARS until market conditions improve will significantly adversely impact our operating cash flows.

Item 8. Financial Statements and Supplementary Data.

INDEX TO AUDITED CONSOLIDATED FINANCIAL STATEMENTS

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

Board of Directors
Vanguard Health Systems, Inc.

We have audited the accompanying consolidated balance sheets of Vanguard Health Systems, Inc. as of June 30, 2009 and 2008, and the related consolidated statements of operations, stockholders' equity and cash flows for each of the three years in the period ended June 30, 2009. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. We were not engaged to perform an audit of the Company's internal control over financial reporting. Our audits included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Vanguard Health Systems, Inc. at June 30, 2009 and 2008, and the consolidated results of its operations and its cash flows for each of the three years in the period ended June 30, 2009, in conformity with U.S. generally accepted accounting principles.

/s/ Ernst & Young LLP

Nashville, Tennessee
September 2, 2009

VANGUARD HEALTH SYSTEMS, INC.
CONSOLIDATED BALANCE SHEETS

	June 30, 2008	June 30, 2009
	(In millions except share and per share amounts)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 141.6	$ 308.2
Restricted cash	2.1	1.9
Marketable securities	26.3	–
Accounts receivable, net of allowance for doubtful accounts of approximately $117.7 and $121.5 at June 30, 2008 and 2009, respectively	300.4	275.3
Inventories	49.2	48.3
Deferred tax assets	24.5	29.6
Prepaid expenses and other current assets	55.8	68.4
Total current assets	599.9	731.7
Property, plant and equipment, net of accumulated depreciation	1,174.0	1,174.1
Goodwill	689.2	692.1
Intangible assets, net of accumulated amortization	61.4	54.6
Investments in and advances to affiliates	6.0	5.4
Investments in auction rate securities	–	21.6
Other assets	51.8	51.6
Total assets	$ 2,582.3	$ 2,731.1
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Accounts payable	$ 155.1	$ 127.9
Accrued salaries and benefits	97.4	133.9
Accrued health plan claims	51.1	117.6
Accrued interest	13.2	13.2
Other accrued expenses and current liabilities	57.3	79.5
Current maturities of long-term debt	8.0	8.0
Total current liabilities	382.1	480.1
Minority interests in equity of consolidated entities	9.1	8.0
Professional and general liability and workers compensation reserves	74.1	76.7
Other liabilities	22.9	34.9
Long-term debt, less current maturities	1,529.5	1,543.6
Commitments and contingencies		
Stockholders' equity:		
Common Stock; $.01 par value, 1,000,000 shares authorized, 749,550 shares issued and outstanding at June 30, 2008 and 2009, respectively	–	–
Additional paid-in capital	647.1	651.3
Accumulated other comprehensive income (loss)	2.8	(6.8)
Retained deficit	(85.3)	(56.7)
Total stockholders' equity	564.6	587.8
Total liabilities and stockholders' equity	$ 2,582.3	$ 2,731.1

See accompanying notes.

VANGUARD HEALTH SYSTEMS, INC.
CONSOLIDATED STATEMENTS OF OPERATIONS

	For the Year Ended June 30,		
	2007	2008	2009
		(In millions)	
Patient service revenues	$ 2,179.3	$ 2,340.5	$ 2,521.7
Premium revenues	401.4	450.2	678.0
Total revenues	2,580.7	2,790.7	3,199.7
Costs and expenses:			
Salaries and benefits (includes stock compensation of $1.2, $2.5 and $4.4, respectively)	1,067.9	1,152.7	1,240.1
Health plan claims expense	297.0	328.2	525.6
Supplies	421.8	434.5	456.3
Provision for doubtful accounts	175.2	205.6	210.8
Purchased services	141.2	149.5	167.4
Non-income taxes	28.6	28.3	52.2
Rents and leases	37.4	41.8	43.5
Other operating expenses	167.8	186.2	205.8
Depreciation and amortization	118.6	131.0	130.6
Interest, net	123.8	122.1	111.6
Impairment loss	123.8	–	6.2
Other expenses	2.8	9.5	5.9
Income (loss) from continuing operations before income taxes	(125.2)	1.3	43.7
Income tax expense (benefit)	(11.6)	1.7	16.0
Income (loss) from continuing operations	(113.6)	(0.4)	27.7
Income (loss) from discontinued operations, net of taxes	(19.1)	(0.3)	0.9
Net income (loss)	$ (132.7)	$ (0.7)	$ 28.6

See accompanying notes.

VANGUARD HEALTH SYSTEMS, INC.
CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

	Common Stock		Additional Paid-In Capital	Accumulated Other Comprehensive Income (Loss)	Retained Earnings (Deficit)	Total Stockholders' Equity
	Shares	Amount				
			(In millions, except share amounts)			
Balance at June 30, 2006	749,550	–	643.7	–	45.5	689.2
Stock compensation (non-cash)	–	–	1.2	–	–	1.2
Repurchase of equity incentive units	–	–	(0.2)	–	–	(0.2)
Issuance of common stock	195	–	0.2	–	–	0.2
Repurchase of common stock	(195)	–	(0.3)	–	–	(0.3)
Net loss	–	–	–	–	(132.7)	(132.7)
Balance at June 30, 2007	749,550	–	644.6	–	(87.2)	557.4
Stock compensation (non-cash)	–	–	2.5	–	–	2.5
Issuance of common stock	168	–	0.2	–	–	0.2
Repurchase of common stock	(168)	–	(0.2)	–	–	(0.2)
Cumulative effect of adoption of FIN 48	–	–	–	–	2.6	2.6
Comprehensive income:						
Change in fair value of interest rate swap (net of tax effect)	–	–	–	2.8	–	2.8
Net income	–	–	–	–	(0.7)	(0.7)
Total comprehensive income	–	–	–	2.8	(0.7)	2.1
Balance at June 30, 2008	749,550	$ –	$ 647.1	$ 2.8	$ (85.3)	$ 564.6
Stock compensation (non-cash)	–	–	4.4	–	–	4.4
Repurchase of equity incentive units	–	–	(0.2)	–	–	(0.2)
Comprehensive income:						
Change in fair value of interest rate swap (net of tax effect)	–	–	–	(7.1)	–	(7.1)
Change in fair value of auction rate securities (net of tax effect)	–	–	–	(2.5)	–	(2.5)
Net income	–	–	–	–	28.6	28.6
Total comprehensive income				(9.6)	28.6	19.0
Balance at June 30, 2009	749,550	$ –	$ 651.3	$ (6.8)	$ (56.7)	$ 587.8

See accompanying notes.

VANGUARD HEALTH SYSTEMS, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS

	For the Year Ended June 30,		
	2007	2008	2009
		(In millions)	
Operating activities:			
Net income (loss)	$ (132.7)	$ (0.7)	$ 28.6
Adjustments to reconcile net income (loss) to net cash provided by operating activities			
Loss (income) from discontinued operations	19.1	0.3	(0.9)
Depreciation and amortization	118.6	131.0	130.6
Provision for doubtful accounts	175.2	205.6	210.8
Amortization of loan costs	4.5	4.9	5.4
Accretion of principal on senior discount notes	17.5	19.5	21.8
Loss (gain) on disposal of assets	(4.1)	0.9	(2.3)
Stock compensation	1.2	2.5	4.4
Deferred income taxes	(12.7)	(2.2)	5.6
Impairment loss	123.8	–	6.2
Realized holding loss on investments	–	–	0.6
Changes in operating assets and liabilities, net of effects of acquisitions and dispositions			
Accounts receivable	(204.0)	(223.6)	(185.2)
Inventories	(1.9)	(4.1)	1.0
Prepaid expenses and other current assets	(30.0)	(19.7)	(13.0)
Accounts payable	7.4	12.2	(27.3)
Accrued expenses and other liabilities	37.8	45.0	121.0
Net cash provided by operating activities – continuing operations	119.7	171.6	307.3
Net cash provided by operating activities – discontinued operations	3.6	1.5	0.9
Net cash provided by operating activities	123.3	173.1	308.2
Investing activities:			
Acquisitions	(0.2)	(0.2)	(4.4)
Capital expenditures	(164.3)	(121.6)	(132.1)
Proceeds from asset dispositions	9.5	0.4	4.9
Purchases of marketable securities	(120.0)	(90.0)	–
Sales of marketable securities	120.0	63.7	–
Other	2.0	1.1	(2.0)
Net cash used in investing activities – continuing operations	(153.0)	(146.6)	(133.6)
Net cash provided by investing activities – discontinued operations	34.5	2.8	–
Net cash used in investing activities	(118.5)	(143.8)	(133.6)
Financing activities:			
Payments of long-term debt	(8.0)	(7.8)	(7.8)
Payments to retire stock, equity incentive units and stock options	(0.5)	(0.2)	(0.2)
Proceeds from the exercise of stock options	0.2	0.2	–
Net cash used in financing activities	(8.3)	(7.8)	(8.0)
Increase (decrease) in cash and cash equivalents	(3.5)	21.5	166.6
Cash and cash equivalents at beginning of year	123.6	120.1	141.6
Cash and cash equivalents at end of year	$ 120.1	$ 141.6	$ 308.2

VANGUARD HEALTH SYSTEMS, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS
(continued)

	For the Year Ended June 30,		
	2007	2008	2009
		(In millions)	
Supplemental cash flow information:			
Net interest paid	$ 107.8	$ 99.1	$ 86.4
Net income taxes paid	$ 0.9	$ 1.3	$ 17.3
Supplemental noncash activities:			
Capitalized interest	$ 3.0	$ 1.4	$ 2.0
Change in fair value of interest rate swap, net of taxes	$ –	$ 2.8	$ (7.1)
Change in fair value of auction rate securities, net of taxes	$ –	$ –	$ (2.5)
Acquisitions of businesses:			
Cash paid, net of cash received	$ 0.2	$ 0.2	$ 4.4
Fair value of assets acquired	–	0.2	2.1
Liabilities assumed	–	–	(0.6)
Net assets acquired	–	0.2	1.5
Goodwill and intangible assets acquired	$ 0.2	$ –	$ 2.9
Dispositions of businesses:			
Cash received	$ 37.0	$ 3.0	$ –
Carrying value of assets sold	(42.1)	–	–
Escrow receivable	3.0	(3.0)	–
Liabilities assumed by buyer	5.5	–	–
Goodwill and intangible assets disposed	$ 3.4	$ –	$ –

See accompanying notes.

1. Business and Basis of Presentation

Business

Vanguard Health Systems, Inc. ("Vanguard") is an investor-owned healthcare company whose affiliates own and operate hospitals and related healthcare businesses in urban and suburban areas. As of June 30, 2009, Vanguard's affiliates owned and managed 15 acute care hospitals with 4,135 licensed beds and related outpatient service locations complementary to the hospitals providing healthcare services in San Antonio, Texas; metropolitan Phoenix, Arizona; metropolitan Chicago, Illinois; and Massachusetts. Vanguard also owns managed health plans in Chicago and Phoenix and two surgery centers in Orange County, California.

Basis of Presentation

The accompanying consolidated financial statements include the accounts of subsidiaries and affiliates controlled by Vanguard. Vanguard generally defines control as the ownership of the majority of an entity's voting interests. Vanguard also consolidates any entities for which it receives the majority of the entity's expected returns or is at risk for the majority of the entity's expected losses based upon its investment or financial interest in the entity. All material intercompany accounts and transactions have been eliminated. Since none of Vanguard's common shares are publicly held, no earnings per share information is presented in the accompanying consolidated financial statements. Certain prior year amounts from the accompanying consolidated balance sheet have been reclassified to conform to current year presentation. The majority of Vanguard's expenses are "cost of revenue" items. Costs that could be classified as general and administrative include certain Vanguard corporate office costs, which approximated $30.2 million, $44.3 million and $54.5 million for the years ended June 30, 2007, 2008 and 2009, respectively.

Use of Estimates

In preparing Vanguard's consolidated financial statements in conformity with accounting principles generally accepted in the United States, management makes estimates and assumptions that affect the amounts recorded or classification of items in the consolidated financial statements and accompanying notes. Actual results could differ from those estimates.

2. Summary of Significant Accounting Policies

Revenues and Revenue Deductions

Vanguard recognizes patient service revenues during the period the healthcare services are provided based upon estimated amounts due from payers. Vanguard estimates contractual adjustments and allowances based upon payment terms set forth in managed care health plan contracts and by federal and state regulations. For the majority of its patient service revenues, Vanguard applies contractual adjustments to patient accounts at the time of billing using specific payer contract terms entered into the accounts receivable systems, but in some cases Vanguard records an estimated allowance until payment is received. Vanguard derives most of its patient service revenues from healthcare services provided to patients with Medicare and related managed Medicare plans or managed care insurance coverage. Medicare, which represented 26%, 26% and 25% of Vanguard's net patient revenues during its fiscal years ended June 30, 2007, 2008 and 2009, respectively, was the only individual payer for which Vanguard derived more than 10% of net patient revenues during those periods.

Services provided to Medicare and related managed Medicare patients are generally reimbursed at prospectively determined rates per diagnosis ("PPS"), while services provided to managed care patients are generally reimbursed based upon predetermined rates per diagnosis, per diem rates or discounted fee-for-service rates. Medicaid reimbursements vary by state.

Medicare regulations and Vanguard's principal managed care contracts are often complex and may include multiple reimbursement mechanisms for different types of services provided in its healthcare facilities. To obtain reimbursement for certain services under the Medicare program, Vanguard must submit annual cost reports and record estimates of amounts owed to or receivable from Medicare. These cost reports include complex calculations and estimates related to indirect medical education, disproportionate share payments, reimbursable Medicare bad debts and other items that are often subject to interpretation that could result in payments that differ from recorded estimates. Vanguard estimates amounts owed to or receivable from the Medicare program using the best information available and its interpretation of the applicable Medicare regulations. Vanguard includes differences between original estimates and subsequent revisions to those estimates (including final cost report settlements) in the consolidated statements of operations in the period in which the revisions are made. Net adjustments for final third party settlements increased patient service revenues and income from continuing operations before income taxes by $6.3 million, $7.9 million and $8.0 million during the years ended June 30, 2007, 2008 and 2009, respectively. Additionally, updated regulations and contract negotiations occur frequently, which necessitates continual review of estimation processes by management. Management believes that future adjustments to its current third party settlement estimates will not significantly impact Vanguard's results of operations or financial position.

Vanguard does not pursue collection of amounts due from uninsured patients that qualify for charity care under its guidelines (currently those uninsured patients whose incomes are equal to or less than 200% of the current federal poverty guidelines set forth by the Department of Health and Human Services). Vanguard deducts charity care accounts from revenues when it determines that the account meets its charity care guidelines. Vanguard also provides discounts from billed charges and alternative payment structures for uninsured patients who do not qualify for charity care but meet certain other minimum income guidelines, primarily those uninsured patients with incomes between 200% and 500% of the federal poverty guidelines. During the years ended June 30, 2007, 2008 and 2009, Vanguard deducted $86.1 million, $86.1 million and $91.8 million of charity care from revenues, respectively.

During the third quarter of its fiscal year ended June 30, 2007, Vanguard was approved to receive payments under the Bexar County, Texas upper payment limit ("UPL") Medicaid payment program. UPL programs allow private hospitals to enter into indigent care affiliation agreements with governmental entities. Within the parameters of these programs, private hospitals expand charity care services to indigent patients and alleviate expenses for the governmental entity. The governmental entity is then able to utilize its tax revenue to fund the Medicaid program for private hospitals. Vanguard recognizes revenues from the UPL program when Vanguard becomes entitled to the expected reimbursements, including a federal match portion, and such reimbursements are assured.

During the third quarter of fiscal 2009, the federal government approved federal matching funds for the Illinois Provider Tax Assessment ("PTA") program. The PTA program enables the state of Illinois to increase funding for its state Medicaid plan. Hospitals providing services to Medicaid enrollees receive funds directly from the state. Hospital providers, with certain exceptions, are then assessed a provider tax, which is payable to the state, and may or may not exceed funds received from the state. Vanguard recognizes revenues equal to the gross payments to be received when such payments are assured. Vanguard received $24.9 million of cash from this program during the year ended June 30, 2009, all of which increased revenues and $13.4 million of which was subsequently paid to the state and is included in non-income taxes in our consolidated statement of operations for the year ended June 30, 2009.

Effective for service dates on or after April 1, 2009, as a result of a state mandate, Vanguard implemented a new uninsured discount policy for those patients receiving services in its Illinois hospitals who had no insurance coverage and who did not otherwise qualify for charity care under its guidelines. Under this policy, Vanguard applies an uninsured discount (calculated as a standard percentage of gross charges) at the time of patient billing and includes this discount as a reduction to patient service revenues. These discounts were approximately $11.7 million for the year ended June 30, 2009. Vanguard implemented this policy for most of its remaining facilities effective July 1, 2009 and expects to implement it at all of its facilities by the end of its fiscal year 2010.

Vanguard had premium revenues from its health plans of $401.4 million, $450.2 million and $678.0 million during the years ended June 30, 2007, 2008 and 2009, respectively. Vanguard's health plans, Phoenix Health Plan ("PHP"), Abrazo Advantage Health Plan ("AAHP") and MacNeal Health Providers ("MHP"), have agreements with the Arizona Health Care Cost Containment System ("AHCCCS"), Centers for Medicare and Medicaid Services ("CMS") and various health maintenance organizations ("HMOs"), respectively, to contract to provide medical services to subscribing participants. Under these agreements, Vanguard's health plans receive monthly payments based on the number of HMO participants in MHP or the number and coverage type of enrollees in PHP and AAHP. Vanguard's health plans recognize the payments as revenues in the month in which members are entitled to healthcare services with the exception of AAHP Medicare Part D reinsurance premiums and low income subsidy cost sharing premiums that are recorded as a liability to fund future healthcare costs or else repaid to the government.

Cash and Cash Equivalents

Vanguard considers all highly liquid investments with maturity of 90 days or less when purchased to be cash equivalents. Vanguard manages its credit exposure by placing its investments in high quality securities and by periodically evaluating the relative credit standing of the financial institutions holding its cash and investments.

Restricted Cash

As of June 30, 2008 and 2009, Vanguard had restricted cash balances of $2.1 million and $1.9 million, respectively. These balances primarily represent restricted cash accounts related to liquidity requirements of AAHP and certain other arrangements.

Accounts Receivable

Vanguard's primary concentration of credit risk is patient accounts receivable, which consists of amounts owed by various governmental agencies, insurance companies and private patients. Vanguard manages the receivables by regularly reviewing its accounts and contracts and by providing appropriate allowances for contractual discounts and uncollectible amounts. Vanguard typically writes off uncollected accounts receivable 180 days subsequent to discharge date. Medicare program net receivables, including managed Medicare receivables, comprised approximately 31% and 33% of net patient receivables as of June 30, 2008 and 2009, respectively. Medicare revenues are included in the acute care services operating segment. Receivables from various state Medicaid programs and managed Medicaid programs comprised approximately 23% and 21% of net patient receivables as of June 30, 2008 and 2009, respectively. Remaining receivables relate primarily to various HMO and Preferred Provider Organization ("PPO") payers, commercial insurers and private patients. Concentration of credit risk for these payers is limited by the number of patients and payers.

Effective July 1, 2007, Vanguard began estimating the allowance for doubtful accounts using a standard policy that reserves 100% of all accounts aged greater than 365 days subsequent to discharge date plus a standard percentage of uninsured accounts less than 365 days old plus a standard percentage of self-pay after insurance/Medicare less than 365 days old. Vanguard's previous policy reserved all accounts greater than 180 days plus a market-specific percentage of uninsured and self-pay after insurance/Medicare balances. Effective June 30, 2008, Vanguard adjusted its policy to increase the standard percentages applied to uninsured accounts and self-pay after insurance/Medicare accounts. Vanguard adjusted its standard percentages again in April 2009 to consider the impact of its new uninsured discount policy, as previously described. Vanguard tests its allowance for doubtful accounts policy quarterly using a hindsight calculation that utilizes write-off data for all payer classes during the previous twelve-month period to estimate the allowance for doubtful accounts at a point in time. Vanguard also supplements its analysis by comparing cash collections to net patient revenues and monitoring self-pay utilization. Significant changes in payer mix, business office operations, general economic conditions and healthcare coverage provided by federal or state governments or private insurers may have a significant impact on Vanguard's estimates and significantly affect its results of operations and cash flows.

Prior to the implementation of its new uninsured discount policy and for those accounts not yet transitioned to the new uninsured discount policy, Vanguard classifies accounts pending Medicaid approval as Medicaid accounts in its accounts receivable aging report and records a manual contractual allowance for these accounts based upon the

average Medicaid reimbursement rate for that specific state. For accounts that do not successfully qualify for Medicaid coverage and do not meet the requisite charity guidelines, the previously recorded Medicaid contractual adjustment remains a revenue deduction, and the remaining net account balance is reclassified to the uninsured status and subjected to the allowance for doubtful accounts policy. If accounts do not qualify for Medicaid but, do qualify as charity care, the contractual adjustments are reversed and the gross account balance is recorded as a charity deduction.

Upon the implementation of the new uninsured discount policy, all uninsured accounts (including those pending Medicaid qualification) that do not qualify for charity care receive the standard uninsured discount with the balance subject to Vanguard's allowance for doubtful accounts policy. For accounts subsequently qualified for Medicaid coverage, the uninsured discount is reversed and the account is reclassified into Medicaid accounts receivable with the appropriate contractual deduction applied.

A summary of Vanguard's allowance for doubtful accounts activity, including those for discontinued operations, during the three most recent fiscal years follows (in millions).

	Balance at Beginning of Period	Additions Charged to Costs and Expenses	Accounts Written Off, Net of Recoveries	Balance at End of Period
Allowance for doubtful accounts:				
Year ended June 30, 2007	$ 103.5	$ 191.3	$ 181.6	$ 113.2
Year ended June 30, 2008	$ 113.2	$ 201.0	$ 196.5	$ 117.7
Year ended June 30, 2009	$ 117.7	$ 210.8	$ 207.0	$ 121.5

Inventories

Inventories, consisting of medical supplies and pharmaceuticals, are stated at the lower of cost (first-in, first-out) or market.

Property, Plant and Equipment

Purchases of property, plant and equipment are stated at cost. Routine maintenance and repairs are charged to expense as incurred. Expenditures that increase values, change capacities or extend useful lives are capitalized. For assets other than leasehold improvements depreciation is computed using the straight-line method over the estimated useful lives of the assets, which approximate 18 months to 44 years. Leasehold improvements are depreciated over the lesser of the estimated useful life or term of the lease. Depreciation expense was approximately $115.4 million, $127.8 million and $127.0 million for the years ended June 30, 2007, 2008 and 2009, respectively. Vanguard tests its property, plant and equipment and other long-lived assets for impairment as management becomes aware of impairment indicators.

During fiscal 2007, 2008 and 2009, Vanguard capitalized $3.0 million, $1.4 million and $2.0 million of interest, respectively, associated with certain of its hospital construction and expansion projects. Vanguard estimates that it is contractually obligated to expend approximately $33.1 million related to projects classified as construction in progress as of June 30, 2009. Vanguard also capitalizes costs associated with developing computer software for internal use under the provisions of AICPA Statement of Position 98-1 ("SOP 98-1"). Under SOP 98-1, Vanguard capitalizes both internal and external direct costs, excluding training, during the application development stage primarily for the purpose of customizing vendor software to integrate with our hospitals' information systems. The estimated net value of capitalized internal use software, under SOP 98-1, included in net property, plant and equipment, was approximately $49.0 million and $52.0 million as of June 30, 2008 and 2009, respectively. The amortization expense for internal use software, included in depreciation expense, was $6.3 million, $9.9 million and $9.5 million for the years ended June 30, 2007, 2008 and 2009, respectively.

The following table provides the gross asset balances for each major class of asset and total accumulated depreciation as of June 30, 2008 and 2009 (in millions).

	June 30, 2008	June 30, 2009
Class of asset:		
Land and improvements	$ 143.5	$ 148.7
Buildings and improvements	826.2	842.4
Equipment	558.9	641.5
Construction in progress	40.4	60.0
	1,569.0	1,692.6
Less: accumulated depreciation	(395.0)	(518.5)
Net property, plant and equipment	$ 1,174.0	$ 1,174.1

Investments in Auction Rate Securities

At June 30, 2009, Vanguard held $21.6 million in total available for sale investments in auction rate securities ("ARS") backed by student loans, which are included in long-term investments in auction rate securities on its consolidated balance sheet due to inactivity in the primary ARS market during the past year. The par value of the ARS was $26.3 million as of June 30, 2009. As of June 30, 2008, Vanguard had reflected the ARS as current marketable securities at par value. Vanguard recorded a $0.6 million realized holding loss on $10.0 million of these marketable securities during the quarter ended September 30, 2008, as a result of a tender offer Vanguard received from the issuer of the ARS and accepted. However, the tender offer contained certain conditions that were not met by the December 2008 deadline, and the tender failed. Thus, Vanguard reclassified the $9.4 million of marketable securities to investments in auction rate securities, along with the other outstanding ARS, on its condensed consolidated balance sheet as of December 31, 2008. Vanguard also recorded temporary impairments totaling $4.1 million ($2.5 million, net of taxes) related to all $26.3 million par value ARS during the year ended June 30, 2009, which are included in accumulated other comprehensive income (loss) on its consolidated balance sheet as of June 30, 2009.

Vanguard's ARS were rated "AAA" by one or more major credit rating agencies at June 30, 2009. The ratings take into account insurance policies guaranteeing both the principal and accrued interest of the investments. The U.S. government guarantees approximately 96%-98% of the principal and accrued interest on each investment in student loans under the Federal Family Education Loan Program or other similar programs.

Vanguard does not currently intend to sell and does not believe it is more likely than not it will be required to sell its ARS prior to liquidity returning to the market and their fair value recovering to par value. Vanguard will continue to monitor market conditions for this type of ARS to ensure that its classification and fair value estimate for the ARS remain appropriate in future periods. If Vanguard intends to sell any of the ARS, prior to maturity, at an amount below carrying value, or if it becomes more likely than not that Vanguard will be required to sell its ARS, Vanguard will be required to recognize an other-than-temporary impairment.

Long-Lived Assets and Goodwill

Long-lived assets, including property, plant and equipment and amortizable intangible assets, comprise a significant portion of Vanguard's total assets. Vanguard evaluates the carrying value of long-lived assets when impairment indicators are present or when circumstances indicate that impairment may exist under the provisions of SFAS 144, *Accounting for the Impairment or Disposal of Long-Lived Assets*. When management believes impairment indicators may exist, projections of the undiscounted future cash flows associated with the use of and eventual disposition of long-lived assets held for use are prepared. If the projections indicate that the carrying values of the long-lived assets are not expected to be recoverable, Vanguard reduces the carrying values to fair value. For long-lived assets held for sale, Vanguard compares the carrying values to an estimate of fair value less selling costs to determine potential impairment. Vanguard tests for impairment of long-lived assets at the lowest level for which

cash flows are measurable. These impairment tests are heavily influenced by assumptions and estimates that are subject to change as additional information becomes available. Given the relatively few number of hospitals Vanguard owns and the significant amounts of long-lived assets attributable to those hospitals, an impairment of the long-lived assets for even a single hospital could materially adversely impact its operating results or financial position.

Goodwill also represents a significant portion of Vanguard's total assets. Vanguard reviews goodwill for impairment annually during its fourth fiscal quarter or more frequently if certain impairment indicators arise under the provisions of SFAS 142, *Goodwill and Other Intangible Assets*. Vanguard reviews goodwill at the reporting unit level, which is one level below an operating segment. Vanguard compares the carrying value of the net assets of each reporting unit to the net present value of estimated discounted future cash flows of the reporting unit. If the carrying value exceeds the net present value of estimated discounted future cash flows, an impairment indicator exists and an estimate of the impairment loss is calculated. The fair value calculation includes multiple assumptions and estimates, including the projected cash flows and discount rates applied. Changes in these assumptions and estimates could result in goodwill impairment that could materially adversely impact Vanguard's results of operations or statement of position.

Amortization of Intangible Assets

Amounts allocated to contract-based intangible assets, which represent PHP's contract with AHCCCS and PHP's various contracts with network providers, are amortized over their useful lives, which equal 10 years. No amortization is recorded for indefinite-lived intangible assets. Deferred loan costs and syndication costs are amortized over the life of the applicable credit facility or notes using the effective interest method. Physician income and service agreement guarantee intangible assets are recorded based upon the estimated future payments under the contracts and are amortized over the applicable contract service periods. The useful lives over which intangible assets are amortized range from two years to ten years.

Income Taxes

Vanguard accounts for income taxes using the asset and liability method in accordance with SFAS No. 109, *Accounting for Income Taxes* ("SFAS 109") and FASB Interpretation No. 48, *Accounting for Uncertainty in Income Taxes – An Interpretation of FASB Statement No. 109* ("FIN 48"). These guidelines require the recognition of deferred tax assets and liabilities for the expected future tax consequences of temporary differences between the carrying amounts and the tax bases of assets and liabilities.

Vanguard believes that its tax return provisions are accurate and supportable, but certain tax matters require interpretations of tax law that may be subject to future challenge and may not be upheld under tax audit. To reflect the possibility that all of its tax positions may not be sustained, Vanguard maintains tax reserves that are subject to adjustment as updated information becomes available or as circumstances change. Vanguard records the impact of tax reserve changes to its income tax provision in the period in which the additional information, including the progress of tax audits, is obtained.

Vanguard assesses the realization of its deferred tax assets to determine whether an income tax valuation allowance is required. Based on all available evidence, both positive and negative, and the weight of that evidence to the extent such evidence can be objectively verified, Vanguard determines whether it is more likely than not that all or a portion of the deferred tax assets will be realized. The factors used in this determination include the following:

- Cumulative losses in recent years
- Income/losses expected in future years
- Unsettled circumstances that, if favorably resolved, would adversely affect future operations
- Availability, or lack thereof, of taxable income in prior carryback periods that would limit realization of tax benefits
- Carryforward period associated with the deferred tax assets and liabilities
- Prudent and feasible tax planning strategies

In addition, financial forecasts used in determining the need for or amount of federal and state valuation allowances are subject to changes in underlying assumptions and fluctuations in market conditions that could significantly alter Vanguard's recoverability analysis and thus have a material adverse impact on Vanguard's consolidated financial condition, results of operations or cash flows.

Accrued Health Plan Claims

During the years ended June 30, 2007, 2008 and 2009, health plan claims expense was $297.0 million, $328.2 million and $525.6 million, respectively, primarily representing health claims incurred by enrollees in PHP. Vanguard estimates PHP's reserve for health claims using historical claims experience (including cost per member and payment lag time) and other actuarial data including number of enrollees and certain enrollee demographic information. Accrued health plan claims, including incurred but not reported claims, for all Vanguard health plans combined was approximately $51.1 million and $117.6 million as of June 30, 2008 and 2009, respectively. While management believes that its estimation methodology effectively captures trends in medical claims costs, actual payments could differ significantly from its estimates given changes in the healthcare cost structure or adverse experience. During the years ended June 30, 2007, 2008 and 2009, approximately $34.2 million, $31.2 million and $34.0 million, respectively, of accrued and paid claims for services provided to Vanguard's health plan enrollees by its hospitals and its other healthcare facilities were eliminated in consolidation. Vanguard's operating results and cash flows could be materially affected by increased or decreased utilization of its healthcare facilities by enrollees in its health plans.

Employee Health Insurance Reserve

Effective July 1, 2008, Vanguard began covering all of its employees under its self-insured medical plan. Prior to that, only a portion of Vanguard's employees were covered under this self-insured plan. Claims are accrued under the self-insured medical plan as the incidents that give rise to them occur. Unpaid claims accruals are based on the estimated ultimate cost of settlement, including claim settlement expenses, in accordance with an average lag time and historical experience. The reserve for self-insured medical plan was approximately $1.5 million and $13.4 million as of June 30, 2008 and 2009, respectively, and is included in accrued salaries and benefits in the accompanying consolidated balance sheets. Vanguard mitigated its self-insured risk by purchasing stop-loss coverage for catastrophic claims at a $500,000 per enrollee annual limit. During the year ended June 30, 2009, approximately $23.1 million was eliminated upon consolidation related to self-insured medical claims expense incurred and revenues earned due to employee utilization of Vanguard's healthcare facilities.

Professional and General Liability and Workers Compensation Reserves

Given the nature of its operating environment, Vanguard is subject to professional and general liability and workers compensation claims and related lawsuits in the ordinary course of business. For professional and general liability claims incurred from June 1, 2002 to May 31, 2006, Vanguard's wholly owned captive subsidiary insured its professional and general liability risks at a $10.0 million retention level. For professional and general liability claims incurred from June 1, 2006 to June 30, 2009, Vanguard self-insured the first $9.0 million per claim, and the captive subsidiary insured the next $1.0 million per claim. Vanguard maintains excess coverage from independent third party insurers on a claims-made basis for individual claims exceeding $10.0 million up to $75.0 million, but limited to total annual payments of $65.0 million in the aggregate.

Vanguard insures its excess coverage under a retrospectively rated policy, and premiums under this policy are recorded based on Vanguard's historical claims experience. Vanguard self-insures its workers compensation claims up to $1.0 million per claim and purchases excess insurance coverage for claims exceeding $1.0 million.

Vanguard's reserves for professional and general liability as of the years ended June 30, 2008 and 2009 were $74.3 million and $92.9 million, respectively. As of June 30, 2008 and 2009 the reserves for workers' compensation were $18.8 million and $18.2 million, respectively. Vanguard utilizes actuarial information to estimate its reserves for professional and general liability and workers compensation claims. Each reserve is comprised of estimated indemnity and expense payments related to: (1) reported events ("case reserves") and (2) incurred but not reported ("IBNR") events as of the end of the period. Management uses information from its risk managers and its best judgment to estimate case reserves. Actuarial IBNR estimates are dependent on multiple variables including

Vanguard's risk exposures, its self-insurance limits, geographic locations in which it operates, the severity of its historical losses compared to industry averages and the reporting pattern of its historical losses compared to industry averages, among others. Most of these variables require judgment, and changes in these variables could result in significant period over period fluctuations in Vanguard's estimates. Vanguard discounts its workers compensation reserve using a 5% factor, an actuarial estimate of projected cash payments in future periods. Vanguard does not discount the reserve for estimated professional and general liability claims. Vanguard adjusts these reserves from time to time as it receives updated information. Due to changes in historical loss trends, during its fiscal years ended June 30, 2007 and 2008, Vanguard decreased its professional and general liability reserve related to prior fiscal years by $4.5 million and $0.6 million, respectively. During its fiscal year ended June 30, 2009, Vanguard increased its professional and general liability reserve related to prior fiscal years by $13.4 million. Similarly, Vanguard decreased its workers compensation reserve related to prior fiscal years by $2.3 million and $3.8 million during its fiscal years ended June 30, 2008 and 2009. Adjustments to the workers compensation reserve related to prior years during the fiscal year ended June 30, 2007 were not significant. Additional adjustments to prior year estimates may be necessary in future periods as Vanguard's reporting history and loss portfolio matures.

Market and Labor Risks

Vanguard operates primarily in four geographic markets. If economic or other factors limit its ability to provide healthcare services in one or more of these markets, Vanguard's cash flows and results of operations could be materially adversely impacted. Approximately 1,600 full-time employees in Vanguard's Massachusetts hospitals are subject to collective organizing agreements. This group represents approximately 8% of Vanguard's workforce. During fiscal 2007, Vanguard entered into a new three-year contract with the union representing the majority of this group that ends on December 31, 2009. If Vanguard experiences significant future labor disruptions related to these unionized employees, its cash flows and results of operations could be materially adversely impacted.

Stock-Based Compensation

Vanguard accounts for stock-based employee compensation granted prior to July 1, 2006 under the provisions of Statement of Financial Accounting Standards No. 123, *Accounting for Stock-Based Compensation* ("SFAS 123"). Effective July 1, 2003, Vanguard adopted SFAS 123 on a prospective basis, an acceptable transition method set forth in SFAS No. 148, *Accounting for Stock-Based Compensation Transition and Disclosure* ("SFAS 148"). For grants dated July 1, 2006 and subsequent, Vanguard accounts for stock-based employee compensation under the provisions of Statement of Financial Accounting Standards No. 123(R), *Share-Based Payment* ("SFAS 123(R)"). Vanguard also adopted SFAS 123(R) on a prospective basis and such adoption did not significantly impact Vanguard's results of operations or cash flows.

The following table sets forth the weighted average assumptions utilized in the minimum value pricing model for stock option grants under the 2004 Option Plan prior to July 1, 2006 and those utilized in the Black-Scholes-Merton valuation model for grants under the 2004 Option Plan subsequent to July 1, 2006.

	Minimum Value	Black-Scholes-Merton
Risk-free interest rate	4.11% - 4.95%	3.61% - 5.13%
Dividend yield	0.0%	0.0%
Volatility (wtd avg)	N/A	30.10%
Volatility (annual)	N/A	26.39% - 37.73%
Expected option life	10 years	6.5 years

For stock options included in the Black-Scholes-Merton valuation model, Vanguard used historical stock price information of certain peer group companies for a period of time equal to the expected option life period to determine estimated volatility. Vanguard determined the expected life of the stock options by averaging the contractual life of the options and the vesting period of the options. The estimated fair value of options is amortized to expense on a straight-line basis over the options' vesting period.

Subsequent Events

In May 2009, the Financial Accounting Standards Board ("FASB") issued Statement of Financial Accounting Standards No. 165, *Subsequent Events* ("SFAS 165"). In accordance with the adoption of SFAS 165, Vanguard has evaluated subsequent events for the year ended June 30, 2009 through September 2, 2009, the date these financial statements were issued. No significant subsequent events were noted that would require recognition or disclosure at this time.

Recently Issued Accounting Pronouncements

In June 2009, FASB issued Statement of Financial Accounting Standards No. 168, *The FASB Codification and the Hierarchy of Generally Accepted Accounting Principles* ("SFAS 168" or "Codification"). When it becomes effective for financial statements covering periods ending after September 15, 2009, the *Codification* will be the single source of authoritative U.S. GAAP applicable to all non-governmental entities and will supersede all existing FASB, AICPA, and Emerging Issues Task Force (EITF) pronouncements and related literature (i.e. all codified literature will carry the same level of authority and non-codified GAAP literature will become non-authoritative). The *Codification* will also include relevant portions of authoritative SEC content relating to matters within the basic financial statements, which are considered as sources of authoritative GAAP for SEC registrants. As of July 1, 2009, the FASB no longer issues Statements, Interpretations, Staff Positions, or EITF abstracts. Irrespective of how they would have been issued under the previous structure, all changes to GAAP will henceforth be only in the form of Accounting Standards Updates, which will serve to update the *Codification* itself. When the *Codification* becomes effective, SFAS No. 162, *The Hierarchy of Generally Accepted Accounting Principles*, will be rendered irrelevant to give effect to the new GAAP hierarchy established in the *Codification*. SFAS 168 is effective for Vanguard's fiscal quarter beginning July 1, 2009. Other than modifications to the currently required disclosures, Vanguard does not expect the adoption of SFAS 168 to have a significant impact on its financial position, results of operations or cash flows.

In June 2009, FASB issued Statement of Financial Accounting Standards No. 167, *Amendments to FASB Interpretation No. 46 (R)*("SFAS 167"). SFAS 167 amends FASB's Interpretation (FIN) No. 46(R) , *Consolidation of Variable Interest Entities*, mainly to (1) require an enterprise to conduct a qualitative analysis for the purpose of determining whether, based on its variable interests, it also has a controlling interest in a variable interest entity (VIE), and (2) make the consequential changes resulting from elimination of the concept of a qualifying special-purpose entity (QSPE) in SFAS No. 140 , *Accounting for Transfers and Servicing of Financial Assets and Extinguishments of Liabilities*, thus subjecting an entity previously designated as a QSPE to the same evaluation as that of any other VIE for consolidation purposes. Amended FIN No. 46(R) is effective as of the start of the first annual reporting period beginning after November 15, 2009, for interim periods within the first annual reporting period, and for all subsequent annual and interim reporting periods. Earlier application is not permitted, but retrospective application to previously issued financial statements for previous years is allowed but, not required. Vanguard does not expect the adoption of SFAS 167 to have a significant impact on its financial position, results of operations or cash flows.

In December 2007, FASB issued Statement of Financial Accounting Standards No. 141(R), *Business Combinations* ("SFAS 141(R)"). SFAS 141(R) applies to all transactions or other events in which an entity obtains control of one or more businesses even if the acquirer does not acquire 100% of all interests of the target. Under SFAS 141(R) the acquirer recognizes 100% of the fair values of acquired assets, including goodwill, and assumed liabilities with only limited exceptions. This methodology replaces the previous cost-allocation process set forth in SFAS No. 141 that often resulted in the measurement of assets and liabilities at values other than fair value at the acquisition date. SFAS 141(R) also requires contingent consideration to be measured at fair value at acquisition date with subsequent adjustments measured in future periods. Transactions costs are not considered part of the acquired assets and thus are expensed as incurred under SFAS 141(R). The acquisition date is deemed to be the date on which the acquisition is completed, not when the acquisition agreement is executed. Vanguard will adopt SFAS 141(R) prospectively for acquisitions completed on or after July 1, 2009. However, SFAS 141(R) requires changes to estimates of deferred taxes arising from business combinations to be adjusted through earnings even if the business combination occurred prior to the effective date of SFAS 141(R).

Since the issuance of SFAS 141(R), constituents have expressed concern regarding certain aspects of its application to pre-acquisition contingencies. Accordingly, in April 2009 the FASB issued FASB Staff Position No. SFAS 141(R)-1, *Accounting for Assets Acquired and Liabilities Assumed in a Business Combination That Arise from Contingencies* ("FSP 141(R)-1"), which amends SFAS 141(R) to provide guidance in respect of initial recognition and measurement, subsequent measurement, and disclosures concerning assets and liabilities arising from pre-acquisition contingencies in a business combination. Vanguard will adopt FSP 141(R)-1 prospectively for acquisitions completed on or after July 1, 2009. SFAS 141(R) and FSP 141(R)-1 will affect Vanguard's future financial position, results of operations or cash flows to the extent Vanguard completes a business combination on or subsequent to July 1, 2009 and could significantly impact Vanguard's future results of operations should deferred tax estimates attributable to the Blackstone merger differ significantly from their ultimate resolution.

In December 2007, FASB issued Statement of Financial Accounting Standards No. 160, *Noncontrolling Interests in Consolidated Financial Statements* ("SFAS 160"). SFAS 160 amended Accounting Research Bulletin No. 51, *Consolidated Financial Statements*, to establish a single method of accounting for non-controlling interests in subsidiaries, or previously referred to as minority interests. SFAS 160 requires that the noncontrolling interest in a subsidiary be reported as a component of stockholder's equity in the consolidated balance sheet. SFAS 160 also requires that consolidated net income include both the parent and noncontrolling interest's portion of the operating results of the subsidiary with separate disclosure on the statement of operations of the amounts attributable to the parent versus the noncontrolling interest. Changes in the parent's ownership interest that do not result in deconsolidation are treated as equity transactions under SFAS 160. Vanguard will adopt SFAS 160 prospectively on July 1, 2009 with retrospective presentation for comparative periods shown. Vanguard does not expect SFAS 160 to have a material impact on its future financial position, results of operations or cash flows.

In February 2007, FASB issued Statement of Financial Accounting Standards No. 159, *The Fair Value Option for Financial Assets and Financial Liabilities* ("SFAS 159"). SFAS 159 gives entities the option to voluntarily choose, at certain election dates, to measure many financial assets and liabilities at fair value. Elections are made on an instrument by instrument basis and are irrevocable once made. Subsequent changes to the fair value of any instrument for which an election is made are reflected through earnings. SFAS 159 was effective for Vanguard as of July 1, 2008. The adoption of SFAS 159 did not significantly impact Vanguard's financial position, results of operations or cash flows.

On September 15, 2006, FASB issued Statement of Financial Accounting Standards No. 157, *Fair Value Measurement* ("SFAS 157"). SFAS 157 sets forth comprehensive guidance for measuring fair value of assets and liabilities. Under the provisions of SFAS 157, fair value should be based on the assumptions market participants would use to complete the sale of an asset or transfer of a liability. SFAS 157 provides a hierarchy of information to be used to determine the applicable market assumptions, and fair value measurements would be separately disclosed under each applicable layer of the hierarchy. SFAS 157 does not expand or restrict the use of fair value for measuring assets and liabilities but provides a single methodology to be used when fair value accounting is applied. For those financial assets and financial liabilities defined in SFAS 159, SFAS 157 was effective for Vanguard's fiscal year beginning July 1, 2008. For non-recurring nonfinancial assets and nonfinancial liabilities, SFAS 157 is effective for Vanguard's fiscal year beginning July 1, 2009. Vanguard does not expect the adoption of SFAS 157 for non-financial assets and non-financial liabilities to significantly impact its future financial position, results of operations or cash flows.

3. Discontinued Operations

On October 1, 2006, certain of Vanguard's subsidiaries completed the sale of their three hospitals in Orange County, California (West Anaheim Medical Center, Huntington Beach Hospital and La Palma Intercommunity Hospital) to subsidiaries of Prime Healthcare, Inc. for net proceeds of $40.0 million, comprised of cash proceeds of $37.0 million and $3.0 million of proceeds placed in escrow which was distributed to a subsidiary of Vanguard on July 2, 2007. Approximately $12.8 million of retained working capital, including $25.3 million of patient accounts receivable, was excluded from the sale.

The operations of the California hospitals are included in discontinued operations, net of taxes, in the accompanying statements of operations for all periods presented in accordance with SFAS 144, *Accounting for the*

Impairment or Disposal of Long-Lived Assets ("SFAS 144") and EITF 03-13, *Applying the Conditions of Paragraph 42 of FASB Statement No. 144 in Determining Whether to Report Discontinued Operations* ("EITF 03-13").

In June 2007, Vanguard ceased providing acute care services at Phoenix Memorial Hospital ("PMH") and began leasing certain floors of the building to various third party healthcare providers. The leases are 5-year and 7-year leases with renewal options. When comparing the projected lease income to the historical total revenues of PMH, Vanguard determined that the expected cash inflows under the leases were insignificant and deemed indirect cash flows. Thus, the acute care operations of PMH are included in discontinued operations, net of taxes in the accompanying statements of operations for all periods presented in accordance with SFAS 144 and EITF 03-13.

The following table sets forth the components of discontinued operations, net of taxes for the years ended June 30, 2007, 2008 and 2009, respectively (in millions).

	Year Ended June 30,		
	2007	2008	2009
Total revenues	$ 91.7	$ (1.5)	$ 1.7
Operating expenses	115.9	(1.6)	0.2
Allocated interest	2.7	–	–
Loss on sale of assets	1.7	0.6	–
Income tax expense (benefit)	(9.5)	(0.2)	0.6
Income (loss) from discontinued operations, net of taxes	$ (19.1)	$ (0.3)	$ 0.9

The interest allocation to discontinued operations for the year ended June 30, 2007 was based upon the ratio of net assets to be divested to the sum of total net assets and Vanguard's outstanding debt. Income taxes were calculated using an effective tax rate of approximately 33.2%, 40.0% and 40.0% for the years ended June 30, 2007, 2008 and 2009, respectively.

4. Fair Value Measurements

On July 1, 2008, Vanguard adopted the provisions of Financial Accounting Standards No. 157, *Fair Value Measurement* ("SFAS 157") for financial assets and financial liabilities defined in Financial Accounting Standards No. 159, *The Fair Value Option for Financial Assets and Financial Liabilities* ("SFAS 159"). For non-recurring nonfinancial assets and nonfinancial liabilities, SFAS 157 is effective for Vanguard's fiscal year beginning July 1, 2009. SFAS 157 defines fair value, establishes a framework for measuring fair value and expands disclosures about fair value measurements.

Under SFAS 157, fair value is determined using assumptions that market participants would use to determine the price of the asset or liability as opposed to measurements determined based upon information specific to the entity holding those assets and liabilities. To determine those market participant assumptions, SFAS 157 established a hierarchy of inputs that the entity must consider including both independent market data inputs and the entity's own assumptions about the market participant assumptions. This hierarchy is summarized as follows.

Level 1 Unadjusted quoted prices in active markets for identical assets and liabilities.

Level 2 Directly or indirectly observable inputs, other than quoted prices included in Level 1. Level 2 inputs may include, among others, interest rates and yield curves observable at commonly quoted intervals, volatilities, loss severities, credit risks and other inputs that are derived principally from or corroborated by observable market data by correlation or other means.

Level 3 Unobservable inputs used when there is little, if any, market activity for the asset or liability at the measurement date. These inputs represent the entity's own assumptions about the assumptions that market participants would use to price the asset or liability developed using the best information available.

In April 2009, the FASB issued FASB Staff Position No. FAS 157-4, *Determining Fair Value When the Volume and Level of Activity for the Asset or Liability Have Significantly Decreased and Identifying Transactions That Are Not Orderly* ("FSP 157-4"). FSP 157-4 clarifies the application of SFAS 157 in cases where the volume and level of activity for an asset or liability have significantly decreased, and identifying circumstances indicating that a transaction is not an orderly one. Vanguard considered the guidance provided by FSP 157-4 in its determination of estimated fair values as of June 30, 2009, and the impact was not material.

The following table summarizes Vanguard's assets measured at fair value on a recurring basis as of June 30, 2009, aggregated by the fair value hierarchy level within which those measurements were made (in millions).

	Fair Value	Level 1 Inputs	Level 2 Inputs	Level 3 Inputs
Assets:				
Investments in auction rate securities	$ 21.6	$ –	$ –	$ 21.6
Liabilities:				
Interest rate swap liability	$ 6.9	$ –	$ 6.9	$ –

The following table provides a reconciliation of the beginning and ending balances for the year ended June 30, 2009 for those fair value measurements using significant Level 3 unobservable inputs (in millions).

	Balance at July 1, 2008	Asset Reclassification	Other-than-temporary impairment	Unrealized holding loss	Balance at June 30, 2009
Marketable securities	$ 26.3	$ (25.7)	$ (0.6)	$ –	$ –
Investments in auction rate securities	–	25.7	–	(4.1)	21.6
Total Level 3 inputs	$ 26.3	$ –	$ (0.6)	$ (4.1)	$ 21.6

Auction Rate Securities

At June 30, 2009, Vanguard held $21.6 million in total available for sale investments in auction rate securities ("ARS") backed by student loans, which are included in investments in auction rate securities on the accompanying consolidated balance sheet. These ARS are accounted for as long-term available for sale securities under SFAS 115, *Accounting for Certain Investments in Debt and Equity Securities*. The par value of the ARS was $26.3 million at June 30, 2009. The ARS have maturity dates ranging from 2039 to 2043 and are guaranteed by the U.S. government at approximately 96%-98% of the principal and accrued interest under the Federal Family Education Loan Program or other similar programs. Due to the lack of market liquidity and other observable market inputs for these ARS, Vanguard utilized Level 3 inputs to estimate the $21.6 million fair value of these ARS. Valuations from forced liquidations or distressed sales are inconsistent with the definition of fair value set forth in SFAS 157, which assumes an orderly market. For its valuation estimate, management utilized a discounted cash flow analysis that included estimates of the timing of liquidation of these ARS and the impact of market risks on exit value. Vanguard does not currently intend to sell and does not believe it is more likely than not it will be required to sell these ARS prior to liquidity returning to the market and their fair value recovering to par value.

In September 2008, Vanguard received a tender offer for $10.0 million par value of ARS at 94% of par value. As a result of Vanguard's acceptance of the tender offer and the other-than-temporary decline in fair value, Vanguard recorded a $0.6 million realized holding loss on these marketable securities during the quarter ended September 30, 2008, which is included in other expenses on the accompanying consolidated statement of operations for the year ended June 30, 2009. However, the tender offer contained certain conditions that were not met as of the December 2008 deadline, and the tender failed. As a result of the failed tender, all $21.6 million of ARS are presented as long-term assets on the accompanying consolidated balance sheet as of June 30, 2009. In addition, Vanguard recorded a temporary impairment of $4.1 million ($2.5 million, net of taxes) related to the ARS during the

year ended June 30, 2009, which is included in accumulated other comprehensive income (loss) ("OCI") on the consolidated balance sheet as of June 30, 2009.

Interest Rate Swap Agreement

Vanguard enters into derivative instruments from time to time to manage the cash flows risk associated with the variable interest component of its outstanding term debt or to manage the fair value risk of its other debt instruments with fixed interest rates. Vanguard does not hold or issue derivative instruments for trading purposes and is not a party to any instrument with leverage features.

During April 2008, Vanguard entered into an interest rate swap agreement with Bank of America, N.A. (the "counterparty") that went into effect on June 30, 2008 for a notional $450.0 million of its outstanding term debt. Under this agreement and through March 31, 2009, Vanguard made or received net interest payments based upon the difference between the 90-day LIBOR rate and the swap fixed interest rate of 2.785%. Vanguard accounted for this swap as a highly effective cash flow hedge with critical terms that substantially match the underlying term debt and measured any ineffectiveness using the hypothetical derivative method.

In March 2009, Vanguard and the counterparty executed an amended swap agreement with the same terms and provisions as the original agreement except that after March 31, 2009, Vanguard will make or receive net interest payments based upon the difference between the 30-day LIBOR rate and the swap fixed interest rate of 2.5775%. As a result of this amended swap agreement, Vanguard de-designated its existing cash flow hedge and re-designated the amended swap agreement as a hedge of the remaining interest payments associated with $450.0 million of Vanguard's outstanding term debt. As the forecasted transactions (i.e. the future interest payments under Vanguard's outstanding term debt) are still probable of occurring, Vanguard did not immediately recognize the accumulated other comprehensive loss balance related to the de-designated swap in earnings. Based on its assessment, Vanguard determined that this re-designated swap will be highly effective in offsetting the changes in cash flows related to the hedged risk. Upon the execution of the amended swap agreement, Vanguard measured hedge ineffectiveness by comparing the fair value of the original swap agreement to a new hypothetical derivative using the amended terms to determine if the underlying term debt has been overhedged. Vanguard determined that the hedge ineffectiveness was not significant as of June 30, 2009. Vanguard will continue this measurement process on a quarterly basis until the termination of the amended swap on March 31, 2010. The valuation of the amended interest rate swap is based upon a discounted cash flows analysis that reflects the term of the agreement and an observable market-based input, the 30-day LIBOR interest rate curve, which is observable at commonly quoted intervals for the full term of the swap. Vanguard also considered potential credit adjustment risks related to its own performance and the counterparty's performance under the swap agreement. Management deemed the credit adjustment risks as Level 3 inputs. However, management determined that any potential credit adjustment risks were not significant and thus classified the entire interest rate swap valuation in Level 2 of the fair value hierarchy.

The following tables provide information regarding the valuation and presentation of assets, liabilities and expenses related to this interest rate swap for the respective periods (in millions).

Interest rate swap contract:	June 30, 2008 Balance Sheet Location	June 30, 2008 Fair Value	June 30, 2009 Balance Sheet Location	June 30, 2009 Fair Value
Gross valuation	Prepaid expenses and other current assets	$ 4.6	Other accrued expenses and current liabilities	$ (6.9)
Tax effect	Deferred tax assets	(1.8)	Deferred tax assets	2.6
Net asset (liability) balance offset to accumulated OCI		$ 2.8		$ (4.3)

	Year ended June 30, 2008 Amount of gain (loss) recognized in OCI on derivative	Location of gain (loss) recognized on derivative-reclassified from OCI	Amount of gain (loss) recognized on derivative - reclassified from OCI	Year ended June 30, 2009 Amount of gain (loss) recognized in OCI on derivative	Location of gain (loss) recognized on derivative-reclassified from OCI	Amount of gain (loss) recognized on derivative - reclassified from OCI
Interest rate swap contract, net of taxes	$ 2.8	n/a	$ –	$ (7.1)	Interest, net	$ (2.8)

The $4.3 million balance included in accumulated OCI, net of taxes, is expected to be reclassified to net interest during the fiscal year ending June 30, 2010 since the interest rate swap expires on March 31, 2010.

Cash and Cash Equivalents and Restricted Cash

The carrying amounts reported for cash and cash equivalents and restricted casb approximate fair value because of the short-term maturity of these instruments.

Accounts Receivable and Accounts Payable

The carrying amounts reported for accounts receivable and accounts payable approximate fair value because of the short-term maturity of these instruments.

Long-Term Debt

The fair values of Vanguard's 9.0% Notes, and 11.25% Notes and term loans as of June 30, 2009 were approximately $547.7 million, $209.3 million and $735.7 million, respectively, based upon stated market prices. The fair values are subject to change as market conditions change.

5. Prepaid Expenses and Other Current Assets

Prepaid expenses and other current assets in the accompanying consolidated balance sheets consist of the following at June 30, 2008 and 2009 (in millions).

	2008	2009
Prepaid insurance	$ 5.2	$ 6.1
Prepaid maintenance contracts	4.5	7.9
Other prepaid expenses	6.0	8.9
Interest rate swap receivable	2.8	–
Third party settlements	4.4	2.1
Reinsurance receivables	9.8	17.2
Other receivables	23.1	26.2
	$ 55.8	$ 68.4

6. Impairment of Long-Lived Assets and Goodwill

Vanguard completed its annual goodwill impairment test required by SFAS 142 during the fourth quarter of fiscal 2009 noting no impairment. However, Vanguard's Chicago market, with goodwill of approximately $43.1 million as of June 30, 2009, will require continual monitoring during fiscal year 2010 due to the sensitivity of the projected operating results of this reporting unit to the goodwill impairment analysis. If actual future cash flows become less favorable than those projected by management, an impairment charge may become necessary that could have a material adverse impact on Vanguard's financial position and results of operations.

In accordance with SFAS 144, during the fourth quarter of fiscal 2009 Vanguard noted events and conditions indicating that the carrying value of the asset group related to a building at one of its non-hospital facilities included in the acute care services segment may not be recoverable. Utilizing management estimates and appraisal information, Vanguard recorded an impairment charge of approximately $6.2 million ($3.8 million, net of taxes) to write down the building carrying value to fair value during the fourth quarter of fiscal 2009.

7. Goodwill and Intangible Assets

The following table provides information regarding the intangible assets, including deferred loan costs, included in the accompanying consolidated balance sheets as of June 30, 2008 and 2009 (in millions).

	Gross Carrying Amount		Accumulated Amortization	
Class of Intangible Asset	2008	2009	2008	2009
Amortized intangible assets:				
Deferred loan costs	$ 43.8	$ 43.8	$ 16.1	$ 21.5
Contracts	31.4	31.4	11.8	14.9
Physician income and other guarantees	22.2	27.2	12.1	18.3
Other	1.3	4.7	0.5	1.0
Subtotal	98.7	107.1	40.5	55.7
Indefinite-lived intangible assets:				
License and accreditation	3.2	3.2	–	–
Total	$ 101.9	$ 110.3	$ 40.5	$ 55.7

Amortization expense for contract-based intangibles and other intangible assets during the fiscal years ended June 30, 2007, 2008 and 2009 was approximately $3.2 million, $3.2 million and $3.6 million, respectively. Total

estimated amortization expense for these intangible assets during the next five years and thereafter is as follows (in millions).

2010	$ 3.7
2011	3.7
2012	3.7
2013	3.7
2014	3.7
Thereafter	1.5
	$ 20.0

In connection with the Blackstone merger, Vanguard incurred $43.8 million of deferred offering and loan costs related to the 9.0% Notes, the 11.25% Notes and term and revolving loan borrowings under the merger credit facilities and the 2005 term loan facility.

Amortization of deferred loan costs of $4.5 million, $4.9 million and $5.4 million during the years ended June 30, 2007, 2008 and 2009, respectively, is included in net interest. Amortization of physician income and other guarantees of $5.1 million, $6.7 million and $6.2 million during the years ended June 30, 2007, 2008 and 2009, respectively, is included in purchased services or other operating expenses.

The following table presents the changes in the carrying amount of goodwill from June 30, 2008 through June 30, 2009 (in millions).

	Acute Care Services	Health Plans	Total
Balance as of June 30, 2008	$ 609.8	$ 79.4	$ 689.2
Acquisition of healthcare entities	2.9	–	2.9
Balance as of June 30, 2009	$ 612.7	$ 79.4	$ 692.1

Vanguard completed its annual impairment test of goodwill and indefinite-lived intangible assets during the fourth quarter of fiscal 2009 noting no impairment. Approximately $151.5 million of Vanguard's goodwill is deductible for tax purposes.

8. Other Accrued Expenses and Current Liabilities

The following table presents summaries of items comprising other accrued expenses and current liabilities in the accompanying consolidated balance sheets as of June 30, 2008 and 2009 (in millions).

	2008	2009
Property taxes	$ 14.6	$ 17.0
Current portion of professional and general liability and workers compensation insurance	19.0	34.4
Accrued income guarantees	4.4	3.0
Income taxes payable (receivable)	2.4	(5.0)
Interest rate swap payable	–	6.9
Other	16.9	23.2
	$ 57.3	$ 79.5

9. Long-Term Debt

A summary of Vanguard's long-term debt at June 30, 2008 and 2009 follows (in millions).

	2008	2009
9.0% Senior Subordinated Notes	$ 575.0	$ 575.0
11.25% Senior Discount Notes	188.4	210.2
Term loans payable under credit facility	774.1	766.4
	1,537.5	1,551.6
Less: current maturities	(8.0)	(8.0)
	$ 1,529.5	$ 1,543.6

9.0% Notes

In connection with the acquisition of Vanguard by merger on September 23, 2004 by certain investment funds affiliated with The Blackstone Group L.P. (collectively "Blackstone"), two of Vanguard's wholly owned subsidiaries, Vanguard Health Holding Company II, LLC and Vanguard Holding Company II, Inc. (collectively, the "Issuers"), completed a private placement of $575.0 million 9% Senior Subordinated Notes due 2014 ("9.0% Notes"). Interest on the 9.0% Notes is payable semi-annually on October 1st and April 1st of each year. The 9.0% Notes are general unsecured senior subordinated obligations and rank junior in right of payment to all existing and future senior indebtedness of the Issuers. All payments on the 9.0% Notes are guaranteed jointly and severally on a senior subordinated basis by Vanguard and its domestic subsidiaries, other than those subsidiaries that do not guarantee the obligations of the borrowers under the senior credit facilities.

Prior to October 1, 2009, the Issuers may redeem the 9.0% Notes, in whole or in part, at a price equal to 100% of the principal amount thereof plus a make-whole premium. On or after October 1, 2009, the Issuers may redeem all or part of the 9.0% Notes at various redemption prices given the date of redemption as set forth in the indenture governing the 9.0% Notes. The initial redemption price for the 9.0% Notes on October 1, 2009 is equal to 104.50% of their principal amount, plus accrued and unpaid interest. The redemption price declines each year after 2009. The redemption price will be 100% of the principal amount, plus accrued and unpaid interest, beginning on October 1, 2012.

11.25% Notes

In connection with the Blackstone merger on September 23, 2004, two of Vanguard's wholly owned subsidiaries, Vanguard Health Holding Company I, LLC and Vanguard Holding Company I, Inc. (collectively, the "Discount Issuers"), completed a private placement of $216.0 million aggregate principal amount at maturity ($124.7 million in gross proceeds) of 11.25% Senior Discount Notes due 2015 ("11.25% Notes"). The 11.25% Notes accrete at the stated rate compounded semi-annually on April 1 and October 1 of each year to, but not including, October 1, 2009. Subsequent to October 1, 2009, cash interest on the 11.25% Notes will accrue at 11.25% per annum, and will be payable on April 1 and October 1 of each year, commencing on April 1, 2010 until maturity. The 11.25% Notes are general senior unsecured obligations and rank junior in right of payment to all existing and future senior indebtedness of the Discount Issuers but senior to any of the Discount Issuers' future senior subordinated indebtedness. All payments on the 11.25% Notes are guaranteed by Vanguard as a holding company guarantee.

Prior to October 1, 2009, the Discount Issuers may redeem the 11.25% Notes, in whole or in part, at a price equal to 100% of the accreted value thereof, plus accrued and unpaid interest, plus a make-whole premium. On or after October 1, 2009, the Discount Issuers may redeem all or a part of the 11.25% Notes at various redemption prices given the date of redemption as set forth in the indenture governing the 11.25% Notes. The initial redemption price for the 11.25% Notes on October 1, 2009 is equal to 105.625% of their principal amount, plus accrued and unpaid interest. The redemption price declines each year after 2009. The redemption price will be 100% of the principal amount, plus accrued and unpaid interest, beginning on October 1, 2012.

Credit Facility Debt

In connection with the Blackstone merger on September 23, 2004, two of Vanguard's wholly owned subsidiaries, Vanguard Health Holding Company II, LLC and Vanguard Holding Company II, Inc. (collectively, the "Co-borrowers"), entered into new senior secured credit facilities (the "merger credit facilities") with various lenders and Bank of America, N.A. as administrative agent and Citicorp North America, Inc. as syndication agent, and repaid all amounts outstanding under its previous credit facility. The merger credit facilities include a seven-year term loan facility in the aggregate principal amount of $800.0 million and a six-year $250.0 million revolving credit facility.

On September 26, 2005, the Co-borrowers refinanced and repriced all $795.7 million of the then outstanding term loans under the merger credit facilities by borrowing $795.7 million of replacement term loans that also mature on September 23, 2011 (the "2005 term loan facility"). In addition, upon the occurrence of certain events, the Co-borrowers may request an incremental term loan facility to be added to the 2005 term loan facility in an amount not to exceed $300.0 million in the aggregate, subject to receipt of commitments by existing lenders or other financing institutions and to the satisfaction of certain other conditions. The revolving loan facility under the merger credit facilities did not change in connection with the term loan refinancing. As of June 30, 2009, $766.4 million of indebtedness was outstanding under the 2005 term loan facility. Vanguard's remaining borrowing capacity under the revolving credit facility, net of letters of credit outstanding, was $218.8 million as of June 30, 2009.

The 2005 term loan facility borrowings bear interest at a rate equal to, at Vanguard's option, LIBOR plus 2.25% per annum or a base rate plus 1.25% per annum. As discussed in Note 4, $450.0 million of the term loan facility borrowings are subject to a fixed interest rate of 4.8275% per annum under the terms of an interest rate swap agreement that expires on March 31, 2010. The interest rate applicable to the unhedged portion of Vanguard's term loan facility borrowings was approximately 2.6% as of June 30, 2009. Borrowings under the revolving credit facility currently bear interest at a rate equal to, at Vanguard's option, LIBOR plus 2.0% per annum or a base rate plus 1.0% per annum, subject to an increase of up to 0.50% per annum should Vanguard's leverage ratio increase over certain designated levels. Vanguard also pays a commitment fee to the lenders under the revolving credit facility in respect of unutilized commitments thereunder at a rate equal to 0.50% per annum. Vanguard also pays customary letter of credit fees under this facility. Vanguard makes quarterly principal payments equal to one-fourth of one percent of the outstanding principal balance of the 2005 term loan facility and will continue to make such payments until maturity of the term debt.

Vanguard is subject to certain restrictive and financial covenants under the credit agreement governing the 2005 term loan facility and the revolving credit facility including a total leverage ratio, senior leverage ratio, interest coverage ratio and capital expenditure restrictions. Vanguard was in compliance with each of these financial covenants as of June 30, 2009. Obligations under the credit agreement are unconditionally guaranteed by Vanguard and Vanguard Health Holding Company I, LLC ("VHS Holdco I") and, subject to certain exceptions, each of VHS Holdco I's wholly-owned domestic subsidiaries (the "U.S. Guarantors"). Obligations under the credit agreement are also secured by substantially all of the assets of Vanguard Health Holding Company II, LLC ("VHS Holdco II") and the U.S. Guarantors including a pledge of 100% of the membership interests of VHS Holdco II, 100% of the capital stock of substantially all U.S. Guarantors (other than VHS Holdco I) and 65% of the capital stock of each of VHS Holdco II's non-U.S. subsidiaries that are directly owned by VHS Holdco II or one of the U.S. Guarantors and a security interest in substantially all tangible and intangible assets of VHS Holdco II and each U.S. Guarantor.

Interest Rate Swap Agreement

In March 2009, Vanguard and Bank of America N.A. ("the counterparty") executed an amended swap agreement with the same terms and provisions as the original agreement except that after March 31, 2009, Vanguard will make or receive net interest payments based upon the difference between the 30-day LIBOR rate and the swap fixed interest rate of 2.5775% (see Note 4). Given the turbulence in the credit markets and the attractive swap rates then available, Vanguard amended the swap agreement to hedge its cash flows related to a portion of the 2005 term loan facility against potential market fluctuations to the variable 30-day LIBOR interest rate. Vanguard will continue to make its normal quarterly interest payments under the 2005 term loan facility as described above. Vanguard deems the counterparty to be creditworthy. As of June 30, 2009, the estimated fair value of the interest rate swap

was a liability for Vanguard of approximately $6.9 million ($4.3 million net of taxes of $2.6 million), which is included in other accrued expenses and current liabilities and accumulated other comprehensive income on the accompanying balance sheet. Vanguard will make quarterly adjustments to other comprehensive income (loss) equal to the change in the fair value of the swap from quarter to quarter until the maturity of the swap on March 31, 2010 with any ineffectiveness included immediately in earnings.

Future Maturities

Future maturities of Vanguard's debt as of June 30, 2009 follow (in millions).

Fiscal Year	Amount
2010	$ 8.0
2011	7.9
2012	750.5
2013	–
2014	–
Thereafter	791.0
	$ 1,557.4

Other Information

Vanguard conducts substantially all of its business through its subsidiaries. Most of Vanguard's subsidiaries jointly and severally guarantee the 9.0% Notes on an unsecured senior subordinated basis. Certain of Vanguard's other consolidated wholly-owned and non wholly-owned entities do not guarantee the 9.0% Notes in conformity with the provisions of the indenture governing the 9.0% Notes and do not guarantee Vanguard's 2005 term loan facility in conformity with the provisions thereof. The condensed consolidating financial information for the parent company, the issuers of the 9.0% Notes, the issuers of the 11.25% Notes, the guarantor subsidiaries, the combined non-guarantor subsidiaries, certain eliminations and consolidated Vanguard as of June 30, 2008 and 2009, and for the years ended June 30, 2007, 2008 and 2009, follows.

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING BALANCE SHEETS
June 30, 2008

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
ASSETS							
Current assets:							
Cash and cash equivalents	$ –	$ –	$ –	$ 82.0	$ 59.6	$ –	$ 141.6
Restricted cash	–	–	–	0.3	1.8	–	2.1
Marketable securities	–	–	–	–	26.3	–	26.3
Accounts receivable, net	–	–	–	275.7	24.7	–	300.4
Inventories	–	–	–	44.3	4.9	–	49.2
Prepaid expenses and other current assets	0.1	–	–	62.5	20.0	(2.3)	80.3
Total current assets	0.1	–	–	464.8	137.3	(2.3)	599.9
Property, plant and equipment, net	–	–	–	1,106.4	67.6	–	1,174.0
Goodwill	–	–	–	605.6	83.6	–	689.2
Intangible assets, net	–	24.5	3.2	12.9	20.8	–	61.4
Investments in consolidated subsidiaries	608.8	–	–	–	16.7	(625.5)	–
Other assets	–	–	–	57.6	0.2	–	57.8
Total assets	$ 608.9	$ 24.5	$ 3.2	$ 2,247.3	$ 326.2	$ (627.8)	$ 2,582.3
LIABILITIES AND STOCKHOLDERS' EQUITY							
Current liabilities:							
Accounts payable	$ –	$ –	$ –	$ 137.2	$ 17.9	$ –	$ 155.1
Accrued expenses and other current liabilities	–	13.2	–	132.9	72.9	–	219.0
Current maturities of long-term debt	–	8.0	–	(0.2)	0.2	–	8.0
Total current liabilities	–	21.2	–	269.9	91.0	–	382.1
Other liabilities	–	–	–	70.6	38.7	(3.2)	106.1
Long-term debt, less current maturities	–	1,341.1	188.4	–	–	–	1,529.5
Intercompany	44.3	(900.0)	(120.8)	1,373.9	(51.9)	(345.5)	–
Stockholders' equity	564.6	(437.8)	(64.4)	532.9	248.4	(279.1)	564.6
Total liabilities and stockholders' equity	$ 608.9	$ 24.5	$ 3.2	$ 2,247.3	$ 326.2	$ (627.8)	$ 2,582.3

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING BALANCE SHEETS
June 30, 2009

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
ASSETS							
Current assets:							
Cash and cash equivalents	$ –	$ –	$ –	$ 168.3	$ 139.9	$ –	$ 308.2
Restricted cash	–	–	–	0.2	1.7	–	1.9
Accounts receivable, net	–	–	–	257.0	18.3	–	275.3
Inventories	–	–	–	44.5	3.8	–	48.3
Prepaid expenses and other current assets	2.5	–	–	94.9	34.6	(34.0)	98.0
Total current assets	2.5	–	–	564.9	198.3	(34.0)	731.7
Property, plant and equipment, net	–	–	–	1,114.7	59.4	–	1,174.1
Goodwill	–	–	–	608.5	83.6	–	692.1
Intangible assets, net	–	19.4	2.9	13.5	18.8	–	54.6
Investments in consolidated subsidiaries	608.8	–	–	–	24.5	(633.3)	–
Investments in auction rate securities	–	–	–	–	21.6	–	21.6
Other assets	–	–	–	56.8	0.2	–	57.0
Total assets	$ 611.3	$ 19.4	$ 2.9	$ 2,358.4	$ 406.4	$ (667.3)	$ 2,731.1
LIABILITIES AND STOCKHOLDERS' EQUITY							
Current liabilities:							
Accounts payable	$ –	$ –	$ –	$ 112.7	$ 15.2	$ –	$ 127.9
Accrued expenses and other current liabilities	–	20.0	–	201.9	122.3	–	344.2
Current maturities of long-term debt	–	8.0	–	(0.2)	0.2	–	8.0
Total current liabilities	–	28.0	–	314.4	137.7	–	480.1
Other liabilities	–	–	–	79.9	73.7	(34.0)	119.6
Long-term debt, less current maturities	–	1,333.4	210.2	–	–	–	1,543.6
Intercompany	23.5	(810.4)	(120.9)	1,306.8	(60.1)	(338.9)	–
Stockholders' equity	587.8	(531.6)	(86.4)	657.3	255.1	(294.4)	587.8
Total liabilities and stockholders' equity	$ 611.3	$ 19.4	$ 2.9	$ 2,358.4	$ 406.4	$ (667.3)	$ 2,731.1

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF OPERATIONS
For the year ended June 30, 2007

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Patient service revenues	$ –	$ –	$ –	$ 2,053.9	$ 150.9	$ (25.5)	$ 2,179.3
Premium revenues	–	–	–	56.5	345.3	(0.4)	401.4
Total revenues	–	–	–	2,110.4	496.2	(25.9)	2,580.7
Salaries and benefits	1.2	–	–	986.6	80.1	–	1,067.9
Supplies	–	–	–	394.1	27.7	–	421.8
Health plan claims expense	–	–	–	35.6	286.9	(25.5)	297.0
Purchased services	–	–	–	126.6	14.6	–	141.2
Provision for doubtful accounts	–	–	–	169.2	6.0	–	175.2
Other operating expenses	0.2	–	–	171.2	25.4	(0.4)	196.4
Rents and leases	–	–	–	30.8	6.6	–	37.4
Depreciation and amortization	–	–	–	104.1	14.5	–	118.6
Interest, net	–	119.5	17.7	(8.2)	(5.2)	–	123.8
Management fees	–	–	–	(8.2)	8.2	–	–
Impairment loss	–	–	–	120.1	3.7	–	123.8
Other	–	–	–	2.8	–	–	2.8
Total costs and expenses	1.4	119.5	17.7	2,124.7	468.5	(25.9)	2,705.9
Income (loss) from continuing operations before income taxes	(1.4)	(119.5)	(17.7)	(14.3)	27.7	–	(125.2)
Income tax expense (benefit)	(11.6)	–	–	–	2.1	(2.1)	(11.6)
Equity in earnings of subsidiaries	(142.9)	–	–	–	–	142.9	–
Income (loss) from continuing operations	(132.7)	(119.5)	(17.7)	(14.3)	25.6	145.0	(113.6)
Loss from discontinued operations, net of taxes	–	–	–	(6.0)	(13.1)	–	(19.1)
Net income (loss)	$ (132.7)	$ (119.5)	$ (17.7)	$ (20.3)	$ 12.5	$ 145.0	$ (132.7)

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF OPERATIONS
For the year ended June 30, 2008

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Patient service revenues	$ –	$ –	$ –	$ 2,212.2	$ 150.8	$ (22.5)	$ 2,340.5
Premium revenues	–	–	–	57.7	392.7	(0.2)	450.2
Total revenues	–	–	–	2,269.9	543.5	(22.7)	2,790.7
Salaries and benefits	2.5	–	–	1,068.7	81.5	–	1,152.7
Supplies	–	–	–	405.8	28.7	–	434.5
Health plan claims expense	–	–	–	35.8	314.9	(22.5)	328.2
Purchased services	–	–	–	136.5	13.0	–	149.5
Provision for doubtful accounts	–	–	–	196.9	8.7	–	205.6
Other operating expenses	0.2	–	–	182.4	32.1	(0.2)	214.5
Rents and leases	–	–	–	34.8	7.0	–	41.8
Depreciation and amortization	–	–	–	116.8	14.2	–	131.0
Interest, net	–	109.9	19.8	(9.3)	1.7	–	122.1
Management fees	–	–	–	(8.2)	8.2	–	–
Other	–	–	–	63.5	(54.0)	–	9.5
Total costs and expenses	2.7	109.9	19.8	2,223.7	456.0	(22.7)	2,789.4
Income (loss) from continuing operations before income taxes	(2.7)	(109.9)	(19.8)	46.2	87.5	–	1.3
Income tax expense (benefit)	1.7	–	–	–	13.4	(13.4)	1.7
Equity in earnings of subsidiaries	3.7	–	–	–	–	(3.7)	–
Income (loss) from continuing operations	(0.7)	(109.9)	(19.8)	46.2	74.1	9.7	(0.4)
Income (loss) from discontinued operations, net of taxes	–	–	–	2.9	(3.2)	–	(0.3)
Net income (loss)	$ (0.7)	$ (109.9)	$ (19.8)	$ 49.1	$ 70.9	$ 9.7	$ (0.7)

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF OPERATIONS
For the year ended June 30, 2009

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Patient service revenues	$ –	$ –	$ –	$ 2,373.8	$ 171.2	$ (23.3)	$ 2,521.7
Premium revenues	–	–	–	60.2	618.0	(0.2)	678.0
Total revenues	–	–	–	2,434.0	789.2	(23.5)	3,199.7
Salaries and benefits	4.4	–	–	1,144.7	91.0	–	1,240.1
Supplies	–	–	–	423.7	32.6	–	456.3
Health plan claims expense	–	–	–	34.8	514.1	(23.3)	525.6
Purchased services	–	–	–	152.7	14.7	–	167.4
Provision for doubtful accounts	–	–	–	200.7	10.1	–	210.8
Other operating expenses	0.2	–	–	201.3	56.7	(0.2)	258.0
Rents and leases	–	–	–	36.5	7.0	–	43.5
Depreciation and amortization	–	–	–	116.4	14.2	–	130.6
Interest, net	–	93.8	22.1	(6.7)	2.4	–	111.6
Management fees	–	–	–	(14.1)	14.1	–	–
Impairment loss	–	–	–	6.2	–	–	6.2
Other	–	–	–	5.9	–	–	5.9
Total costs and expenses	4.6	93.8	22.1	2,302.1	756.9	(23.5)	3,156.0
Income (loss) from continuing operations before income taxes	(4.6)	(93.8)	(22.1)	131.9	32.3	–	43.7
Income tax expense (benefit)	16.0	–	–	–	9.4	(9.4)	16.0
Equity in earnings of subsidiaries	49.2	–	–	–	–	(49.2)	–
Income (loss) from continuing operations	28.6	(93.8)	(22.1)	131.9	22.9	(39.8)	27.7
Income from discontinued operations, net of taxes	–	–	–	0.6	0.3	–	0.9
Net income (loss)	$ 28.6	$ (93.8)	$ (22.1)	$ 132.5	$ 23.2	$ (39.8)	$ 28.6

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS
For the year ended June 30, 2007

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Operating activities:							
Net income (loss)	$ (132.7)	$ (119.5)	$ (17.7)	$ (20.3)	$ 12.5	$ 145.0	$ (132.7)
Adjustments to reconcile net income (loss) to net cash provided by (used in) operating activities							
Loss from discontinued operations	–	–	–	6.0	13.1	–	19.1
Depreciation and amortization	–	–	–	104.1	14.5	–	118.6
Provision for doubtful accounts	–	–	–	169.2	6.0	–	175.2
Deferred income taxes	(12.7)	–	–	–	–	–	(12.7)
Amortization of loan costs	–	4.3	0.2	–	–	–	4.5
Accretion of principal on senior discount notes	–	–	17.5	–	–	–	17.5
Gain on disposal of assets	–	–	–	(4.1)	–	–	(4.1)
Stock compensation	1.2	–	–	–	–	–	1.2
Impairment loss	–	–	–	120.1	3.7	–	123.8
Changes in operating assets and liabilities, net of effects of acquisitions:							
Equity in earnings of subsidiaries	142.9	–	–	–	–	(142.9)	–
Accounts receivable	–	–	–	(206.9)	2.9	–	(204.0)
Inventories	–	–	–	(2.9)	1.0	–	(1.9)
Prepaid expenses and other current assets	–	–	–	(28.5)	(1.5)	–	(30.0)
Accounts payable	–	–	–	11.2	(3.8)	–	7.4
Accrued expenses and other liabilities	1.3	0.1	–	61.3	(22.8)	(2.1)	37.8
Net cash provided by (used in) operating activities – continuing operations	–	(115.1)	–	209.2	25.6	–	119.7
Net cash provided by operating activities - discontinued operations	–	–	–	0.5	3.1	–	3.6
Net cash provided by (used in) operating activities	–	(115.1)	–	209.7	28.7	–	123.3
Investing activities:							
Acquisitions	–	–	–	(0.2)	–	–	(0.2)
Capital expenditures	–	–	–	(153.3)	(11.0)	–	(164.3)
Proceeds from asset dispositions	–	–	–	9.5	–	–	9.5
Purchases of short-term investments	–	–	–	–	(120.0)	–	(120.0)
Sales of short-term investments	–	–	–	–	120.0	–	120.0
Other	–	–	–	1.8	0.2	–	2.0
Net cash used in investing activities-continuing operations	–	–	–	(142.2)	(10.8)	–	(153.0)
Net cash provided by (used in) operating activities – discontinued operations	–	–	–	36.3	(1.8)	–	34.5
Net cash used in investing activities	–	–	–	(105.9)	(12.6)	–	(118.5)

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS
For the year ended June 30, 2007
(continued)

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Financing activities:							
Payments of long-term debt	–	(7.9)	–	–	(0.1)	–	(8.0)
Payments to retire stock, equity incentive units and stock options	–	–	–	(0.5)	–	–	(0.5)
Cash provided by (used in) intercompany activity	–	123.0	–	(130.3)	7.3	–	–
Exercise of stock options	–	–	–	0.2	–	–	0.2
Net cash provided by (used in) financing activities	–	115.1	–	(130.6)	7.2	–	(8.3)
Net increase (decrease) in cash and cash equivalents	–	–	–	(26.8)	23.3	–	(3.5)
Cash and cash equivalents, beginning of period	–	–	–	38.5	85.1	–	123.6
Cash and cash equivalents, end of period	$ –	$ –	$ –	$ 11.7	$ 108.4	$ –	$ 120.1

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS
For the year ended June 30, 2008

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Operating activities:							
Net income (loss)	$ (0.7)	$ (109.9)	$ (19.8)	$ 49.1	$ 70.9	$ 9.7	$ (0.7)
Adjustments to reconcile net income (loss) to net cash provided by (used in) operating activities							
Loss (income) from discontinued operations	–	–	–	(2.9)	3.2	–	0.3
Depreciation and amortization	–	–	–	116.8	14.2	–	131.0
Provision for doubtful accounts	–	–	–	196.9	8.7	–	205.6
Deferred income taxes	(2.2)	–	–	–	–	–	(2.2)
Amortization of loan costs	–	4.6	0.3	–	–	–	4.9
Accretion of principal on senior discount notes	–	–	19.5	–	–	–	19.5
Loss on disposal of assets	–	–	–	0.9	–	–	0.9
Stock compensation	2.5	–	–	–	–	–	2.5
Changes in operating assets and liabilities, net of effects of acquisitions:							
Equity in earnings of subsidiaries	(3.7)	–	–	–	–	3.7	–
Accounts receivable	–	–	–	(217.5)	(6.1)	–	(223.6)
Inventories	–	–	–	(4.3)	0.2	–	(4.1)
Prepaid expenses and other current assets	(4.5)	–	–	(17.6)	2.4	–	(19.7)
Accounts payable	–	–	–	5.6	6.6	–	12.2
Accrued expenses and other liabilities	4.9	(0.2)	–	75.3	(21.6)	(13.4)	45.0
Net cash provided by (used in) operating activities – continuing operations	(3.7)	(105.5)	–	202.3	78.5	–	171.6
Net cash provided by operating activities – discontinued operations	–	–	–	0.2	1.3	–	1.5
Net cash provided by (used in) operating activities	(3.7)	(105.5)	–	202.5	79.8	–	173.1
Investing activities:							
Acquisitions	–	–	–	(0.2)	–	–	(0.2)
Capital expenditures	–	–	–	(118.1)	(3.5)	–	(121.6)
Purchases of marketable securities	–	–	–	–	(90.0)	–	(90.0)
Sales of marketable securities	–	–	–	–	63.7	–	63.7
Other	–	–	–	–	1.5	–	1.5
Net cash used in investing activities – continuing operations	–	–	–	(118.3)	(28.3)	–	(146.6)
Net cash provided by (used in) operating activities – discontinued operations	–	–	–	3.1	(0.3)	–	2.8
Net cash used in investing activities	–	–	–	(115.2)	(28.6)	–	(143.8)

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS
For the year ended June 30, 2008
(continued)

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Financing activities:							
Payments of long-term debt	–	(7.8)	–	–	–	–	(7.8)
Payments to retire stock, equity incentive units and stock options	–	–	–	(0.2)	–	–	(0.2)
Cash provided by (used in) intercompany activity	3.7	113.3	–	(17.0)	(100.0)	–	–
Exercise of stock options	–	–	–	0.2	–	–	0.2
Net cash provided by (used in) financing activities	3.7	105.5	–	(17.0)	(100.0)	–	(7.8)
Net increase (decrease) in cash and cash equivalents	–	–	–	70.3	(48.8)	–	21.5
Cash and cash equivalents, beginning of period	–	–	–	11.7	108.4	–	120.1
Cash and cash equivalents, end of period	$ –	$ –	$ –	$ 82.0	$ 59.6	$ –	$ 141.6

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS
For the year ended June 30, 2009

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Operating activities:							
Net income (loss)	$ 28.6	$ (93.8)	$ (22.1)	$ 132.5	$ 23.2	$ (39.8)	$ 28.6
Adjustments to reconcile net income (loss) to net cash provided by (used in) operating activities							
Income from discontinued operations	–	–	–	(0.6)	(0.3)	–	(0.9)
Depreciation and amortization	–	–	–	116.4	14.2	–	130.6
Provision for doubtful accounts	–	–	–	200.7	10.1	–	210.8
Deferred income taxes	5.6	–	–	–	–	–	5.6
Amortization of loan costs	–	5.1	0.3	–	–	–	5.4
Accretion of principal on senior discount notes	–	–	21.8	–	–	–	21.8
Gain on disposal of assets	–	–	–	(2.3)	–	–	(2.3)
Stock compensation	4.4	–	–	–	–	–	4.4
Impairment loss	–	–	–	6.2	–	–	6.2
Realized holding loss on investments	–	–	–	–	0.6	–	0.6
Changes in operating assets and liabilities, net of effects of acquisitions:							
Equity in earnings of subsidiaries	(49.2)	–	–	–	–	49.2	–
Accounts receivable	–	–	–	(182.2)	(3.0)	–	(185.2)
Inventories	–	–	–	0.8	0.2	–	1.0
Prepaid expenses and other current assets	–	–	–	7.6	(20.6)	–	(13.0)
Accounts payable	–	–	–	(24.6)	(2.7)	–	(27.3)
Accrued expenses and other liabilities	10.6	6.8	–	29.6	83.4	(9.4)	121.0
Net cash provided by (used in) operating activities – continuing operations	–	(81.9)	–	284.1	105.1	–	307.3
Net cash provided by operating activities – discontinued operations	–	–	–	0.6	0.3	–	0.9
Net cash provided by (used in) operating activities	–	(81.9)	–	284.7	105.4	–	308.2
Investing activities:							
Acquisitions	–	–	–	(4.4)	–	–	(4.4)
Capital expenditures	–	–	–	(122.3)	(9.8)	–	(132.1)
Proceeds from asset dispositions	–	–	–	4.9	–	–	4.9
Other	–	–	–	(1.7)	(0.3)	–	(2.0)
Net cash used in investing activities	–	–	–	(123.5)	(10.1)	–	(133.6)

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS
For the year ended June 30, 2009
(continued)

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Financing activities:							
Payments of long-term debt	–	(7.8)	–	–	–	–	(7.8)
Payments to retire stock, equity incentive units and stock options	–	–	–	(0.2)	–	–	(0.2)
Cash provided by (used in) intercompany activity	–	89.7	–	(74.7)	(15.0)	–	–
Net cash provided by (used in) financing activities	–	81.9	–	(74.9)	(15.0)	–	(8.0)
Net increase in cash and cash equivalents	–	–	–	86.3	80.3	–	166.6
Cash and cash equivalents, beginning of period	–	–	–	82.0	59.6	–	141.6
Cash and cash equivalents, end of period	$ –	$ –	$ –	$ 168.3	$ 139.9	$ –	$ 308.2

10. Income Taxes

Significant components of income tax expense/benefit attributable to continuing operations are as follows (in millions):

	2007	2008	2009
Current:			
Federal	$ 0.9	$ 1.5	$ 8.2
State	0.1	2.4	2.2
	1.0	3.9	10.4
Deferred:			
Federal	(13.7)	(1.2)	7.9
State	(4.8)	(8.6)	(1.0)
	(18.5)	(9.8)	6.9
Change in valuation allowance	5.9	7.6	(1.3)
Total	$ (11.6)	$ 1.7	$ 16.0

The following table presents the income taxes associated with continuing operations and discontinued operations as reflected in the accompanying consolidated statements of operations (in millions).

	2007	2008	2009
Continuing operations	$ (11.6)	$ 1.7	$ 16.0
Discontinued operations	(9.5)	(0.2)	0.6
Total	$ (21.1)	$ 1.5	$ 16.6

The increases in the valuation allowance during all three years presented result from state net operating loss carryforwards that may not ultimately be utilized because of the uncertainty regarding Vanguard's ability to generate taxable income in certain states. The effective income tax rate differed from the federal statutory rate for the years ended June 30, 2007, 2008 and 2009 as follows:

	2007	2008	2009
Income tax expense at federal statutory rate	35.0%	35.0%	35.0%
Income tax expense at state statutory rate	3.6	(564.6)	0.9
Nondeductible expenses and other	(0.6)	44.0	3.6
Change in valuation allowance	(4.7)	616.4	(2.9)
Nondeductible impairment loss	(24.0)	–	–
Effective income tax rate	9.3%	130.8%	36.6%

Deferred income taxes reflect the net tax effects of temporary differences between the carrying amounts of assets and liabilities for financial reporting purposes and the amounts used for income tax purposes. Significant components of Vanguard's deferred tax assets and liabilities as of June 30, 2008 and 2009, were as follows (in millions):

	2008	2009
Deferred tax assets:		
Net operating loss carryover	$ 69.7	$ 33.7
Excess tax basis over book basis of accounts receivable	8.2	10.2
Accrued expenses and other	24.7	42.2
Deferred loan costs	2.3	1.4
Professional and general liabilities reserves	16.4	21.6
Health plan claims, workers compensation and employee health reserves	9.4	13.7
Alternative minimum tax credit and other credits	3.4	–
Deferred interest expense	–	30.9
Total deferred tax assets	134.1	153.7
Valuation allowance	(29.9)	(28.6)
Total deferred tax assets, net of valuation allowance	104.2	125.1
Deferred tax liabilities:		
Depreciation, amortization and fixed assets basis differences	29.3	33.1
Excess book basis over tax basis of prepaid assets and other	8.0	24.4
Total deferred tax liabilities	37.3	57.5
Net deferred tax assets and liabilities	$ 66.9	$ 67.6

Net non-current deferred tax assets of $42.4 million and $38.0 million as of June 30, 2008 and 2009, respectively, are included in the accompanying consolidated balance sheets in other assets. Net current deferred tax assets were $24.5 million and $29.6 million as of June 30, 2008 and 2009, respectively.

As of June 30, 2009, Vanguard had generated net operating loss ("NOL") carryforwards for federal income tax purposes and state income tax purposes of approximately $9.0 million and $560.0 million, respectively. The significant decrease in the federal income tax NOL carryforward from $107.0 million as of June 30, 2008 to $9.0 million as of June 30, 2009 and the related $30.9 million deferred tax asset recognized during fiscal 2009 is primarily due to certain interest deductions that Vanguard determined will not be deductible until paid. The federal and state NOL carryforwards expire from 2020 to 2027 and 2010 to 2028, respectively. Approximately $2.5 million of these NOLs are subject to annual limitations for federal purposes. These limitations are not expected to significantly affect Vanguard's ability to ultimately recognize the benefit of these NOLs in future years.

Accounting for Uncertainty in Income Taxes

Effective July 1, 2007, Vanguard adopted the provisions of FIN 48. In connection with the adoption of FIN 48, Vanguard recorded a $0.4 million net liability for unrecognized tax benefits, accrued interest and penalties.

The table below summarizes the total changes in unrecognized tax benefits during the years ended June 30, 2008 and 2009 (in millions).

Balance at July 1, 2007	$	0.4
Additions based on tax positions related to the current year		–
Additions for tax positions of prior years		0.2
Reductions for tax positions of prior years		–
Settlements		–
Balance at June 30, 2008	$	0.6
Additions based on tax positions related to the current year		–
Additions for tax positions of prior years		2.9
Reductions for tax positions of prior years		(0.3)
Settlements		–
Balance at June 30, 2009	$	3.2

The $3.2 million balance as of June 30, 2009 of unrecognized tax benefits would impact the effective tax rate if recognized.

The provisions of FIN 48 allow for the classification of interest on an underpayment of income taxes, when the tax law required interest to be paid, and penalties, when a tax position does not meet the minimum statutory threshold to avoid payment of penalties, in income taxes, interest expense or another appropriate expense classification based on the accounting policy election of the company. Vanguard has elected to classify interest and penalties related to the unrecognized tax benefits as a component of income tax expense. During the years ended June 30, 2008 and 2009, Vanguard recognized approximately $20,000 and $40,000, respectively, of such interest and penalties.

$2.6 million of the current year increase in the FIN 48 liability was formerly accounted for as a reduction in Vanguard's net operating loss carryforward deferred tax asset. This amount is now accounted for as a tax liability due to Vanguard utilizing its federal net operating loss carryforward during the period.

Vanguard's U.S. federal income tax returns for tax years 2005 and beyond remain subject to examination by the Internal Revenue Service.

11. Stockholders' Equity

Vanguard has the authority to issue 1,000,000 shares of common stock, par value $.01 per share.

Common Stock of Vanguard and Class A Membership Units of Holdings

In connection with the Blackstone merger, Blackstone, Morgan Stanley Capital Partners and its affiliates (collectively, "MSCP"), management and other investors purchased $624.0 million of Class A Membership Units of Holdings. Holdings then invested the $624.0 million in the common stock of Vanguard, and in addition Blackstone invested $125.0 million directly in the common stock of Vanguard. In February 2005, other investors purchased approximately $0.6 million of Class A membership units of Holdings. Holdings then invested the $0.6 million in the common stock of Vanguard.

Equity Incentive Membership Units of Holdings

In connection with the Blackstone merger, certain members of senior management purchased Class B, Class C and Class D membership units in Holdings (collectively the "equity incentive units") for approximately $5.7 million pursuant to the Amended and Restated Limited Liability Company Operating Agreement of Holdings dated September 23, 2004 ("LLC Agreement"). Vanguard determined the value of the equity incentive units by utilizing appraisal information. The Class B and D units vest 20% on each of the first five anniversaries of the purchase date, while the Class C units vest on the eighth anniversary of the purchase date subject to accelerated vesting upon the

occurrence of a sale by Blackstone of at least 25% of its Class A units at a price per unit exceeding 2.5 times the per unit price paid on September 23, 2004. Upon a change of control (as defined in the LLC Agreement), all Class B and D units fully vest, and Class C units fully vest if the change in control constitutes a liquidity event (as defined in the LLC Agreement). In exchange for a cash payment of $5.7 million, Vanguard issued to Holdings 83,890 warrants with an exercise price of $1,000 per share and 35,952 warrants with an exercise price of $3,000 per share to purchase Vanguard's common stock. The warrants may be exercised at any time. Vanguard reserved 119,842 shares of its common stock to be issued upon exercise of the warrants.

During the years ended June 30, 2007, 2008 and 2009, Vanguard and Holdings repurchased a total of 7,491 outstanding equity incentive units from former executive officers for approximately $0.4 million. The purchase price for unvested units was based upon the lower of cost or fair market value (determined by an independent appraisal) or the lower of cost or fair market value less a 25% discount, as set forth in the LLC Agreement. The purchase price for vested units was fair market value or fair market value less a 25% discount.

Put and Call Features of Acquisition Subsidiary Stock

For a period of 30 days commencing June 1, 2007 and each June 1 thereafter, University of Chicago Hospitals ("UCH") has the right to require Vanguard to purchase its shares in the subsidiary that acquired Louis A. Weiss Memorial Hospital for a purchase price equal to four times the acquisition subsidiary's Adjusted EBITDA (as defined in the shareholders agreement between the parties) for the most recent 12 months of operations less all indebtedness of the acquisition subsidiary (including capital leases) at such time, multiplied by UCH's percentage interest in the acquisition subsidiary on the date of purchase. Similarly, during the same 30-day periods, Vanguard has the right to require UCH to sell to it UCH's shares in the acquisition subsidiary for a purchase price equal to the greater of (i) six times the acquisition subsidiary's Adjusted EBITDA (as defined in the shareholders agreement among the parties) for the most recent 12 months of operations less all indebtedness of the acquisition subsidiary (including capital leases) at such time, times UCH's percentage interest in the acquisition subsidiary on the date of purchase, and (ii) the price paid by UCH for its interest in the acquisition subsidiary minus dividends or other distributions to UCH in respect of that interest.

12. Comprehensive Income (Loss)

Comprehensive income consists of two components: net income (loss) and other comprehensive income (loss). Other comprehensive income refers to revenues, expenses, gains and losses that under SFAS 130, *Reporting Comprehensive Income,* are recorded as an element of stockholders' equity but are excluded from net income. The following table presents the components of comprehensive income (loss) for the years ended June 30, 2007, 2008 and 2009 (in millions).

	June 30, 2007	June 30 2008	June 30 2009
Net income (loss)	$ (132.7)	$ (0.7)	$ 28.6
Change in fair value of interest rate swap	–	4.6	(11.5)
Change in unrealized holding losses on auction rate securities	–	–	(4.1)
Change in income tax (expense) benefit	–	(1.8)	6.0
Comprehensive income (loss)	$ (132.7)	$ 2.1	$ 19.0

The components of accumulated other comprehensive income (loss) as of June 30, 2008 and June 30, 2009 are as follows (in millions).

	June 30, 2008	June 30, 2009
Fair value of interest rate swap	$ 4.6	$ (6.9)
Unrealized holding loss on investments in auction rate securities	–	(4.1)
Income tax (expense) benefit	(1.8)	4.2
Accumulated other comprehensive income (loss)	$ 2.8	$ (6.8)

13. Stock Based Compensation

As previously discussed, Vanguard used the minimum value pricing model permitted under SFAS 123 to determine stock compensation costs related to stock option grants prior to July 1, 2006. On July 1, 2006, Vanguard adopted the provisions of SFAS 123(R), to account for stock option grants subsequent to July 1, 2006. Vanguard adopted SFAS 123(R) on a prospective basis as required for companies that chose to adopt SFAS 123 using the transition guidance set forth in SFAS 148. During fiscal years 2007, 2008 and 2009, Vanguard incurred stock compensation of $1.2 million and $2.5 million and $4.4 million, respectively, related to grants under its 2004 Stock Incentive Plan.

2004 Stock Incentive Plan

After the Blackstone merger, Vanguard adopted the 2004 Stock Incentive Plan ("the 2004 Option Plan"). As of June 30, 2009, the 2004 Option Plan, as amended, allows for the issuance of up to 105,611 options to purchase common stock of Vanguard to its employees, members of its Board of Directors or other service providers of Vanguard or any of its affiliates. The stock options may be granted as Liquidity Event Options, Time Options or Performance Options at the discretion of the Board. The Liquidity Event Options vest 100% at the eighth anniversary of the date of grant and have an exercise price per share as determined by the Board or a committee thereof. The Time Options vest 20% at each of the first five anniversaries of the date of grant and have an exercise price per share as determined by the Board or a committee thereof. The Performance Options vest 20% at each of the first five anniversaries of the date of grant and have an exercise price equal to $3,000 per share or as determined by the Board. The Time Options and Performance Options immediately vest upon a change of control, while the Liquidity Event Options immediately vest only upon a qualifying Liquidity Event, as defined in the Plan Document. As of June 30, 2009, 102,455 options were outstanding under the 2004 Option Plan, as amended.

The following tables summarize options transactions during the years ended June 30, 2007, 2008 and 2009.

	2004 Stock Incentive Plan	
	# of Options	Wtd Avg Exercise Price
Options outstanding at June 30, 2006	70,657	$ 1,644.12
Options granted	10,110	1,715.06
Options exercised	(195)	1,000.00
Options cancelled	(14,998)	1,624.81
Options outstanding at June 30, 2007	65,574	1,661.39
Options granted	30,583	1,611.90
Options exercised	(168)	1,038.49
Options cancelled	(7,291)	1,667.85
Options outstanding at June 30, 2008	88,698	1,644.97
Options granted	17,341	1,634.36
Options exercised	-	-
Options cancelled	(3,584)	1,648.93
Options outstanding at June 30, 2009	102,455	$ 1,643.04
Options available for grant at June 30, 2009	2,652	$ 1,640.19
Options exercisable at June 30, 2009	27,436	$ 1,960.02

The following table provides information relating to the 2004 Option Plan during each period presented.

	Year ended June 30,		
	2007	2008	2009
Weighted average fair value of options granted during each year	$ 590.70	$ 408.59	$ 315.20
Intrinsic value of options exercised during each year (in millions)	$ 0.1	$ 0.1	$ -
Fair value of outstanding options that vested during each year (in millions)	$ 1.0	$ 1.2	$ 1.6

The following table sets forth certain information regarding vested options at June 30, 2009, options expected to vest subsequent to June 30, 2009 and the total options expected to vest over the life of all options granted.

	Currently Vested	Additional Expected to Vest	Total Expected to Vest
Number of options at June 30, 2009	27,436	54,584	82,020
Weighted average exercise price	$ 1,960.02	$ 1,192.32	$ 1,449.12
Aggregate intrinsic value at June 30, 2009 (in millions)	$ 5.9	$ 13.4	$ 19.2
Weighted average remaining contractual term	6.43 years	7.5 years	7.1 years

14. Defined Contribution Plan

Effective June 1, 1998, Vanguard adopted its defined contribution employee benefit plan, the Vanguard 401(k) Retirement Savings Plan (the "401(k) Plan"). The 401(k) Plan is a multiple employer defined contribution plan whereby employees who are age 21 or older are eligible to participate.

The 401(k) Plan allows eligible employees to make contributions of 2% to 20% of their annual compensation. Employer matching contributions, which vary by employer, vest 20% after two years of service and continue vesting at 20% per year until fully vested. For purposes of determining vesting percentages in the 401(k) Plan, many employees received credit for years of service with their respective predecessor companies. Vanguard's matching

expense for the years ended June 30, 2007, 2008 and 2009 was approximately $13.8 million, $14.5 million and $15.7 million, respectively.

15. Leases

Vanguard leases certain real estate properties and equipment under operating leases having various expiration dates. Future minimum operating lease payments under non-cancelable leases for each fiscal year presented below are approximately as follows (in millions).

	Operating Leases
2010	$ 30.4
2011	25.8
2012	22.3
2013	17.8
2014	14.4
Thereafter	42.3
Total minimum lease payments	$ 153.0

During the years ended June 30, 2007, 2008 and 2009, rent expense was approximately $37.4 million, $41.8 million and $43.5 million, respectively.

16. Contingencies and Healthcare Regulation

Contingencies

Vanguard is presently, and from time to time, subject to various claims and lawsuits arising in the normal course of business. In the opinion of management, the ultimate resolution of these matters is not expected to have a material adverse effect on Vanguard's financial position or results of operations.

Professional and General Liability Insurance

Given the nature of its operating environment, Vanguard is subject to professional and general liability claims and related lawsuits in the ordinary course of business. For professional and general liability claims incurred from June 1, 2002 to May 31, 2006, Vanguard's wholly owned captive subsidiary insured its risks at a $10.0 million retention level. For claims incurred from June 1, 2006 to June 30, 2009, Vanguard self-insured the first $9.0 million per claim, and the captive subsidiary insured the next $1.0 million per claim. Vanguard's captive subsidiary maintains excess coverage from independent third party insurers on a claims-made basis for individual claims exceeding $10.0 million up to $75.0 million, but limited to total annual payments of $65.0 million in the aggregate. In April 2009, a jury awarded damages to the plaintiff in a professional liability case against one of Vanguard's hospitals in the amount of approximately $14.9 million, which exceeded Vanguard's captive subsidiary's $10.0 million self insured limit. Based upon this verdict, Vanguard increased its professional and general liability reserve for the year ended June 30, 2009, by the excess of the verdict amount over its previously established case reserve estimate and recorded a receivable from its captive subsidiary's third party excess carrier for that portion exceeding $10.0 million. Vanguard then reduced this receivable by the additional premium due to the excess carrier under Vanguard's retrospectively rated insurance policy for that particular policy year. Vanguard has appealed this verdict since most of the verdict represented non-economic damages like pain and suffering, but can not predict whether or not the verdict will be reduced upon appeal at this time.

Governmental Regulation

Laws and regulations governing the Medicare, Medicaid and other federal healthcare programs are complex and subject to interpretation. Vanguard's management believes that it is in compliance with all applicable laws and regulations in all material respects. However, compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties, and exclusion from the Medicare, Medicaid and other federal healthcare programs. Vanguard is not aware of any material regulatory proceeding or investigation underway or threatened involving allegations of potential wrongdoing.

Reimbursement

Final determination of amounts earned under prospective payment and cost-reimbursement activities is subject to review by appropriate governmental authorities or their agents. In the opinion of Vanguard's management, adequate provision has been made for any adjustments that may result from such reviews.

Laws and regulations governing the Medicare and Medicaid and other federal healthcare programs are complex and subject to interpretation. Vanguard's management believes that it is in compliance with all applicable laws and regulations in all material respects and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing related to Medicare and Medicaid programs. While no such regulatory inquiries have been made, Vanguard's compliance with such laws and regulations is subject to future government review and interpretation. Non-compliance with such laws and regulations could result in significant regulatory action including fines, penalties, and exclusion from the Medicare, Medicaid and other federal healthcare programs.

Acquisitions

Vanguard has acquired and may continue to acquire businesses with prior operating histories. Acquired companies may have unknown or contingent liabilities, including liabilities for failure to comply with healthcare laws and regulations, such as billing and reimbursement, fraud and abuse and similar anti-referral laws. Although Vanguard institutes policies designed to conform practices to its standards following the completion of its acquisitions, there can be no assurance that it will not become liable for past activities of prior owners that may later be asserted to be improper by private plaintiffs or government agencies. Although Vanguard generally seeks to obtain indemnification from prospective sellers covering such matters, there can be no assurance that any such matter will be covered by indemnification, or if covered, that such indemnification will be adequate to cover potential losses and fines.

Employment-Related Agreements

Effective June 1, 1998, Vanguard executed employment agreements with three of its current senior executive officers. Vanguard executed an employment agreement with a fourth current senior executive officer on September 1, 1999. The employment agreements were amended on September 23, 2004 to extend the term of each employment agreement another 5 years and to provide that the Blackstone merger did not constitute a change of control, as defined in the agreements. On November 15, 2007, Vanguard entered into written employment agreements with two other executive officers for terms expiring on November 15, 2012. The employment agreements will renew automatically for additional one-year periods, unless terminated by Vanguard or the executive officer. The employment agreements provide, among other things, for minimum salary levels, for participation in bonus plans, and for amounts to be paid as liquidated damages in the event of a change in control or termination by Vanguard without cause.

Vanguard has executed severance protection agreements ("severance agreements") between Vanguard and each of its other officers who do not have employment agreements. The severance agreements are automatically extended for successive one year terms at the discretion of Vanguard unless a change in control occurs, as defined in the severance agreement, at which time the severance agreement continues in effect for a period of not less than three years beyond the date of such event. Vanguard may be obligated to pay severance payments as set forth in the severance agreements in the event of a change in control and the termination of the executive's employment of Vanguard.

Guarantees

Physician Guarantees

In the normal course of its business, Vanguard enters into physician relocation agreements under which it guarantees minimum monthly income, revenues or collections or guarantees reimbursement of expenses up to maximum limits to physicians during a specified period of time (typically, 12 months to 24 months). In return for the guarantee payments, the physicians are required to practice in the community for a stated period of time (typically, 3 to 4 years) or else return the guarantee payments to Vanguard. In January 2006, Vanguard adopted Financial Accounting Standards Board Staff Position FIN 45-3, *Application of FASB Interpretation No. 45 to Minimum Revenue Guarantees Granted to a Business or Its Owners* ("FSP 45-3"). FSP 45-3 requires that a liability be recorded at fair value for all guarantees entered into on or after January 1, 2006. Vanguard determines this liability and an offsetting intangible asset by calculating an estimate of expected payments to be made over the guarantee period. Vanguard reduces the liability as it makes guarantee payments and amortizes the intangible asset over the term of the physicians' relocation agreements. Vanguard also estimates the fair value of liabilities and offsetting intangible assets related to payment guarantees for physician service agreements for which no repayment provisions exist. As of June 30, 2009, Vanguard had a net intangible asset of $8.4 million and a remaining liability of $3.0 million related to these physician income and service guarantees. The maximum amount of Vanguard's unpaid physician income and service guarantees under FSP 45-3 as of June 30, 2009 was approximately $5.1 million.

Other Guarantees

As part of its contract with the Arizona Health Care Cost Containment System, one of Vanguard's health plans, Phoenix Health Plan, is required to maintain a performance guarantee, the amount of which is based upon Plan membership and capitation premiums received. As of June 30, 2009, Vanguard maintained this performance guarantee in the form of $40.0 million of surety bonds with independent third party insurers collateralized by letters of credit of approximately $5.0 million. These surety bonds expire on September 30, 2009.

17. Related Party Transactions

Pursuant to the Blackstone merger agreement, Vanguard entered into a transaction and monitoring fee agreement with Blackstone and Metalmark Subadvisor LLC ("Metalmark SA"), which is an affiliate of Metalmark Capital LLC, which has shared voting or investment power in Holdings' units owned by the MSCP Funds. Under the terms of the agreement, Vanguard agreed to pay Blackstone and Metalmark SA an annual monitoring fee of $4.0 million and $1.2 million, respectively, plus out of pocket expenses. The monitoring fee represents compensation to Blackstone and Metalmark SA for their advisory and consulting services with respect to financing transactions, strategic decisions, dispositions or acquisitions of assets and other Vanguard affairs from time to time. Blackstone also has the option under the agreement to elect at any time in anticipation of a change in control or initial public offering to require Vanguard to pay both Blackstone and Metalmark SA a lump sum monitoring fee, calculated as the net present value of future annual monitoring fees assuming a remaining ten-year payment period, in lieu of the remaining annual monitoring fee payments. If Blackstone chooses a lump sum payment, Metalmark SA is entitled to receive not less than 15% of the sum of the initial $20.0 million Blackstone transaction fee and the cumulative monitoring fees and lump sum monitoring fee paid to Blackstone less the cumulative aggregate monitoring fees paid to Metalmark SA to date. During the years ended 2007 and 2009, Vanguard paid $4.0 million and $1.2 million in monitoring fees to Blackstone and Metalmark SA, respectively. During fiscal 2008, Vanguard paid approximately $5.2 million and $1.2 million in monitoring fees and expenses to Blackstone and Metalmark SA, respectively.

Blackstone and Metalmark SA have the ability to control Vanguard's policies and operations, and their interests may not in all cases be aligned with Vanguard's interests. Vanguard also conducts business with other entities controlled by Blackstone or Metalmark SA. Vanguard's results of operations could be materially different as a result of Blackstone and Metalmark SA's control than such results would be if Vanguard were autonomous.

Effective July 1, 2008, Vanguard entered into an Employer Health Program Agreement with Equity Healthcare LLC ("Equity Healthcare"), which is an affiliate of Blackstone. Equity Healthcare negotiates with providers of standard administrative services for health benefit plans as well as other related services for cost discounts and

quality of service monitoring capability by Equity Healthcare. Equity Healthcare receives from Vanguard a fee of $2 per employee per month ("PEPM Fee"). As of June 30, 2009, Vanguard has approximately 11,750 employees enrolled in these health and welfare benefit plans.

18. Segment Information

Vanguard's acute care hospitals and related healthcare businesses are similar in their activities and economic environments in which they operate (i.e. urban markets). Accordingly, Vanguard's reportable operating segments consist of 1) acute care hospitals and related healthcare businesses, collectively, and 2) health plans consisting of MacNeal Health Providers, a contracting entity for MacNeal Hospital and Weiss Memorial Hospital in the metropolitan Chicago area, Phoenix Health Plan, a Medicaid managed health plan operating in Arizona, and Abrazo Advantage Health Plan, a Medicare and Medicaid dual eligible managed health plan operating in Arizona. The following tables provide financial information by business segment for the years ended June 30, 2007, 2008 and 2009.

	For the Year Ended June 30, 2007			
	Health Plans	Acute Care Services	Eliminations	Consolidated
		(In millions)		
Patient service revenues (1)	$ –	$ 2,179.3	$ –	$ 2,179.3
Capitation premiums	401.4	–	–	401.4
Inter-segment revenues	–	34.2	(34.2)	–
Total revenues	401.4	2,213.5	(34.2)	2,580.7
Salaries and benefits (excludes stock compensation of $1.2 million)	14.7	1,052.0	–	1,066.7
Supplies	0.2	421.6	–	421.8
Health plan claims expense (1)	297.0	–	–	297.0
Provision for doubtful accounts	–	175.2	–	175.2
Other operating expenses – external	27.3	347.7	–	375.0
Operating expenses – inter-segment	34.2	–	(34.2)	–
Total operating expenses	373.4	1,996.5	(34.2)	2,335.7
Segment EBITDA (2)	28.0	217.0	–	245.0
Depreciation and amortization	4.3	114.3	–	118.6
Interest, net	(5.8)	129.6	–	123.8
Minority interests	–	2.6	–	2.6
Equity method income	–	(0.9)	–	(0.9)
Stock compensation	–	1.2	–	1.2
Gain on disposal of assets	–	(4.1)	–	(4.1)
Impairment loss	–	123.8	–	123.8
Monitoring fees and expenses	–	5.2	–	5.2
Income (loss) from continuing operations before income taxes	$ 29.5	$ (154.7)	$ –	$ (125.2)
Segment assets	$ 197.3	$ 2,340.8	$ –	$ 2,538.1
Capital expenditures	$ 0.2	$ 164.1	$ –	$ 164.3

(1) Vanguard eliminates in consolidation those patient service revenues earned by its hospitals and related healthcare facilities attributable to services provided to enrollees in its owned health plans and also eliminates the corresponding medical claims expenses incurred by the health plans for those services.

(2) Segment EBITDA is defined as income before interest expense (net of interest income), income taxes, depreciation and amortization, minority interests, equity method income or loss, stock compensation, debt extinguishment costs, gain or loss on disposal of assets, monitoring fees and expenses, impairment loss, realized loss on investments and discontinued operations. Management uses Segment EBITDA to measure performance for Vanguard's segments and to develop strategic objectives and operating plans for those segments. Segment EBITDA eliminates the uneven effect of non-cash depreciation of tangible assets and amortization of intangible assets, much of which results from acquisitions accounted for under the purchase method of accounting. Segment EBITDA also eliminates the effects of changes in interest rates which management believes relate to general trends in global capital markets, but are not necessarily indicative of the operating performance of Vanguard's segments. Management believes that Segment EBITDA provides useful information about the financial performance of Vanguard's segments to investors, lenders, financial analysts and rating agencies. Additionally, management believes that investors and lenders view Segment EBITDA as an important factor in making investment decisions and assessing the value of Vanguard. Segment EBITDA is not a substitute for net income, operating cash flows or other cash flow statement data determined in accordance with accounting principles generally accepted in the United States. Segment EBITDA, as presented, may not be comparable to similarly titled measures of other companies.

	For the Year Ended June 30, 2008			
	Health Plans	Acute Care Services	Eliminations	Consolidated
		(In millions)		
Patient service revenues (1)	$ –	$ 2,340.5	$ –	$ 2,340.5
Capitation premiums	450.2	–	–	450.2
Inter-segment revenues	–	31.2	(31.2)	–
Total revenues	450.2	2,371.7	(31.2)	2,790.7
Salaries and benefits (excludes stock compensation of $2.5 million)	16.0	1,134.2	–	1,150.2
Supplies	0.2	434.3	–	434.5
Health plan claims expense (1)	328.2	–	–	328.2
Provision for doubtful accounts	–	205.6	–	205.6
Other operating expenses – external	29.9	375.9	–	405.8
Operating expenses – inter-segment	31.2	–	(31.2)	–
Total operating expenses	405.5	2,150.0	(31.2)	2,524.3
Segment EBITDA (2)	44.7	221.7	–	266.4
Depreciation and amortization	4.2	126.8	–	131.0
Interest, net	(4.5)	126.6	–	122.1
Minority interests	–	3.0	–	3.0
Equity method income	–	(0.7)	–	(0.7)
Stock compensation	–	2.5	–	2.5
Loss on disposal of assets	–	0.9	–	0.9
Monitoring fees and expenses	–	6.3	–	6.3
Income (loss) from continuing operations before income taxes	$ 45.0	$ (43.7)	$ –	$ 1.3
Segment assets	$ 181.5	$ 2,400.8	$ –	$ 2,582.3
Capital expenditures	$ 0.6	$ 121.0	$ –	$ 121.6

(1) Vanguard eliminates in consolidation those patient service revenues earned by its hospitals and related healthcare facilities attributable to services provided to enrollees in its owned health plans and also eliminates the corresponding medical claims expenses incurred by the health plans for those services.

(2) Segment EBITDA is defined as income before interest expense (net of interest income), income taxes, depreciation and amortization, minority interests, equity method income or loss, stock compensation, debt extinguishment costs, gain or loss on disposal of assets, monitoring fees and expenses, impairment loss, realized loss on investments and discontinued operations. Management uses Segment EBITDA to measure performance for Vanguard's segments and to develop strategic objectives and operating plans for those segments. Segment EBITDA eliminates the uneven effect of non-cash depreciation of tangible assets and amortization of intangible assets, much of which results from acquisitions accounted for under the purchase method of accounting. Segment EBITDA also eliminates the effects of changes in interest rates which management believes relate to general trends in global capital markets, but are not necessarily indicative of the operating performance of Vanguard's segments. Management believes that Segment EBITDA provides useful information about the financial performance of Vanguard's segments to investors, lenders, financial analysts and rating agencies. Additionally, management believes that investors and lenders view Segment EBITDA as an important factor in making investment decisions and assessing the value of Vanguard. Segment EBITDA is not a substitute for net income, operating cash flows or other cash flow statement data determined in accordance with accounting principles generally accepted in the United States. Segment EBITDA, as presented, may not be comparable to similarly titled measures of other companies.

	For the Year Ended June 30, 2009			
	Health Plans	Acute Care Services	Eliminations	Consolidated
		(In millions)		
Patient service revenues (1)	$ –	$ 2,521.7	$ –	$ 2,521.7
Capitation premiums	678.0	–	–	678.0
Inter-segment revenues	–	34.0	(34.0)	–
Total revenues	678.0	2,555.7	(34.0)	3,199.7
Salaries and benefits (excludes stock compensation of $4.4 million)	30.6	1,205.1	–	1,235.7
Supplies	0.3	456.0	–	456.3
Health plan claims expense (1)	525.6	–	–	525.6
Provision for doubtful accounts	–	210.8	–	210.8
Other operating expenses – external	36.4	432.5	–	468.9
Operating expenses – inter-segment	34.0	–	(34.0)	–
Total operating expenses	626.9	2,304.4	(34.0)	2,897.3
Segment EBITDA (2)	51.1	251.3	–	302.4
Depreciation and amortization	4.1	126.5	–	130.6
Interest, net	(0.6)	112.2	–	111.6
Minority interests	–	3.2	–	3.2
Equity method income	–	(0.8)	–	(0.8)
Stock compensation	–	4.4	–	4.4
Gain on disposal of assets	–	(2.3)	–	(2.3)
Monitoring fees and expenses	–	5.2	–	5.2
Realized loss on investments	–	0.6	–	0.6
Impairment loss	–	6.2	–	6.2
Income (loss) from continuing operations before income taxes	$ 47.6	$ (3.9)	$ –	$ 43.7
Segment assets	$ 250.3	$ 2,480.8	$ –	$ 2,731.1
Capital expenditures	$ 1.7	$ 130.4	$ –	$ 132.1

(1) Vanguard eliminates in consolidation those patient service revenues earned by its hospitals and related healthcare facilities attributable to services provided to enrollees in its owned health plans and also eliminates the corresponding medical claims expenses incurred by the health plans for those services.

(2) Segment EBITDA is defined as income before interest expense (net of interest income), income taxes, depreciation and amortization, minority interests, equity method income or loss, stock compensation, debt extinguishment costs, gain or loss on disposal of assets, monitoring fees and expenses, impairment loss, realized loss on investments and discontinued operations. Management uses Segment EBITDA to measure performance for Vanguard's segments and to develop strategic objectives and operating plans for those segments. Segment EBITDA eliminates the uneven effect of non-cash depreciation of tangible assets and amortization of intangible assets, much of which results from acquisitions accounted for under the purchase method of accounting. Segment EBITDA also eliminates the effects of changes in interest rates which management believes relate to general trends in global capital markets, but are not necessarily indicative of the operating performance of Vanguard's segments. Management believes that Segment EBITDA provides useful information about the financial performance of Vanguard's segments to investors, lenders, financial analysts and rating agencies. Additionally, management believes that investors and lenders view Segment EBITDA as an important factor in making investment decisions and assessing the value of Vanguard. Segment EBITDA is not a substitute for net income, operating cash flows or other cash flow statement data determined in accordance with accounting principles generally accepted in the United States. Segment EBITDA, as presented, may not be comparable to similarly titled measures of other companies.

19. Unaudited Quarterly Operating Results

The following table presents summarized unaudited quarterly results of operations for the fiscal years ended June 30, 2008 and 2009. Management believes that all necessary adjustments have been included in the amounts stated below for a fair presentation of the results of operations for the periods presented when read in conjunction with Vanguard's consolidated financial statements for the fiscal years ended June 30, 2008 and 2009. Results of operations for a particular quarter are not necessarily indicative of results of operations for an annual period and are not predictive of future periods (in millions).

	September 30, 2007	December 31, 2007	March 31, 2008	June 30, 2008
Total revenues	$ 662.5	$ 686.0	$ 725.6	$ 716.6
Net income (loss)	$ (6.9)	$ 0.5	$ 6.5	$ (0.8)

	September 30, 2008	December 31, 2008	March 31, 2009	June 30, 2009
Total revenues	$ 719.0	$ 792.6	$ 858.0	$ 830.1
Net income	$ 0.9	$ 10.1	$ 15.8	$ 1.8

Item 9. Changes in and Disagreements With Accountants on Accounting and Financial Disclosure.

None.

Item 9A(T). Controls and Procedures.

Evaluation of Disclosure Control and Procedures

As of the end of the period covered by this report, our management conducted an evaluation, with the participation of our chief executive officer and chief financial officer, of the effectiveness of our disclosure controls and procedures (as defined in Rules 13a-15(c) and 15d-15(e) under the Securities Exchange Act of 1934 (the "Exchange Act")). Based on this evaluation, our chief executive officer and chief financial officer have concluded that our disclosure controls and procedures are effective to ensure that information required to be disclosed by us in the reports that we file or submit under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in Securities and Exchange Commission's rules and forms and that such information is accumulated and communicated to management, including our chief executive officer and chief financial officer, as appropriate to allow timely decisions regarding required disclosure.

Report of Management on Internal Control over Financial Reporting

The management of Vanguard Health Systems, Inc. is responsible for the preparation, integrity and fair presentation of the consolidated financial statements appearing in our periodic filings with the Securities and Exchange Commission. The consolidated financial statements were prepared in conformity with generally accepted accounting principles appropriate in the circumstances and, accordingly, include certain amounts based on our best judgments and estimates.

Management is also responsible for establishing and maintaining adequate internal control over financial reporting as such term is defined in Rules 13a-15(f) under the Securities and Exchange Act of 1934. Internal control over financial reporting is a process to provide reasonable assurance regarding the reliability of our financial reporting in accordance with accounting principles generally accepted in the United States of America. Our internal control over financial reporting includes a program of internal audits and appropriate reviews by management, written policies and guidelines, careful selection and training of qualified personnel including a dedicated Compliance department and a written Code of Business Conduct and Ethics adopted by our Board of Directors, applicable to all of our directors, officers and employees.

Internal control over financial reporting includes maintaining records that in reasonable detail accurately and fairly reflect our transactions; providing reasonable assurance that transactions are recorded as necessary for preparation of our financial statements; providing reasonable assurance that receipts and expenditures of company assets are made in accordance with management authorization; and providing reasonable assurance that unauthorized acquisition, use or disposition of company assets that could have a material effect on our financial statements would be prevented or detected in a timely manner. Because of its inherent limitations, including the possibility of human error and the circumvention or overriding of control procedures, internal control over financial reporting is not intended to provide absolute assurance that a misstatement of our financial statements would be prevented or detected. Therefore, even those internal controls determined to be effective can provide only reasonable assurance with respect to financial statement preparation and presentation.

Management conducted an evaluation of the effectiveness of our internal control over financial reporting based on the framework in *Internal Control – Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission. Based on this evaluation, management concluded that the Company's internal control over financial reporting was effective as of June 30, 2009.

This annual report does not include an attestation report of the Company's independent registered public accounting firm regarding internal control over financial reporting. Management's report was not subject to attestation by the Company's independent registered public accounting firm pursuant to the rules of the United States Securities and Exchange Commission that permit the Company to provide only management's report in this annual report for the year ended June 30, 2009.

Changes in Internal Control Over Financial Reporting

There was no change in our internal control over financial reporting during our fiscal quarter ended June 30, 2009 that materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

Item 9B. Other Information.

None.

PART III

Item 10. Directors, Executive Officers and Corporate Governance.

The table below presents information with respect to the members of our board of directors and our executive officers and their ages as of September 1, 2009.

Name	Age	Position
Charles N. Martin, Jr.	66	Chairman of the Board & Chief Executive Officer; Director
Kent H. Wallace	54	President & Chief Operating Officer
Keith B. Pitts	52	Vice Chairman
Mark R. Montoney, MD	52	Executive Vice President & Chief Medical Officer
Joseph D. Moore	62	Executive Vice President
Bradley A. Perkins, MD	50	Executive Vice President-Strategy and Innovation & Chief Transformation Officer
Phillip W. Roe	48	Executive Vice President, Chief Financial Officer & Treasurer
Ronald P. Soltman	63	Executive Vice President, General Counsel & Secretary
Dan F. Ausman	54	Senior Vice President-Operations
Reginald M. Ballantyne III	65	Senior Vice President-Market Strategy & Government Affairs
Bruce F. Chafin	53	Senior Vice President-Compliance & Ethics
Paul T. Dorsa	52	Senior Vice President-Development
Karen Fowler	48	Senior Vice President-Physician & Ambulatory Services
Larry Fultz	54	Senior Vice President-Human Resources
Joseph J. Mullany	45	Senior Vice President-Operations
Harold H. Pilgrim III	48	Senior Vice President & Chief Development Officer
Graham Reeve	45	Senior Vice President-Operations
James H. Spalding	50	Senior Vice President, Assistant General Counsel & Assistant Secretary
Jana S. Stonestreet	56	Senior Vice President & Chief Nursing Executive
Alan G. Thomas	55	Senior Vice President-Operations Finance
Thomas M. Ways	59	Senior Vice President-Managed Care
Gary D. Willis	44	Senior Vice President, Controller & Chief Accounting Officer
Deanna L. Wise	40	Senior Vice President & Chief Information Officer
Michael A. Dal Bello	38	Director
M. Fazle Husain	45	Director
Alan M. Muney, MD	56	Director
Michael J. Parsons	54	Director
James A. Quella	59	Director
Neil P. Simpkins	43	Director

Charles N. Martin, Jr. has served as Chairman of the board of directors and Chief Executive Officer of Vanguard since July 1997. Until May 31, 2001, he was also Vanguard's President. From January 1992 until January 1997, Mr. Martin was Chairman, President and Chief Executive Officer of OrNda HealthCorp ("OrNda"), a hospital management company. Prior thereto Mr. Martin was President and Chief Operating Officer of HealthTrust, Inc., a hospital management company, from September 1987 until October 1991. Mr. Martin is also a director of several privately held companies.

Kent H. Wallace has served as Vanguard's President & Chief Operating Officer since September 2005. Prior thereto he was a Senior Vice President - Operations of Vanguard from February 2003 until September 2005. Prior thereto from July 2001 to December 2002 he was Regional Vice President of Province Healthcare Company of Brentwood, Tennessee, an owner and operator of 20 non-urban, acute care hospitals in 13 states of the United States. During this time Mr. Wallace had managerial responsibility for seven of these hospitals. From June 1999 until June 2001 Mr. Wallace was President and Chief Executive Officer of Custom Curb, Inc. of Chattanooga, Tennessee, a family owned company which manufactured roof accessories. Prior thereto from January 1997 until May 1999 Mr.

Wallace was a Vice President - Acquisitions and Development of Tenet Healthcare Corporation of Dallas, Texas, a hospital management company ("Tenet").

Keith B. Pitts has been Vanguard's Vice Chairman since May 2001, was a director of Vanguard from August 1999 until September 2004, and was an Executive Vice President of Vanguard from August 1999 until May 2001. Prior thereto, from November 1997 until June 1999, he was the Chairman and Chief Executive Officer of Mariner Post-Acute Network, Inc. and its predecessor, Paragon Health Network, Inc., which is a nursing home management company. Prior thereto from August 1992 until January 1997, Mr. Pitts served as Executive Vice President and Chief Financial Officer of OrNda.

Mark R. Montoney, MD has been Vanguard's Executive Vice President & Chief Medical Officer since December 2008. Prior to his employment with Vanguard, from July 2005 to December 2008 Dr. Montoney was System Vice President and Chief Medical Officer of OhioHealth Corporation, a not-for-profit regional hospital management company headquartered in Columbus, Ohio, which operates 8 hospitals, over 20 health and surgery centers, and has affiliation agreements with 9 hospitals, within a 40-county area in central Ohio. Prior thereto, from July 2000 to July 2005, Dr. Montoney was Vice President – Quality & Clinical Support, of Riverside Methodist Hospital, a 985-bed tertiary care hospital in Columbus, Ohio.

Joseph D. Moore has served as an Executive Vice President of Vanguard since November 2007. He served as Executive Vice President, Chief Financial Officer and Treasurer of Vanguard from July 1997 until November 2007 and was a director of Vanguard from July 1997 until September 2004. From February 1994 to April 1997, he was Senior Vice President - Development of Columbia/HCA Healthcare Corporation ("Columbia"), a hospital management company. Mr. Moore first joined Hospital Corporation of America (a predecessor of Columbia) in April 1970, rising to Senior Vice President - Finance and Development in January 1993.

Bradley A. Perkins, MD has been Executive Vice President – Strategy and Innovation & Chief Transformation Officer of Vanguard since July 2009. Prior to his employment with Vanguard, Dr. Perkins held various positions with the Centers for Disease Control & Prevention ("CDC") from July 1989 to June 2009, including Chief Strategy & Innovation Officer and Chief, Office of Strategy & Innovation from December 2005 to June 2009, and Deputy Director, Office of Strategy & Innovation, from May 2004 to December 2005.

Phillip W. Roe has been Executive Vice President, Chief Financial Officer and Treasurer since November 2007. He was Senior Vice President, Controller and Chief Accounting Officer of Vanguard from July 1997 to November 2007. Prior thereto he was Senior Vice President, Controller and Chief Accounting Officer of OrNda from September 1996 until January 1997 and was Vice President, Controller and Chief Accounting Officer of OrNda from October 1994 until September 1996.

Ronald P. Soltman has been Vanguard's Executive Vice President, General Counsel and Secretary since July 1997 and was a director of Vanguard from July 1997 until September 2004. From April 1994 until January 1997, he was Senior Vice President, General Counsel and Secretary of OrNda. From February 1994 until March 1994, he was Vice President and Assistant General Counsel of Columbia. From 1984 until February 1994, he was Vice President and Assistant General Counsel of Hospital Corporation of America.

Dan F. Ausman has served as a Senior Vice President - Operations of Vanguard since February 2006. Prior thereto from May 2005 to February 2006 he was Vice President - Operations of Vanguard. From 1998 to April 2005 Mr. Ausman was the President & Chief Executive Officer of Irvine Regional Hospital and Medical Center, a 176-bed acute care hospital in Irvine, CA which is owned by an affiliate of Tenet.

Reginald M. Ballantyne III, joined Vanguard in May 2001 and has served as Senior Vice President - Market Strategy & Government Affairs of Vanguard since January 2002. From 1984 to 2001, he served as President of PMH Health Resources, Inc., an Arizona based multi-unit healthcare system. Prior to 1984, Mr. Ballantyne served as President of Phoenix Memorial Hospital in Phoenix, Arizona. Mr. Ballantyne served as Chairman of the American Hospital Association ("AHA") in 1997 and as Speaker of the AHA House of Delegates in 1998. He is a Fellow of the American College of Healthcare Executives ("ACHE") and a recipient of the ACHE Gold Medal Award for Management Excellence. Mr. Ballantyne also served as a member of the national Board of Commissioners for the Joint Commission on Accreditation of Healthcare Organizations and as Chairman of the

AHA Committee of Commissioners from 1992 until 1995. Mr. Ballantyne was recently elected Chairman-elect of the Arizona Chamber of Commerce and Industry. He has previously served as a director of Superior Consultant Holdings Corporation and is currently a director of several privately held companies.

Bruce F. Chafin has served as Senior Vice President - Compliance & Ethics of Vanguard since July 1997. Prior thereto, from April 1995 to January 1997, he served as Vice President - Compliance & Ethics of OrNda.

Paul T. Dorsa has served Senior Vice President – Development of Vanguard since September 2008. Prior to his employment with Vanguard, from May 2004 to September 2008 he was the Vice President – Mergers & Acquisition of DaVita Inc., an El Segundo, California-based provider of dialysis services and education for patients with chronic kidney failure and end stage renal disease, managing in the United States more than 1,000 outpatient facilities and acute units in more than 700 hospitals.

Karen Fowler has served as Senior Vice President - Physician & Ambulatory Services of Vanguard since September 11, 2007. Prior thereto from May 1999 until July 2007 she was Vice President - Physician Integration/Managed Care of Triad Hospitals, Inc., an investor owned hospital management company headquartered in Plano, Texas. Prior thereto from May 1996 until May 1999 she was Vice President - Physician Integration/Managed Care of the Central and Pacific Group of Columbia.

Larry Fultz has served as Senior Vice President - Human Resources of Vanguard since February 2009. Prior to his employment with Vanguard, from October 2007 to January 2009 he was Executive Vice President – Human Resources of the Victoria Secret Brand division of Limited Brands, Inc., headquartered in Columbus, Ohio. The Victoria Secret Brand division sells women's intimate and other apparel, personal care and beauty products and accessories under the Victoria's Secret brand name through retail stores, its website and its catalogue. Prior thereto from April 2006 to October 2007, Mr. Fultz was Executive Vice President – Human Resources of the Victoria Secret retail store division of Limited Brands, Inc. Prior to joining Victoria Secret, from September 2000 to April 2006 Mr. Fultz was Vice President – Human Resources of Cintas Corporation, headquartered in Cincinnati, Ohio. Cintas designs, manufactures and implements corporate identity uniform programs, and provides entrance mats, restroom supplies, promotional products, first aid, safety, fire protection products and services and document management services for other businesses.

Joseph J. Mullany has served as a Senior Vice President - Operations of Vanguard since September 2005. Prior thereto from October 2002 to August 2005 he was a Regional Vice President of Essent Healthcare, Inc. of Nashville, TN, an investor-owned hospital management company, responsible for its New England Division. Prior thereto from October 1998 to October 2002 Mr. Mullany was a Division Vice President of Health Management Associates, Inc. of Naples, Florida, an investor-owned hospital management company, responsible for its Mississippi Division.

Harold H. Pilgrim III has served as the Senior Vice President & Chief Development Officer of Vanguard since July 2009. Prior thereto from September 2005 to June 2009 he was a Senior Vice President - Operations of Vanguard. From February 2003 to September 2005 he was Vice President - Business Development of Vanguard, responsible for development for Vanguard's Texas operations. Prior thereto from November 2001 to January 2003 Mr. Pilgrim was Vanguard's Vice President - Investor Relations, and during that period he was also involved in Vanguard's acquisitions and development activities.

Graham Reeve has served as a Senior Vice President - Operations of Vanguard since July 2009. Prior thereto from April 2009 to June 2009 he was Vice President and Chief Operating Officer of Vanguard's Texas operations. From December 2005 to April 2009 he was President and Chief Executive Officer of Vanguard's St. Luke's Baptist Hospital in San Antonio, Texas. Prior thereto from September 2003 to November 2005 he was Vice President – Ambulatory Services of Vanguard's Texas operations. Prior to joining Vanguard, Mr. Reeve was employed by HealthSouth Corporation, a Birmingham, Alabama-based owner of rehabilitation and surgery hospitals and rehabilitation and surgery outpatient centers, holding various positions from December 1995 through August 2003, with his last position being Vice President - Surgical Operations for HealthSouth's southwestern surgery hospitals and surgery centers.

James H. Spalding has served as Senior Vice President, Assistant General Counsel and Assistant Secretary of Vanguard since November 1998. Prior thereto he was Vice President, Assistant General Counsel and Assistant

Secretary of Vanguard from July 1997 until November 1998. Prior thereto from April 1994 until January 1997, he served as Vice President, Assistant General Counsel and Assistant Secretary of OrNda.

Jana S. Stonestreet has served as Vanguard's Senior Vice President & Chief Nursing Executive since June 2009. Prior thereto from January 2006 to June 2009, Dr. Stonestreet was Chief Nursing Executive of Vanguard's Texas operations. Prior to joining Vanguard, from June 2004 to January 2006 Dr. Stonestreet was Chief Patient Care Officer of Memorial Hermann Southwest Hospital, a 563-bed hospital located in Houston, Texas.

Alan G. Thomas has been Senior Vice President - Operations Finance of Vanguard since July 1997. Prior thereto, Mr. Thomas was Senior Vice President - Hospital Financial Operations of OrNda from April 1995 until January 1997. Prior thereto he was Vice President - Reimbursement and Revenue Enhancement of OrNda from June 1994 until April 1995.

Thomas M. Ways has served as Senior Vice President - Managed Care of Vanguard since March 1998. Prior thereto from February 1997 to February 1998, he was Chief Executive Officer of MSO/Physician Practice Development for the Southern California Region of Tenet. Prior thereto from August 1994 to January 1997, he was Vice President - Physician Integration of OrNda.

Gary D. Willis has served as Senior Vice President, Controller and Chief Accounting Officer of Vanguard since May 2008. From February 2006 to May 2008, he was Senior Vice President and Chief Accounting Officer of LifePoint Hospitals ("LifePoint"), a hospital management company based in Brentwood, Tennessee. From December 2002 to February 2006, he was Vice President and Controller of LifePoint.

Deanna L. Wise has served as Senior Vice President and Chief Information Officer of Vanguard since November 2006. Prior thereto from August 2004 to October 2006 she was the Chief Information Officer of Vanguard's operating region managing its Phoenix-area healthcare facilities. From November 2002 until August 2004 she was chief information officer of the Maricopa Integrated Health System in Phoenix, Arizona, which was a county integrated health care system including an acute care hospital, health clinics and health plans. Prior thereto, from October 1997 to November 2002 she was the director of applications of Ascension Health –Central Indiana Health System in Indianapolis, Indiana, a regional healthcare management organization supervising the operations of twelve acute care hospitals.

Michael A. Dal Bello became a member of Vanguard's board of directors on September 23, 2004. Mr. Dal Bello is a Managing Director in the Private Equity Group of Blackstone and has been with the firm since 2002. While at Blackstone, Mr. Dal Bello has been actively involved in Blackstone's healthcare investment activities. Prior to joining Blackstone, Mr. Dal Bello received an M.B.A. from Harvard Business School in 2002. Mr. Dal Bello worked at Hellman & Friedman LLC from 1998 to 2000 and prior thereto at Bain & Company. He currently serves on the board of representatives or directors of Apria Healthcare Group Inc., Alliant Holdings I, Inc., Team Finance LLC, Biomet, Inc., Catalent Pharma Solutions, Inc. and Sithe Global.

M. Fazle Husain became a member of Vanguard's board of directors on November 7, 2007. Mr. Husain is a Managing Director of Metalmark Capital, the private equity division of Citigroup Alternative Investments. Prior to joining Metalmark, Mr. Husain was with Morgan Stanley & Co. for 18 years, where he was a Managing Director in the private equity and venture capital investment business. Mr. Husain currently also serves on the board of directors of SouthernCare, Inc. and National Healing Corporation.

Alan M. Muney, MD became a member of Vanguard's board of directors on May 6, 2008. Dr. Muney has served as an Executive Director in the Private Equity Group of Blackstone since October 2007. Before joining Blackstone Dr. Muney was the executive vice president and chief medical officer of Oxford Health Plans and the chief medical officer of United Healthcare (Northeast region) from 1998 to September 2007. He also currently serves as a member of the board of representatives of Team Finance LLC.

Michael J. Parsons became a member of Vanguard's board of directors on May 6, 2008. In April 2009 Mr. Parson became the Chief Executive Officer of SouthernCare, Inc., a hospice provider based in Birmingham, Alabama with offices in 15 states. Beginning in March 2009 he became the interim Chief Executive Officer of SouthernCare. SouthernCare provides hospice services to patients who reside in private homes, group homes,

assisted living facilities and skilled nursing facilities. From July 2007 to March 2009 Mr. Parsons was a private investor. From May 1999 until July 2007 he served as Executive Vice President and Chief Operating Officer of Triad Hospitals, Inc., an investor owned hospital management company headquartered in Plano, Texas, which was acquired by Community Health Systems, Inc. in July 2007. Mr. Parsons currently serves as a director of SouthernCare, Inc.

James A. Quella became a member of Vanguard's board of directors on September 11, 2007. Mr. Quella is a Senior Managing Director and Senior Operating Partner in the Private Equity Group at Blackstone. Prior to joining Blackstone in 2004, Mr. Quella was a Managing Director and Senior Operating Partner with DLJ Merchant Banking Partners-CSFB Private Equity from June 2000 to February 2004. Prior to that, Mr. Quella worked at Mercer Management Consulting and Strategic Planning Associates, its predecessor firm, from September 1981 to January 2000 where he served as a Senior Consultant to chief executive officers and senior management teams, and was Co-Vice Chairman with shared responsibility for overall management of the firm. Mr. Quella currently serves as a director of Graham Packaging Holdings Company, Intelenet Global Services, The Nielsen Company, Michaels Stores, Inc. and Freescale Semiconductor, Inc.

Neil P. Simpkins became a member of Vanguard's board of directors on September 23, 2004. Mr. Simpkins has served as a Senior Managing Director in the Private Equity Group of Blackstone since December 1999. From 1993 until the time he joined Blackstone, Mr. Simpkins was a Principal at Bain Capital. Prior to joining Bain Capital, Mr. Simpkins was a consultant at Bain & Company in London and the Asia Pacific region. He currently serves as Chairman of the board of directors of TRW Automotive Holdings Corp. and is a member of the board of representatives of Team Finance LLC and of the board of directors of Apria Healthcare Group Inc.

Composition of the Board of Directors

General

As of the date of this report, the board of directors of Vanguard consists of seven members, four of whom were nominated by Blackstone, one of whom was nominated by MSCP, one of whom is our chief executive officer (and, if our chief executive officer is not Charles N. Martin, Jr., such other person designated by senior management) and one independent director. Blackstone has the right to increase the size of Vanguard's board from seven to nine members, with one additional director to be designated by Blackstone and one additional director to be an independent person identified by our chief executive officer and acceptable to Blackstone. MSCP and, subject to the conditions above, senior management, will each continue to be entitled to nominate and elect one director unless and until the respective group ceases to own at least 50.0% of the Class A membership units in VHS Holdings LLC ("Holdings") owned on September 23, 2004. Holdings acquired Vanguard pursuant to a merger (the "Merger") on September 23, 2004. See "Item 1. Business – The Merger".

Committees

Our board of directors currently does not have any standing committees, including an audit committee. Our entire board of directors is acting as our audit committee to oversee our accounting and financial reporting processes and the audits of our financial statements, as allowed under the Securities Exchange Act of 1934 for issuers without securities listed on a national securities exchange or on an automated national quotation system. Additionally, because our securities are not so listed, our board of directors is not required to have on it a person who qualifies under the rules of the Securities and Exchange Commission as an "audit committee financial expert" or as having accounting or financial management expertise under the similar rules of the national securities exchanges. While our board of directors has not designated any of its members as an audit committee financial expert, we believe that each of the current board members is fully qualified to address any accounting, financial reporting or audit issues that may come before it.

Code of Ethics

We have adopted a Code of Business Conduct and Ethics that applies to all of our officers and employees, including our principal executive officer, principal financial officer and principal accounting officer, which has been posted on our Internet website at www.vanguardhealth.com/pdfs/codeofbusinessconductandethics.pdf. Our Code of

Business Conduct and Ethics is a "code of ethics", as defined in Item 406(b) of Regulation S-K of the Securities and Exchange Commission. Please note that our Internet website address is provided as an inactive textual reference only. We will make any legally required disclosures regarding amendments to, or waivers of, provisions of our code of ethics on our Internet website.

Item 11. Executive Compensation.

COMPENSATION DISCUSSION AND ANALYSIS

Overview

This section discusses the principles underlying our executive compensation policies and decisions. It provides qualitative information regarding the manner in which compensation is earned by our executive officers and places in context the data presented in the tables that follow. In addition, in this section, we address the compensation paid or awarded during fiscal year 2008 to: Charles N. Martin, Jr., our Chief Executive Officer (principal executive officer); Phillip W. Roe, our Chief Financial Officer (principal financial officer); and three other executive officers who were our three other most highly compensated executive officers in fiscal year 2009, Keith B. Pitts, our Vice Chairman; Kent H. Wallace, our President and Chief Operating Officer; and Joseph J. Mullany, one of our Senior Vice Presidents-Operations. We refer to these five executive officers as our "named executive officers."

On September 23, 2004, we were acquired in the Merger by private equity investment funds associated with Blackstone Group who invested $494.4 million in our equity for a 66% equity interest, with private equity funds associated with our former equity sponsor, MSCP, retaining a 17.3% equity interest in us by reinvesting $130 million in our equity and with 12 of our 23 current executive officers retaining a 11.4% equity interest in us by reinvesting $85.7 million in us (such $85.7 million exclusive of amounts invested by our executive officers in Holdings' Class B, C and D units, as discussed below). As a result of the Merger, we are privately held and controlled by private equity funds associated with Blackstone and MSCP (the "Sponsors") with a board of directors made up of five representatives of the Sponsors, one independent director and our Chief Executive Officer. As discussed in more detail below, various aspects of named executive officer compensation were negotiated and determined at the time of the Merger.

As a privately-owned company with a relatively small board of directors, our entire board of directors acts as our Compensation Committee (hereinafter referred to either as the "Committee", the "Compensation Committee" or the "board of directors"). Our executive compensation program is overseen and administered by the Compensation Committee. The Compensation Committee operates somewhat informally without a written charter and has responsibility for discharging the responsibilities of the board of directors relating to the compensation of our executive officers and related duties. As a member of the Compensation Committee, our Chief Executive Officer presents cash, equity and benefits compensation recommendations to the Compensation Committee for its consideration and approval. The Compensation Committee reviews these proposals and makes all final compensation decisions for executive officers by exercising its discretion in accepting, modifying or rejecting any such recommendations.

Philosophy of Executive Compensation Programs

Our overall executive compensation objective is to provide a comprehensive plan designed to focus on our strategic business initiatives, financial performance objectives and the creation and maintenance of equity value. The following are the principal objectives in the design of our executive compensation programs:

- Attract, retain, and motivate superior management talent critical to our long-term success with compensation that is competitive within the marketplace;
- Maintain a reasonable balance among base salary, annual incentive payments and long-term equity-based incentive compensation and other benefits;
- Ensure compensation levels reflect the internal value and future potential of each executive within the Company and the achievement of outstanding individual results;

- Link executive compensation to the creation and maintenance of long-term equity value;
- Promote equity ownership by executives in order to align their interests with the interests of our equity holders; and
- Ensure that incentive compensation is linked to the achievement of specific financial and strategic objectives, which are established in advance and approved by the Committee.

To meet these objectives, our compensation program balances short-term and long-term performance goals and mixes fixed and at-risk compensation that is directly related to stockholder value and overall performance.

During our fiscal year ended June 30, 2009, the Committee did not retain the services of any external compensation consultant. Our Chief Executive Officer, Charles N. Martin, Jr., as a member of the board of directors, is also a member of the Committee, presents his recommendations to the Committee on all executive compensation matters and participates in discussions and deliberations of the Committee. While other named executive officers may also attend the Committee meetings and participate in Committee discussions, they would do so only if and when required by the Committee and such attendance has been rare in recent years. Any deliberations and decisions by the Committee regarding compensation for Mr. Martin or other named executive officers take place while the Committee is in executive session without such persons in attendance.

The Committee believes that compensation to its executive officers should be aligned closely with our short-term and long-term financial performance goals. As a result, a portion of executive compensation is "at risk" and is tied to the attainment of previously established financial goals. However, the Committee also believes that it is prudent to provide competitive base salaries and benefits to attract and retain superior talent in order to achieve our strategic objectives.

Elements of Our Executive Compensation Program

In fiscal year 2009, the principal elements of our compensation for our executive officers, including our named executive officers were:

- Base Salary;
- Annual cash incentive opportunities;
- Long-term equity based incentives; and
- Benefits and executive perquisites.

Detail regarding each of these elements is discussed below.

Base Salaries

Annual base salaries reflect the fixed component of the compensation for an executive's ongoing contribution to the operating performance of his or her functional area of responsibility with us. The Committee believes that base salaries must be competitive based upon the scope of responsibilities and market compensation of similar executives while also reserving a substantial portion of compensation for the other compensation elements that are directly related to company performance. To determine base salary market compensation, our Human Resources Department provides our Chief Executive Officer and the Committee with market data which it obtained in our fiscal year ended June 30, 2009 from the following human resources sources: Mercer; Sullivan, Cotter & Associates; Salary.com; and/or Management Performance International, Inc. Other factors such as internal equity and comparability are also considered when establishing a base salary for a given executive. The Committee also utilizes the experience, market knowledge and insight of its members in evaluating the competitiveness of current salary levels. Our Human Resources Department is also a resource for such additional information as needed by our Chief Executive Officer or by the Committee.

Generally, base salaries of all executive officers, including the named executive officers, are reviewed and adjusted by the Committee once a year based upon the recommendations of our Chief Executive Officer (except he makes no recommendation as to his own salary). In turn, our Chief Executive Officer bases his recommendations upon his assessment of each executive's performance, our overall budgetary guidelines and market data provided to him by our Human Resources Department. In previous fiscal years, the annual salary review for executive officers (including the named executive officers) was done effective January 1 of each year. However, in our fiscal year ended June 30, 2009, the annual salary review was done effective April 1, 2009, and the next salary review is expected to occur effective July 1, 2010, with future yearly reviews currently planned to remain at July 1 of each year (which is the first day of our fiscal year). As a result, our executive officer raises this year, including those of the named executive officers, were increased by additional amounts to reflect this year's 15-month salary review cycle and next year's planned 15-month salary review cycle. In addition to the annual salary review, based upon the recommendations of our Chief Executive Officer, the Committee may also adjust base salaries at other times during the year in connection with promotions, increased responsibilities or to maintain competitiveness within the market.

In our fiscal year ended June 30, 2009, the base salaries of our named executive officers were increased by the following amounts, effective April 1, 2009: Mr. Martin: 4.55%; Mr. Roe: 10.53%; Mr. Pitts: 6.72%; Mr. Wallace: 14.17% and Mr. Mullany: 7.37%. As a result of these increases, the annual base salary rates of our named executive officers increased to the following amounts as of April 1, 2009: Mr. Martin: $1,098,079; Mr. Roe: $525,000; Mr. Pitts: $685,000; Mr. Wallace: $685,000; and Mr. Mullany: $510,000. The salary for each named executive officer for our fiscal year ended June 30, 2009 is reported in the Summary Compensation Table below.

Annual Incentive Compensation

Annual cash incentive awards are available to the named executive officers, as well as to Vanguard's other executive officers, under the Vanguard Health Systems, Inc. 2001 Annual Incentive Plan (the "Annual Incentive Plan"). The Annual Incentive Plan is designed to align our executives' short-term compensation opportunity with our annual financial and operation goals and the growth objectives of our stockholders and to motivate our executives' annual performance.

Each year under the Annual Incentive Plan the Committee establishes specific earnings-related or operations-related goals for all of our executive officers, including the named executive officers, for the fiscal year based upon the recommendations of our Chief Executive Officer. The executive officers are eligible to receive a cash award or awards based primarily on the extent to which the Company meets its pre-established earnings and/or cash flow and/or other operations-related goals. The Committee determines one or more target awards for each executive officer, designates a Company performance level or levels required to earn each target award and may also determine threshold performance levels at which minimum awards are earned and performance levels that result in maximum awards to be paid. Target awards may vary among executives based on competitive market practices for comparable positions, their decision-making authority and their ability to affect financial and operational performance. In addition to performance-related awards, the Committee may make and pay out discretionary awards at any time. Also, the Committee has the discretion to adjust the annual performance targets during the year in the event of acquisitions and divestitures, restructured or discontinued operations, or other extraordinary or unusual issues occurring during the year. The Committee evaluates the allocation factors within the Annual Incentive Plan on an annual basis and has the flexibility to adjust the structure including allocation percentages as needed in order to better align the incentives under the Annual Incentive Plan.

For fiscal year 2009, Annual Incentive Plan target awards for our named executive officers (except Mr. Mullany) were 50% based upon the Company achieving a certain consolidated Adjusted EBITDA performance level goal and 50% based upon the Company achieving a certain consolidated free cash flow performance level goal. For Mr. Mullany, his Annual Incentive Plan target award was 6.25% based upon the Company achieving a certain consolidated Adjusted EBITDA performance level goal (the same goal we used for the four other named executive officers); 6.25% based upon the Company achieving a certain consolidated free cash flow performance level goal (the same goal we used for the four other named executive officers); 21.875% based upon the Company achieving a regional Adjusted EBITDA performance level goal for the two regions in which the hospitals for which he is responsible are located; 21.875% based upon achieving a regional free cash flow performance level goal for the two regions in which the hospitals for which he is responsible are located; and 43.75% based upon the hospitals for

which he is responsible achieving certain specified quality, employee engagement and patient and physician satisfaction goals.

The Committee also set for fiscal 2009 threshold and maximum awards for the named executive officers. For the named executive officers (except for Mr. Mullany) threshold awards of an aggregate of 10% of the target awards were payable upon reaching 91% of the Adjusted EBITDA goal and 91% of the free cash flow goal, with increased awards of 20% to 90% of the target awards payable upon the Company reaching 92% to 99% of the Adjusted EBITDA goal and the free cash flow goal. For the named executive officers (except for Mr. Mullany) maximum awards of an aggregate of 150% of the target awards were payable upon reaching 110% of the Adjusted EBITDA goal and 110% of the free cash flow goal, with increased awards of 105% to 145% of the target awards payable upon the Company reaching 101% to 109% of the Adjusted EBITDA goal and the free cash flow goal. For Mr. Mullany threshold awards of 10% of his target awards for regional Adjusted EBITDA and regional free cash flow were payable upon reaching 91% of the regional Adjusted EBITDA goal and 91% of the regional free cash flow goal, with increased awards of 20% to 90% of the target awards payable upon his regions reaching 92% to 99% of the regional Adjusted EBITDA goal and the regional free cash flow goal. For Mr. Mullany threshold awards of 55% to 99% of some of his target quality awards were payable for achieving a quality score for his hospitals of 55 to 99 (on a 100 point scale) and a threshold award of 50% of his patient satisfaction award was payable if he achieved a certain goal below the target goal in a Press Ganey database. No threshold awards were available to him for his employee engagement goal. Maximum awards of an aggregate of 130% of his salary were payable upon reaching actual regional Adjusted EBITDA and actual regional free cash flow at certain levels above his goals, with other lesser awards available to him also of 1 to 25% of his salary for actual regional Adjusted EBITDA exceeding his goal and 1 to 25% of his salary for actual regional free cash flow exceeding his goal.

The target percentages set for fiscal 2009 and the threshold, target and maximum payments for each of the named executive officers for fiscal 2009 were as follows:

Percentage of Base Salary	Charles N. Martin, Jr.	Phillip W. Roe	Keith B. Pitts	Kent H. Wallace	Joseph J. Mullany
Target	100%	70%	90%	90%	80%
Threshold	10%	7%	9%	9%	21.9%
Maximum	150%	105%	135%	135%	130%
Financial Weightings					
Adjusted EBITDA (1)	50%	50%	50%	50%	6.25%
Regional Adjusted EBITDA	–	–	–	–	21.875%
Free cash flow (2)	50%	50%	50%	50%	6.25%
Regional free cash flow	–	–	–	–	21.875%
Hospital Quality/Employee Engagement/Patient Satisfaction	–	–	–	–	43.75%

(1) Adjusted EBITDA is defined by us as income before interest expense (net of interest income), income taxes, depreciation and amortization, minority interests, gain or loss on the disposal of assets, equity method income, stock compensation, monitoring fees and expenses, realized holding loss on investments, impairment loss and discontinued operations, net of taxes. Monitoring fees and expenses represent fees and reimbursed expenses paid to affiliates of The Blackstone Group and Metalmark Subadvisor LLC for advisory and oversight services.

(2) Free cash flow is defined by us as Adjusted EBITDA minus capital expenditures except those construction projects which we are allowed to exclude from our covenant limiting our annual capital expenditures found in our principal credit facility.

All of our five named executive officers earned in excess of their target awards with respect to their financial performance level goals under our Annual Incentive Plan for fiscal year 2009. These awards were approved by the Committee and will be paid to the named executive officers in September 2009 in the individual amounts set forth in the column of the Summary Compensation Table entitled "Non-Equity Incentive Plan Compensation", except for all named executive officers (other than Mr. Mullany) amounts earned in excess of 100% of the target awards are payable as follows: 1/3 in September 2009; 1/3 in September 2010 and 1/3 in September 2011; and for Mr. Mullany only, the amounts he earned in respect of the consolidated Adjusted EBITDA goal and the consolidated free cash flow goal are payable to him 1/3 in September 2009, 1/3 in September 2010 and 1/3 in September 2011.

The Committee has historically attempted to maintain consistency year over year with respect to the difficulty of achieving the performance level goals under our Annual Incentive Plan. The financial performance goals used by

the Committee in recent years for the annual incentive awards for most of our executive officers (Adjusted EBITDA and free cash flow) are identical to or derived from our consolidated annual Adjusted EBITDA and capital expenditures budgets approved at the beginning of each fiscal year by our board of directors. Our annual Adjusted EBITDA budget, and, thus, the annual Adjusted EBITDA financial target, typically increases each year to promote continuous growth consistent with our business plan. Despite such increase, the financial performance targets are designed to be realistic and attainable though slightly aggressive, requiring in each fiscal year strong performance and execution that in our view provides an annual incentive firmly aligned with stockholder interests. This balance is reflected in the fact that none of these named executive officers (except Mr. Mullany) earned any awards under the Plan for fiscal year 2007 when our Company's financial performance was not strong (other than in Mr. Mullany's regions), but they did earn their target awards under the Plan for fiscal years 2008 and 2009 when our Company's financial performance was much stronger.

Long Term Incentive Compensation

The Committee provides equity incentives to executive officers and other key employees in order to directly align their interests with the long term interests of the other equity holders who are principally the Sponsors.

Holdings LLC Units Plan

Holdings acquired Vanguard in the Merger on September 23, 2004. The following contains a summary of the material terms of the Holdings LLC Units Plan, which we refer to as the 2004 Unit Plan, pursuant to which Holdings granted the right to purchase units to members of our management on September 23, 2004 in connection with consummation of the Merger. All of our named executive officers, and certain other members of our management, have been granted the right to purchase units under the 2004 Units Plan.

General

The 2004 Unit Plan permits the grant of the right to purchase Class A Units, Class B Units, Class C Units and Class D Units to employees of Holdings or its affiliates. A maximum of 117,067 Class A Units, 41,945 Class B Units, 41,945 Class C Units and 35,952 Class D Units may be subject to awards under the 2004 Unit Plan. Units covered by awards that expire, terminate or lapse will again be available for option or grant under the 2004 Unit Plan. On September 23, 2004, certain members of management purchased all 117,067 Class A Units for an aggregate purchase price of $117,067,000 and all 41,945 Class B units, all 41,945 Class C Units and all 35,952 of the Class D Units for an aggregate purchase price of $5.7 million.

Administration

The 2004 Unit Plan is administered by a committee of Holdings' board of representatives or, in the board of representatives' discretion, the board of representatives. The committee has the sole discretion to determine the employees to whom awards may be granted under the 2004 Unit Plan, the number and/or class of Units to be covered by an award, the purchase price, if any, of such awards, determine the terms and conditions of any award and determine under what circumstances awards may be settled or cancelled. The committee is authorized to interpret the 2004 Unit Plan, to establish, amend and rescind any rules and regulations relating to the 2004 Unit Plan, and to make any other determinations that it deems necessary or desirable for the administration of the plan. The committee may correct any defect or supply any omission or reconcile any inconsistency in the 2004 Unit Plan in the manner and to the extent the committee deems necessary or desirable.

Adjustments Upon Certain Events

In the event of any changes in the Units by reason of any reorganization, recapitalization, merger, unit exchange or any other similar transaction, the board of representatives, in its sole discretion, may adjust (1) the number or kind of Units or other securities that may be issued or reserved for issuance pursuant to the 2004 Unit Plan or pursuant to any outstanding awards or (2) any other affected terms of such awards.

Amendment and Termination

The Holdings board of representatives may amend or terminate the 2004 Unit Plan at any time, provided that no amendment or termination is permitted that would diminish any rights of a management member pursuant to a previously granted award without his or her consent, subject to the committee's authority to adjust awards upon certain events as described in the previous paragraph. No awards may be made under the 2004 Unit Plan after the tenth anniversary of the effective date of the plan.

Holdings LLC Units Held by Certain of our Managers

The units of Holdings consist of Class A units, Class B units, Class C units and Class D units. As of September 1, 2009, approximately 59.2% of Holdings' Class A Units were held by Blackstone, approximately 20.8% were held by MSCP, approximately 14.9% were held by certain members of our management and approximately 5.1% were held by other investors. The Class B units, Class C units and Class D units are held exclusively by members of our senior management and all such units were purchased on September 23, 2004.

Of our named executive officers, Charles N. Martin, Jr. beneficially owns 40,000 class A units, 8,913 class B units, 8,913 class C units and 7,640 class D units; Phillip W. Roe beneficially owns 3,030 class A units, 2,097 class B units, 2,097 class C units and 1,798 class D units; Keith B. Pitts beneficially owns 11,000 class A units, 5,243 class B units, 5,243 class C units and 4,494 class D units; Kent H. Wallace beneficially owns 850 class A units, 2,622 class B units, 2,622 class C units and 2,247 class D units; and Joseph J. Mullany owns no units. As of September 1, 2009, none of the class C units are vested, but 80% of the Class B and D units are vested; and an additional 20% of such class B and D units will vest on September 23, 2009. See the vesting provisions in respect of the class A, B, C and D units in the discussion immediately below.

Terms of the Holdings' Class A Units, Class B Units, Class C Units and Class D Units

The following is a summary of certain terms of the Holdings' Class A units, Class B units, Class C units and Class D units and certain rights and restrictions applicable to those units.

Class A units have economic characteristics that are similar to those of shares of common stock in a private corporation. Subject to applicable law, only the holders of Class A units are entitled to vote on any matter. Class A units are fully vested. The Class B units, Class C units and Class D units are subject to the vesting provisions described below.

Class B units vest in five equal annual installments on the first five anniversaries of the date of purchase, subject to an employee's continued service with Holdings and its affiliates. However, the Class B units will vest earlier upon a change of control of Holdings. In the event of an employee's termination of employment with Vanguard, other than due to termination by Vanguard for "cause" or by the employee without "good reason", the employee shall be deemed vested in any Class B unit that would otherwise have vested in the calendar year in which such termination of employment occurs. No employee who holds Class B units will receive any distributions until the holders of the Class A units receive the aggregate amount invested for their Class A units. Following return of the aggregate amount invested for the Class A units, the holders of Class B units will be entitled to receive the amount of their investment in the Class B units and, once all the aggregate investment amount invested for all of the units has been returned to their holders, the vested Class B units will share in any distributions pro rata with the Class A units and vested Class C units.

Class C units vest on the eighth anniversary of the date of purchase, subject to the employee's continued service with Holdings and its affiliates. However, the Class C units will vest earlier upon the occurrence of a sale by Blackstone of at least 25.0% of its Class A Units at a price per Class A unit exceeding two and one-half times the price per Class A Unit invested by Blackstone in connection with the Merger. No employee who holds Class C units will receive any distributions until the holders of the Class A units receive the aggregate amount invested for their Class A units. Following return of the aggregate amount invested for the Class A units, the holders of Class C units will be entitled to receive the amount of their investment in the Class C units and, once all the aggregate investment amount invested for all of the units has been returned to their holders, the vested Class C units will share in any distributions pro rata with the Class A units and vested Class B units.

Class D units vest in five equal annual installments on the fifth anniversary of the date of purchase, subject to an employee's continued service with Holdings and its affiliates. However, the Class D units will vest earlier upon a change of control of Holdings. In the event of an employee's termination of employment with Vanguard, other than due to termination by Vanguard for "cause" or by the employee without "good reason", the employee shall be deemed vested in any Class D unit that would otherwise have vested in the calendar year in which such termination of employment occurs. No employee who holds Class D units will receive any distributions until the holders of the Class A units receive the aggregate amount invested for their Class A units. Following return of the aggregate amount invested for the Class A units, the holders of Class D units will be entitled to receive the amount of their investment in the Class D units and, once all the aggregate investment amount invested for all of the units has been returned to their holders and the holders of the Class A units have received an amount representing a 300% return on their aggregate investment along with pro rata distributions to the vested Class B and Class C units, the vested Class D units will share in any distributions pro rata with the Class A units, the vested Class B units and the vested Class C units.

Certain Rights and Restrictions Applicable to the Units Held by Our Managers

The units held by members of our management are not transferable for a limited period of time except in certain circumstances. In addition, the units (other then Class A units) may be repurchased by Holdings, and in certain cases, Blackstone, in the event that the employees cease to be employed by us. Blackstone has the ability to force the employees to sell their units along with Blackstone if Blackstone decides to sell its units.

The employees that hold units are entitled to participate in certain sales by Blackstone. In addition, in the event that Holdings were to make a public offering of its equity securities, the employees would have limited rights to participate in subsequent registered public offerings.

Our 2004 Stock Incentive Plan

General

Since all Units have been granted under the 2004 Unit Plan, we intend for our option program pursuant to our 2004 Stock Incentive Plan to be the primary vehicle currently for offering long-term incentives and rewarding our executive officers, managers and key employees. Because of the direct relationship between the value of an option and the value of our stock, we believe that granting options is the best method of motivating our executive officers to manage our Company in a manner that is consistent with our interests and our stockholders' interests. We also regard our option program as a key retention tool.

We adopted the 2004 Stock Incentive Plan upon consummation of the Merger which permits the grant of non-qualified stock options, incentive stock options, stock appreciation rights, restricted stock and other stock-based awards to our employees or our affiliates' employees. The awards available under the 2004 Stock Incentive Plan, together with Holdings' equity incentive units, represented 20.0% of our fully-diluted equity at the closing of the Merger. Shares covered by awards that expire, terminate or lapse are again available for option or grant under the 2004 Stock Incentive Plan. The total number of shares of our common stock which may be issued under the 2004 Stock Incentive Plan as of September 1, 2009, was 145,611. All of our previous option plans were terminated upon consummation of the Merger on September 23, 2004.

Administration

The 2004 Stock Incentive Plan is administered by a committee of the board of directors or, in the sole discretion of the board of directors, the board of directors. The committee has the sole discretion to determine the employees, representatives and consultants to whom awards may be granted under the 2004 Stock Incentive Plan and the manner in which such awards will vest. Options, stock appreciation rights, restricted stock and other stock-based awards will be granted by the committee to employees, representatives and consultants in such numbers and at such times during the term of the 2004 Stock Incentive Plan as the committee shall determine. The committee is authorized to interpret the 2004 Stock Incentive Plan, to establish, amend and rescind any rules and regulations relating to the 2004 Stock Incentive Plan, and to make any other determinations that it deems necessary or desirable for the administration of the plan. The committee may correct any defect or supply any omission or reconcile any

inconsistency in the 2004 Stock Incentive Plan in the manner and to the extent the committee deems necessary or desirable.

Stock Options and Stock Appreciation Rights

Options granted under the 2004 Stock Incentive Plan are vested and exercisable at such times and upon such terms and conditions as may be determined by the committee, but in no event will an option be exercisable more than 10 years after it is granted. Under the 2004 Stock Incentive Plan, the exercise price per share for any option awarded is determined by the committee, but may not be less than 100% of the fair market value of a share on the day the option is granted with respect to incentive stock options.

Stock option grants under the 2004 Stock Incentive Plan are generally made at the commencement of employment and occasionally following a significant change in job responsibilities or on a periodic basis to meet other special retention or performance objectives. All stock options granted by our board of directors to date under the 2004 Stock Incentive Plan have been granted at or above the fair market value of our common stock at the grant date based upon the most recent appraisal of our common stock. We have not back-dated any option awards.

As a privately-owned company, there has been no market for our common stock. Accordingly, in fiscal year 2007, we had no program, plan or practice pertaining to the timing of stock option grants to executive officers, coinciding with the release of material non-public information.

An option may be exercised by paying the exercise price in cash or its equivalent, and/or, to the extent permitted by the committee, shares, a combination of cash and shares or, if there is a public market for the shares, through the delivery of irrevocable instruments to a broker to sell the shares obtained upon the exercise of the option and to deliver to us an amount equal to the exercise price.

The committee may grant stock appreciation rights independent of or in conjunction with an option. The exercise price of a stock appreciation right is an amount determined by the committee. Generally, each stock appreciation right entitles a participant upon exercise to an amount equal to (i) the excess of (1) the fair market value on the exercise date of one share over (2) the exercise price, times (ii) the number of shares covered by the stock appreciation right. Payment will be made in shares or in cash or partly in shares and partly in cash (any shares valued at fair market value), as determined by the committee.

As of June 30, 2009, options to purchase 102,455 shares of our common stock (the "New Options") were outstanding under the 2004 Stock Incentive Plan. The New Options were granted in part as "time options," and in part as "performance options" which vest and become exercisable ratably on a yearly basis on each of the first five anniversaries following the date of grant (or earlier upon a change of control). 35% of the options granted were time options with an exercise price equal to the greater of the fair market price per share or $1,000 per share at the time of grant (a range of $1,000 to $1,167.50 per share). 30% of the options granted were performance options with an exercise price of $3,000 per share. 35% of the options granted were "liquidity options" with an exercise price equal to greater of the fair market price per share or $1,000 per share at the time of grant (a range of $1,000 to $1,167.50 per share) that become fully vested and exercisable upon the completion of any of certain designated business events ("liquidity events"), and in any event on the eighth anniversary of the date of grant. Any common stock for which such options are exercised are governed by a stockholders agreement, which is described below under "Item 13. Certain Relationships and Related Transactions - Stockholders Agreement."

Of our named executive officers, Mr. Martin has been granted no New Options as of September 1, 2009, Mr. Roe has been granted 3,008 New Options, Mr. Pitts has been granted 1,500 New Options, Mr. Wallace has been granted 13,500 New Options and Mr. Mullany has been granted 5,500 New Options. During fiscal year 2009 the Committee granted 5,000 New Options to Mr. Wallace, but no other named executive officers were granted any New Options.

Other Stock-Based Awards

The committee, in its sole discretion, may grant restricted stock, stock awards, stock appreciation rights, unrestricted stock and other awards that are valued in whole or in part by reference to, or are otherwise based on the

fair market value of our shares. Such other stock-based awards shall be in such form, and dependent on such conditions, as the committee shall determine, including, without limitation, the right to receive, or vest with respect to, one or more shares (or the equivalent cash value of such shares) upon the completion of a specified period of service, the occurrence of an event and/or the attainment of performance objectives.

Adjustments Upon Certain Events

In the event of any stock dividend or split, reorganization, recapitalization, merger, share exchange or any other similar transaction, the committee, in its sole discretion, may adjust (i) the number or kind of shares or other securities that may be issued or reserved for issuance pursuant to the 2004 Stock Incentive Plan or pursuant to any outstanding awards, (ii) the option price or exercise price and/or (iii) any other affected terms of such awards. In the event of a change of control, the committee may, in its sole discretion, provide for the (i) termination of an award upon the consummation of the change of control, but only if such award has vested and been paid out or the participant has been permitted to exercise the option in full for a period of not less than 30 days prior to the change of control, (ii) acceleration of all or any portion of an award, (iii) payment of a cash amount in exchange for the cancellation of an award, which, in the case of options and stock appreciation rights, may equal the excess, if any, of the fair market value of the shares subject to such options or stock appreciation rights over the aggregate option price or grant price of such option or stock appreciation rights, and/or (iv) issuance of substitute awards that will substantially preserve the otherwise applicable terms of any affected awards previously granted hereunder.

Amendment and Termination

The committee may amend or terminate the 2004 Stock Incentive Plan at any time, provided that no amendment or termination shall diminish any rights of a participant pursuant to a previously granted award without his or her consent, subject to the committee's authority to adjust awards upon certain events (described under "Adjustments Upon Certain Events" above). No awards may be made under the 2004 Stock Incentive Plan after the tenth anniversary of the effective date of the plan.

Benefits and Executive Perquisites

The Committee believes that attracting and retaining superior management talent requires an executive compensation program that is competitive in all respects with the programs provided at similar companies. In addition to salaries, incentive bonus and equity awards, competitive executive compensation programs include retirement and welfare benefits and reasonable executive perquisites.

Retirement Benefits

Substantially all of our salaried employees, including our named executive officers, participate in our 401(k) savings plan. Employees are permitted to defer a portion of their income under the 401(k) plan. At our discretion, we may make a matching contribution of either (1) up to 50%, subject to annual limits established under the Internal Revenue Code, of the first 6% of an employee's contributions under this 401(k) plan as determined each year or (2) in respect of a few of our employees who came to us with plans in place having a larger match than this match, a match of 100% of the first 5% of an employee's contributions under this 401(k) plan. Most recently, we authorized such maximum discretionary amounts as a match on employees' aggregate 401(k) Plan contributions for calendar year 2007, including the named executive officers. Employee contributions are fully vested immediately. Our matching contributions vest to the employee's account over time related to the employee's years of service with us, with 20% of our contribution vesting after 2 years of service, 40% after 3 years, 60% after 4 years, 80% after 5 years and 100% after 6 years. Participants may receive distribution of their 401(k) accounts any time after they cease service with us.

We maintain no defined benefit plans.

Other Benefits

All executive officers, including the named executive officers, are eligible for other benefits including: medical, dental, life insurance, and short term disability. The executives participate in these plans on the same basis, terms,

and conditions as other administrative employees. In addition, we provide long-term disability insurance coverage on behalf of the named executive officers at an amount equal to 60% of current base salary (up to $10,000 per month). The named executive officers also participate in our vacation, holiday and sick program which provides paid leave during the year at various amounts based upon the executive's position and length of service.

Perquisites

Our executive officers may have limited use of our corporate plane for personal purposes as well as very modest other usual and customary perquisites. All of such perquisites are reflected in the All Other Compensation column of the Summary Compensation Table and the accompanying footnotes.

Our Employment Agreements with Certain of the Named Executive Officers

We have entered into written employment agreements with all of our named executive officers except Mr. Mullany. On June 1, 1998, we entered into a written employment agreement with our Chief Executive Officer (Mr. Martin) which was amended and restated on September 23, 2004 to extend the term of the employment agreement for five years, and to provide that the Merger did not constitute a change in control under the agreement. On September 1, 1999, we entered into a written employment agreement with Keith B. Pitts to be our Executive Vice President for a term expiring on September 1, 2004. Effective May 31, 2001, Mr. Pitts was promoted to the position of Vice Chairman, and on September 23, 2004, his employment agreement was amended and restated to extend the term of the employment agreement for five years, and to provide that the Merger did not constitute a change in control under the agreement. On November 15, 2007, we entered into written employment agreements with our Chief Operating Officer and our Chief Financial Office (Messrs. Wallace and Roe, respectively) for terms expiring on November 15, 2012.

The term of each employment agreement will renew automatically for additional one-year periods, unless any such agreement is terminated by us or by the named executive officer officer by delivering notice of termination no later than 90 days before the end of the five-year term or any such renewal term. The base salaries of Messrs. Martin, Roe, Pitts and Wallace under such written employment agreements are, effective on and after April 1, 2009, $1,098,079, $525,000, $685,000 and $685,000, respectively. Pursuant to these agreements the officers are eligible to participate in an annual bonus plan giving each of them an opportunity to earn an annual bonus in such amount as our board of directors should determine, as well as pension, medical and other customary employee benefits. The terms of these agreements state that if the officer terminates his employment for Good Reason (as defined in the agreements) or if we terminate the officer's employment without Cause (as defined in the agreements), he will receive within a specified time after the termination a payment of up to three times the sum of (i) his annual salary plus (ii) the average of the bonuses given to him in the two years immediately preceding his termination.

Our Severance Protection Agreements

We provide all of our corporate officers at the Vice President level and above with severance protection agreements granting them severance payments in amounts of 200% to 250% of annual salary and bonus, except for those officers who have written employment agreements with us. Generally, severance payments are due under these agreements if a change in control (as defined in the agreements) should occur and employment of the officer is terminated during the term of the agreement by us (or our successor) without Cause (as defined in the agreements) or by the executive for Good Reason (as defined in the agreement). In addition, these agreements state that in the event of a Potential Change in Control (defined as the time at which an agreement which would result in a change in control is signed, an acquisition attempt relating to us is publicly announced or there is an increase in the number of shares owned by one of our 10% shareholders by 5% or more), the executives have an obligation to remain in our employ until the earliest of (1) six months after the Potential Change in Control; (2) a change in control; (3) a termination of employment by us; or (4) a termination of employment by the employee for Good Reason (treating Potential Change in Control as a change in control for the purposes of determining whether the executive had a Good Reason) or due to death, disability or retirement. On September 23, 2004, all the outstanding severance protection agreements were amended and restated to provide that the Merger did not constitute a change in control under the agreements, and that we would not terminate the agreements prior to the third anniversary of the closing of the Merger.

Stock Ownership

We do not have a formal policy requiring stock ownership by management. Our senior managers, including all of our named executive officers, however, have committed significant personal capital to our Company in connection with the consummation of the Merger. See the beneficial ownership chart below under Item 12, "Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters". Our stock is not publicly traded and is subject to a stockholder agreement that limits a stockholder's ability to transfer his or her shares. See "Holdings Limited Liability Company Agreement" and "Stockholders Agreement" under Item 13, "Certain Relationships and Related Transactions, and Director Independence."

Impact of Tax and Accounting Rules

The forms of our executive compensation are largely dictated by our capital structure and have not been designed to achieve any particular accounting treatment. We do take tax considerations into account, both to avoid tax disadvantages, and obtain tax advantages where reasonably possible consistent with our compensation goals. (Tax advantages for our executives benefit us by reducing the overall compensation we must pay to provide the same after-tax income to our executives.) Thus our severance pay plans are designed or are being reviewed to take account of and avoid "parachute" excise taxes under Section 280G of the Internal Revenue Code. Similarly we have taken steps to structure and assure that our executive compensation program is applied in compliance with Section 409A of the Internal Revenue Code. Since we currently have no publicly traded common stock, we are not currently subject to the $1,000,000 limitation on deductions for certain executive compensation under Section 162(m) of the Internal Revenue Code, though that rule will be considered if our common stock becomes publicly traded. Incentives paid to executives under our annual incentive plan are taxable at the time paid to our executives.

The expenses associated with the stock options issued by us to our executive officers and other key employees are reflected in our consolidated financial statements. In the first quarter of the fiscal year ended June 30, 2007, we began accounting for these stock-based payments in accordance with the requirements of SFAS 123(R), which requires all share-based payments to employees, including grants of employee stock options, to be recognized as expense in the consolidated financial statements based on their fair values. For further discussion see "ITEM 8, Note 2-Summary of Critical and Significant Accounting Policies" under the heading "Stock-Based Compensation." We previously accounted for these awards under the provisions of SFAS 123, which allowed us to estimate the fair value of options using the minimum value method.

Recovery of Certain Awards

We do not have a formal policy for recovery of annual incentives paid on the basis of financial results which are subsequently restated. Under the Sarbanes-Oxley Act, our chief executive officer and chief financial officer must forfeit incentive compensation paid on the basis of financial statements for which they were responsible and which have to be restated. In that event we would expect to recover such bonuses and incentive compensation. If and when the situation arises in other events, we would consider our course of action in light of the particular facts and circumstances, including the culpability of the individuals involved.

Compensation Committee Report

The Committee has reviewed and discussed the Compensation Discussion and Analysis with management. Based upon the review and discussions, the Committee directed that the Compensation Discussion and Analysis be included in this annual report on Form 10-K.

Compensation Committee:

Michael Dal Bello
M. Fazle Husain
Charles N. Martin, Jr.
Alan M. Muney, M.D.
James A. Quella
Michael J. Parsons
Neil P. Simpkins

Summary Compensation Table

The following table sets forth, for the fiscal years ended June 30, 2009, 2008 and 2007, the compensation earned by the Chief Executive Officer and Chief Financial Officer and the three other most highly compensated executive officers of the registrant, Vanguard, at the end of Vanguard's last fiscal year ended June 30, 2009. We refer to these persons as our named executive officers.

Name and Principal Position	Year	Salary ($)	Bonus($)	Non-Equity Incentive Plan Compensation ($)(a)	Option Awards($)(b)	All Other Compensation ($)(c)	Total ($)
Charles N. Martin, Jr. Chairman of the Board & Chief Executive Officer	2009	1,062,238	–	1,454,956	–	13,758	2,530,952
	2008	1,050,291	–	1,050,291	–	13,608	2,114,190
	2007	1,050,291	–	–	–	10,164	1,060,455
Phillip W. Roe Executive Vice President, Chief Financial Officer & Treasurer	2009	487,500	–	486,939	99,437	7,640	1,081,516
	2008	440,192	–	332,500	50,859	7,620	831,171
	2007	350,000	–	–	17,462	7,410	374,872
Keith B. Pitts Vice Chairman	2009	652,633	–	816,864	46,905	8,142	1,524,544
	2008	641,845	100,000	577,661	19,004	7,992	1,346,502
	2007	641,845	–	–	–	7,410	649,255
Kent H. Wallace President & Chief Operating Officer	2009	621,250	–	816,864	333,776	8,142	1,780,032
	2008	600,000	100,000	540,000	197,141	7,992	1,445,133
	2007	600,000	–	–	124,292	230,212	954,504
Joseph J. Mullany Senior Vice President-Operations	2009	483,800	–	571,289	171,983	60,900	1,287,972
	2008	450,000	–	351,500	113,530	60,810	975,840
	2007	400,000	–	251,260	69,067	72,847	793,174

(a) The Compensation Committee has determined the amount of the Annual Incentive Plan compensation that was earned by each of these named executive officers for fiscal year 2009. This amount will be paid to the named executive officers in September 2009, except for Messrs. Martin, Roe, Pitts and Wallace amounts earned in excess of 100% of the target awards are payable as follows: 1/3 in September 2009; 1/3 in September 2010 and 1/3 in September 2011; and except for Mr. Mullany, the target amounts earned by him in respect of the consolidated Adjusted EBITDA and consolidated free cash flow goals are payable to him 1/3 in September 2009, 1/3 in September 2010 and 1/3 in September 2011. See "Compensation Discussion and Analysis – Annual Incentive Compensation" for more details in respect of the incentive plan awards.

(b) Option Awards reflect the compensation expense recognized in our financial statements for fiscal years 2009, 2008 and 2007 in accordance with SFAS 123(R) with respect to options to purchase shares of our common stock which have been awarded under our 2004 Stock Incentive Plan in our 2006, 2008 and 2009 fiscal years to four of our named executive officers. See Note 12 to our consolidated financial statements for assumptions used in calculation of these amounts. The actual number of Option Awards granted in fiscal year 2009 is shown in the "Grants of Plan Based Awards in Fiscal Year 2009" table included below in this report. Because these amounts represent expense for financial reporting purposes, they are not representative of the actual value that the named executive officer would receive upon exercise of these options.

(c) The amounts disclosed under All Other Compensation in the Summary Compensation Table represent for the named executive officers in fiscal 2009 (i) the following amounts of our matching contributions made under our 401(k) Plan: Mr. Martin: $6,900; Mr. Roe: $6,900; Mr. Pitts: $6,900; Mr. Wallace $6,900; and Mr. Mullany: $6,900; and (ii) the following amounts of insurance premiums paid by Vanguard with respect to group term life insurance: Mr. Martin: $6,858; Mr. Roe: $740; Mr. Pitts: $1,242 Mr. Wallace: $1,242; and Mr. Mullany: $0. The amounts in this column also include for Mr. Mullany in fiscal 2009 $54,000, consisting of a $4,500 monthly housing allowance in connection with his relocation of his residence to Massachusetts from his residence in Tennessee after he joined us in September 2005. No amounts for perquisites and other personal benefits, or property, have been included in this column for 2009 for Messrs. Martin, Roe, Pitts and Wallace because the aggregate value thereof for each of these named executive officers was below the $10,000 reporting threshold established by the Securities and Exchange Commission for this column.

Grants of Plan-Based Awards in Fiscal Year 2009

Name	Grant Date	Estimated Future Payouts Under Non-Equity Incentive Plan Awards (a) Threshold ($)	Target ($)	Maximum ($)	All Other Option Awards: Number of Securities Underlying Options (b)(#)	Exercise or Base Price of Option Awards ($/Sh)(b)	Grant Date Fair Value of Option Awards ($)(b)
Charles N. Martin, Jr.	n/a	109,808	1,098,079	1,647,119			
Phillip W. Roe	n/a	36,750	367,500	551,250			
Keith B. Pitts	n/a	61,650	616,500	924,750			
Kent H. Wallace	n/a	61,650	616,500	924,750			
	5/5/09				1,750	1,057.41	740,565
	5/5/09				1,750	1,057.41	877,153
	5/5/09				1,500	3,000.00	0
Joseph J. Mullany	n/a	111,690	408,000	663,000			

(a) The threshold, target and maximum amounts in these columns have been provided in accordance with Item 402(d) of Regulation S-K and show the range of payouts targeted for fiscal 2009 for performance under the Annual Incentive Plan. For fiscal year 2009, each of the named executive officers earned non-equity incentive plan awards, the Committee approved them and they were paid in cash to the named executive officers in September 2009 (except for certain portions thereof payable in September 2010 and September 2011, as disclosed in footnote (n) of the Summary Compensation Table,) and the full amounts of the awards are reflected in the Summary Compensation Table under the column labeled "Non-Equity Incentive Plan Compensation." See "Compensation Discussion and Analysis – Annual Incentive Compensation" for a detailed description of our Annual Incentive Plan.

(b) These are stock options awarded under the 2004 Stock Incentive Plan by the Committee as part of the named executive officer's long term equity incentive compensation. None of these options were granted with exercise prices below the fair market value of the underlying common stock on the date of grant. Since we are a privately-held company, the Committee determines the fair market value of our common stock primarily from an independent appraisal of our common stock which we obtain no less frequently than annually. The terms of these option awards are described in more detail under "Compensation Discussion and Analysis – Long Term Incentive Compensation – Our 2004 Stock Incentive Plan." We utilize a Black-Scholes-Merton model to estimate the fair value of options granted. The compensation expense recognized in our financial statements for fiscal year 2009 in accordance with SFAS 123(R) with respect to these option grants is reflected in the "Option Awards" column of the Summary Compensation Table.

Outstanding Equity Awards at Fiscal 2009 Year-End

The following table summarizes the outstanding equity awards held by each named executive officer at June 30, 2009. The table reflects options to purchase common stock of Vanguard which were granted under the Vanguard Health Systems, Inc. 2004 Stock Incentive Plan.

Name	Number of Securities Underlying Unexercised Options (#) Exercisable(a)	Number of Securities Underlying Unexercised Options (#) Unexercisable(b)	Option Exercise Price ($)(c)	Option Expiration Date
Charles N. Martin, Jr.	–	–	–	–
Phillip W. Roe	213(d)	140(d)	1,150.37	11/3/15
	–	353(e)	1,150.37	11/3/15
	182(d)	120(d)	3,000.00	11/3/15
	140(f)	560(f)	1,000.00	2/5/18
	–	700(g)	1,000.00	2/5/18
	120(f)	480(f)	3,000.00	2/5/18
Keith B. Pitts	105(f)	420(f)	1,000.00	2/5/18
	–	525(g)	1,000.00	2/5/18
	90(f)	360(f)	3,000.00	2/5/18
Kent H. Wallace	516(d)	342(d)	1,150.37	11/3/15
	–	858(e)	1,150.37	11/3/15
	442(d)	294(d)	3,000.00	11/3/15
	956(h)	636(h)	1,150.37	11/28/15
	–	1,592(i)	1,150.37	11/28/15
	819(h)	545(h)	3,000.00	11/28/15
	105(f)	420(f)	1,000.00	2/5/18
	–	525(g)	1,000.00	2/5/18
	90(f)	360(f)	3,000.00	2/5/18
	–	1,750(j)	1,057.41	5/5/19
	–	1,750(k)	1,057.41	5/5/19
	–	1,500(j)	3,000.00	5/5/19
Joseph J. Mullany	1,050(l)	700(l)	1,000.00	9/19/15
	–	1,750(m)	1,000.00	9/19/15
	900(l)	600(l)	3,000.00	9/19/15
	35(f)	140(f)	1,000.00	2/5/18
	–	175(g)	1,000.00	2/5/18
	30(f)	120(f)	3,000.00	2/5/18

(a) This column represents the number of stock options that had vested and were exercisable as of June 30, 2009.

(b) This column represents the number of stock options that had not vested and were not exercisable as of June 30, 2009.

(c) The exercise price for the options was never less than the grant date fair market value of a share of Vanguard common stock as determined by the Compensation Committee.

(d) 20% of the options represented by this option grant vest and become exercisable on each of the first five anniversaries of the November 3, 2005 grant date of these options (or earlier upon a change of control). 60% of this option grant was vested as of June 30, 2009.

(e) 100% of the options represented by this option grant vest and become exercisable on the eighth anniversary of the November 3, 2005 grant date of these options (or earlier upon a liquidity event).

(f) 20% of the options represented by this option grant vest and become exercisable on each of the first five anniversaries of the February 5, 2008 grant date of these options (or earlier upon a change of control). 20% of this option grant was vested as of June 30, 2009.

(g) 100% of the options represented by this option grant vest and become exercisable on the eighth anniversary of the February 5, 2008 grant date of these options (or earlier upon a liquidity event).

(h) 20% of the options represented by this option grant vest and become exercisable on each of the first five anniversaries of the November 28, 2005 grant date of these options (or earlier upon a change of control). 60% of this option grant was vested as of June 30, 2009.

(i) 100% of the options represented by this option grant vest and become exercisable on the eighth anniversary of the November 28, 2005 grant date of these options (or earlier upon a liquidity event).

(j) 20% of the options represented by this option grant vest and become exercisable on each of the first five anniversaries of the May 5, 2009 grant date of these options (or earlier upon a change of control). None of this option grant was vested as of June 30, 2009.

(k) 100% of the options represented by this option grant vest and become exercisable on the eighth anniversary of the May 5, 2009 grant date of these options (or earlier upon a liquidity event).

(l) 20% of the options represented by this option grant vest and become exercisable on each of the first five anniversaries of the September 19, 2005 grant date of these options (or earlier upon a change of control). 60% of this option grant was vested as of June 30, 2009.

(m) 100% of the options represented by this option grant vest and become exercisable on the eighth anniversary of the September 19, 2005 grant date of these options (or earlier upon a liquidity event).

Option Exercises and Stock Vested

No named executive officer exercised any stock options of Vanguard during fiscal 2009 nor were any restricted stock awards vested during fiscal 2009. Vanguard has made no restricted stock awards of its common stock since the Merger.

Pension Benefits

Vanguard maintains a 401(k) plan as previously discussed in the Compensation Discussion and Analysis. Vanguard maintains no defined benefit plans.

Nonqualified Deferred Compensation

None of the named executive officers receive nonqualified deferred compensation benefits.

Employment and Severance Protection Agreements

As discussed above, we have entered into definitive employment or severance protection agreements with four of the named executive officers (Messrs. Martin, Roe, Pitts and Wallace). The terms of these agreements are described above under Compensation Discussion and Analysis.

Potential Payments Upon Termination or Change of Control

The following table describes the potential payments and benefits under our compensation and benefit plans and arrangements to which the named executive officers would be entitled upon a termination of their employment under their employment agreement, if they have an employment agreement, or if they do not have an employment agreement, under their severance protection agreement. In accordance with SEC disclosure rules, dollar amounts below assume a termination of employment on June 30, 2009 (the last business day of our last completed fiscal year).

Current	Cash Severance Payment ($)	Continuation of Medical/Welfare Benefits (present value) ($)	Total Termination Benefits ($)
Charles N. Martin, Jr.			
·Voluntary retirement	0	0	0
·Involuntary termination	4,296,740	23,463	4,320,203
·Involuntary or Good Reason termination after change in control	6,445,110	23,463	6,468,573
Phillip W. Roe			
·Voluntary retirement	0	0	0
·Involuntary termination	1,715,000	23,463	1,738,463
·Involuntary or Good Reason termination after change in control	2,572,500	23,463	2,595,963
Keith B. Pitts			
·Voluntary retirement	0	0	0
·Involuntary termination	2,525,322	23,463	2,548,785
·Involuntary or Good Reason termination after change in control	3,787,983	23,463	3,811,446
Kent H. Wallace			
·Voluntary retirement	0	0	0
·Involuntary termination	2,450,000	23,463	2,473,463
·Involuntary or Good Reason termination after change in control	3,675,000	23,463	3,698,463
Joseph J. Mullany			
·Voluntary retirement	0	0	0
·Involuntary termination	0	0	0
·Involuntary or Good Reason termination after change in control	2,295,000	27,041	2,322,041

Accrued Pay and Regular Retirement Benefits. The amounts shown in the table above do not include payments and benefits to the extent they are provided on a non-discriminatory basis to salaried employees generally upon termination of employment. These include:

- Accrued salary and vacation pay and earned but unpaid bonus.
- Distributions of plan balances under our 401(k) plan.

Death and Disability. A termination of employment due to death or disability does not entitle the named executive officers to any payments or benefits that are not available to salaried employees generally.

Involuntary Termination and Change-in-Control Severance Pay Program. As described above under "—Our Employment Agreements," all of the named executive officers (except for Mr. Mullany who has no employment agreement with us) are entitled to severance pay in the event that their employment is terminated by us without Cause or if the named executive officer terminates the agreement as a result of our breach of his employment agreement. Additionally, they are entitled to severance pay under their employment agreements in the event they terminate the agreements after a change in control if their termination is for Good Reason.

As described above under "—Our Severance Protection Agreements", Mr. Mullany is entitled to severance pay in the event that his employment is terminated by us after a change of control without Cause. Additionally, he may terminate his agreement and be entitled to severance pay after a change in control if his termination is for Good Reason.

Under our executive severance pay program, no payments due in respect of a change of control are "single trigger", that is, payments of severance due to the named executive officers merely upon a change of control. All of our change of control payments are "double trigger", due to the executive only subsequent to a change of control and after a termination of employment has occurred.

Under their employment agreements, all of our named executive officers (except Mr. Mullany) owe the following obligations to us:

- Not to disclose our confidential business information;
- Not to solicit for employment any of our employees for a period expiring two years after the termination of their employment; and
- Not to accept employment with or consult with, or have any ownership interest in, any hospital or hospital management entity for a period expiring two years after the termination of their employment, except there shall be not such prohibitions if (1) we terminate the executive under his employment agreement or (2) the executive terminates his agreement for Good Reason or because we have breached his agreement.

The amounts shown in the table are for such involuntary or Good Reason terminations for the named executive officers and are based on the following assumptions and provisions in the employment agreements.

• *Covered terminations following a Change in Control.* Eligible terminations for Messrs. Martin, Roe, Pitts and Wallace include an involuntary termination for reasons other than Cause both before and following a change of control, or a voluntary resignation by the executive as a result of Good Reason following a change in control. Eligible terminations for Mr. Mullany include an involuntary termination for reasons other the Cause following a change of control, or a voluntary resignation as a result of Good Reason following a change of control.

• *Definitions of Cause and Good Reason*

A termination of a named executive officer by us is for Cause if it is for any of the following reasons:

(a) the conviction of the executive of a criminal act classified as a felony;

(b) the willful failure by the executive to substantially perform the executive's duties with us (other than any such failure resulting from the executive's incapacity due to physical or mental illness); or

(c) the willful engaging by the executive in conduct which is materially injurious to us monetarily or otherwise.

A termination by the named executive officer is for Good Reason if it results from, after a change of control has occurred, one of the following events:

(a) a material diminution in the executive's base compensation;

(b) a material diminution in the executive's authority, duties or responsibilities;

(c) a material diminution in the authority, duties or responsibilities of the supervisor to whom the executive is required to report, including a requirement that the executive's supervisor report to a corporate officer or employee instead of reporting directly to our Board of Directors;

(d) a material diminution in the budget over which the executive retains authority;

(e) a material change in the geographic location at which the executive must perform services, except for required travel on our business to an extent substantially consistent with his business travel obligations prior to the change in control; or

(f) any other action or inaction that constitutes a material breach by us of the terms of the employment agreement.

• *Cash severance payments; Timing*. Represents, for each of Messrs. Martin, Roe, Pitts and Wallace, (1) if it relates to an involuntary termination without Cause by us prior to a change of control, a payment of 2 times the named executive officer's base salary and average annual incentive actually paid during the last two years plus an additional amount equal to such officer's pro rata annual target incentive for the year of termination and (2) if it relates to an involuntary termination without cause by us or a Good Reason termination by the executive after a change of control, payment of 3 times the named executive officer's base salary and average annual incentive actually paid during the last two years plus an additional amount equal to such officer's pro rata annual target incentive for the year of termination. Represents, for Mr. Mullany, if it relates to either an involuntary termination without cause by us or a Good Reason termination by the executive after a change of control, payment of 2.5 times Mr. Mullany's base salary and target incentive plus an additional amount equal to Mr. Mullany's pro rata annual incentive for the year of termination. All of these severance payments are "lump sum" payments by us to the named executive officers due within 5 days of termination of employment, except that the amounts of severance described above payable to Messrs. Martin, Roe, Pitts and Wallace in respect of a termination of their employment prior to a change of control are payable monthly in equal monthly installments starting with the month after employment terminates and ending with the month that their 5-year employment agreements terminate (which is September 2010 for Messrs. Martin and Pitts and November 2012 for Messrs. Roe and Wallace).

• *Continuation of health, welfare and other benefits*. Represents the value of coverage for 18 months following a covered termination equivalent to our current active employee medical, dental, life, long-term disability insurances and other covered benefits.

Director Compensation

During fiscal 2009, our directors who are either our employees or affiliated with our private equity Sponsors did not receive any fees or other compensation services as our directors. As described in the table below, Michael J. Parsons, a director who is not our employee or an affiliate of our Sponsors, receives our current standardized director compensation plan for our independent directors of $60,000 per annum in cash plus an initial grant, upon election to our board of directors, of 85 stock options pursuant to our 2004 Stock Incentive Plan, as described in this Item under the caption "Our 2004 Stock Incentive Plan". We do, however, reimburse all of our directors for travel expenses and other out-of-pocket costs incurred in connection with attendance at meetings of the board.

The following table summarizes all compensation for our non-employee directors for our fiscal year ended June 30, 2009.

Name	Fees Earned or Paid in Cash(1) ($)	Stock Awards ($)	Option Awards(2)(3) ($)	Non-Equity Incentive Plan Compensation ($)	Change in Pension Value and Nonqualified Deferred Compensation Earnings	All Other Compensation ($)	Total ($)
Michael J. Parsons	60,000	–	2,812	–	–	–	62,812

(1) The director compensation in the above table reflects an annual cash retainer paid to each independent, non-employee director of $60,000. The employee director and the Sponsor-affiliated directors receive no additional compensation for serving on the board and, as a result, are not listed in the above table.

(2) The amount in this column reflects the dollar amount recorded for financial statement reporting purposes for the fiscal year ended June 30, 2009, in accordance with FAS 123(R), relating to Mr. Parsons' option award on May 6, 2008 granted pursuant to our 2004 Stock Option Plan. Assumptions used in the calculation of this amount are included in Note 12 of the Notes to our consolidated financial statements for the fiscal year ended June 30, 2009 included in this report.

(3) This represents a grant of 85 stock options on May 6, 2008 under our 2004 Stock Option Plan. 20% of such options (11 options) were exercisable on June 30, 2009. 30 of the options had an option exercise price of $1,000 per share and become exercisable 20% on each of the first five anniversaries of their May 6, 2008 grant date (or earlier upon a change of control). 30 of the options also had an option exercise price of $1,000 per share and become exercisable on the eighth anniversary of the May 6, 2008 grant date (or earlier upon a liquidity event). 25 of the options had an option exercise price of $3,000 per share and become exercisable 20% on each of the first five anniversaries of their May 6, 2008 grant date (or earlier upon a change of control). The exercise price for the options is not less than the fair market value of a share of our common stock as determined by the Compensation Committee. All of these 85 options have an expiration date of May 6, 2018. For more information about options granted under our 2004 Stock Option Plan, see information in this Item under the caption "Our 2004 Stock Incentive Plan".

Compensation Committee Interlocks and Insider Participation

During fiscal 2009, we had no compensation committee of our board of directors. Charles N. Martin, Jr., one of our named executive officers, participated in deliberations of our board of directors concerning executive officer compensation during fiscal 2009. Also, during fiscal 2009, Keith B. Pitts, one of our named executive officers, served on the board of directors of SouthernCare, Inc., one of whose executive officers, Michael J. Parsons, served on our board of directors. Both our board of directors and the board of directors of SouthernCare, Inc. act as the compensation committees for each such entity, each such entity having no such standing compensation committee or other committee performing similar functions.

Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters.

As of September 1, 2009, VHS Holdings LLC ("Holdings") directly owned 624,550 of the outstanding shares of the common stock of Vanguard (representing a 83.3% ownership interest), certain investment funds affiliated with Blackstone directly owned 125,000 of the outstanding shares of the common stock of Vanguard (representing a 16.7% ownership interest) and no other person or entity had a direct beneficial ownership interest in the common stock of Vanguard, except for certain key employees who held an aggregate of 27,804 exercisable options into 27,804 shares of the common stock of Vanguard as of such date. However, ignoring only the direct ownership of Holdings in the common stock of Vanguard, the following table sets forth information with respect to the direct or indirect beneficial ownership of the common stock of Vanguard as of September 1, 2009 by (1) each person (other than Holdings) known to own beneficially more than 5.0% of the common stock of Vanguard, (2) each named executive officer, (3) each of our directors and (4) all executive officers and directors as a group. The indirect beneficial ownership of the common stock of Vanguard reflects the direct beneficial ownership of all Class A units and all vested Class B and D units of Holdings. None of the shares listed in the table are pledged as security pursuant to any pledge arrangement or agreement. Additionally, there are no arrangements with respect to the share, the operation of which may result in a change in control of Vanguard.

Notwithstanding the beneficial ownership of the common stock of Vanguard presented below, the limited liability company agreement of Holdings governs the holders' exercise of their voting rights with respect to election

of Vanguard's directors and certain other material events. See "Item 13. Certain Relationships and Related Transactions - Holdings Limited Liability Company Agreement."

Name of Beneficial Owner	Beneficial Ownership	Ownership Percentage
Blackstone Funds(1)	494,930	66.0%
MSCP Funds(2)	130,000	17.3%
Charles N. Martin Jr.(3)	56,553	7.4%
Phillip W. Roe(4)	7,580	1.0%
Keith B. Pitts(5)	20,932	2.8%
Kent H. Wallace(6)	8,647	1.1%
Joseph J. Mullany(7)	2,665	*
M. Fazle Husain(8)	126,750	16.9%
James A. Quella(1)	494,930	66.0%
Neil P. Simpkins (1)	494,930	66.0%
Michael A. Dal Bello	-(9)	- (9)
Alan M. Muney, M.D.	-(9)	- (9)
Michael J. Parsons (10)	11	*
All directors and executive officers as a group (29 persons) (11)	773,854	94.8%

* Less than 1% of shares of common stock outstanding (excluding, in the case of all directors and executive officers as a group, shares beneficially owned by Blackstone and by the MSCP Funds).

(1) Includes common stock interests directly and indirectly owned by each of Blackstone FCH Capital Partners IV L.P., Blackstone FCH Capital Partners IV-A L.P., Blackstone FCH Capital Partners IV-B L.P., Blackstone Capital Partners IV-A L.P., Blackstone Family Investment Partnership IV-A L.P., Blackstone Health Commitment Partners L.P. and Blackstone Health Commitment Partners-A L.P. (the "Blackstone Funds"), for which Blackstone Management Associates IV L.L.C. ("BMA") is the general partner having voting and investment power over the membership interests in Holdings and the shares in Vanguard held or controlled by each of the Blackstone Funds. Messrs. Quella and Simpkins are members of BMA, but disclaim any beneficial ownership of the membership interests or the shares beneficially owned by BMA. Mr. Stephen A. Schwarzman is the founding member of BMA and as such may be deemed to share beneficial ownership of the membership interests or shares held or controlled by the Blackstone Funds. Mr. Schwarzman disclaims beneficial ownership of such membership interests and shares. The address of BMA and the Blackstone Funds is c/o The Blackstone Group L.P., 345 Park Avenue, New York, New York 10154

(2) The MSCP Funds consist of the following six funds: Morgan Stanley Capital Partners III, L.P., MSCP III 892 Investors, L.P., Morgan Stanley Capital Investors, L.P., Morgan Stanley Dean Witter Capital Partners IV, L.P., MSDW IV 892 Investors, L.P., and Morgan Stanley Dean Witter Capital Investors IV, L.P. The address of each of Morgan Stanley Capital Partners III, L.P., MSCP III 892 Investors, L.P., Morgan Stanley Dean Witter Capital Partners IV, L.P. and MSDW IV 892 Investors, L.P. is c/o Metalmark Capital LLC, 1177 Avenue of the Americas, New York, New York 10036. The address of each of Morgan Stanley Capital Investors, L.P. and Morgan Stanley Dean Witter Capital Investors IV, L.P. is c/o Morgan Stanley, 1585 Broadway, New York, New York 10036. Metalmark Capital LLC shares investment and voting power with Morgan Stanley Capital Partners III, L.P., MSCP III 892 Investors, L.P., Morgan Stanley Dean Witter Capital Partners IV, L.P. and MSDW IV 892 Investors, L.P. over 126,750 of these 130,000 shares of Vanguard common stock indirectly owned by these four funds.

(3) Includes 8,913 B units and 7,640 D units in Holdings which are vested or vest within 60 days of September 1, 2009. Also, includes 5,000 A units in Holdings owned by the Charles N. Martin, Jr. 2008 Irrevocable Grantor Retained Annuity Trust u/a/d December 5, 2008, of which Mr. Martin is Trustee and one of its beneficiaries.

(4) Includes 655 options on Vanguard common stock and 2,097 B units and 1,798 D units in Holdings which are vested or vest within 60 days of September 1, 2009.

(5) Includes 195 options on Vanguard common stock and 5,243 B units and 4,494 D units in Holdings which are vested or vest within 60 days of September 1, 2009.

(6) Includes 2,928 options on Vanguard common stock and 2,622 B units and 2,247 D units in Holdings which are vested or vest within 60 days of September 1, 2009. Also, includes 850 A units in Holdings owned by the 2008 Kent H. Wallace Trust u/a/d October 10, 2008, of which Mr. Wallace is sole beneficiary. The 2,622 B units and the 2,247 D units in Holding are also owed by the Trust.

(7) Includes solely 2,665 options on Vanguard common stock which are vested or vest within 60 days of September 1, 2009.

(8) Mr. Husain is a Managing Director of Metalmark Capital LLC and exercises shared voting or investment power over the membership interests in Holdings owned by Morgan Stanley Capital Partners III, L.P., MSCP III 892 Investors, L.P., Morgan Stanley Dean Witter Capital Partners IV, L.P., and MSDW IV 892 Investors, L.P. and, as a result, may be deemed to be the beneficial owner of such membership interests and the 126,750 shares of Vanguard common stock indirectly owned by these four funds. Mr. Husain disclaims beneficial ownership of such membership interests and shares of common stock as a result of his employment arrangements with Metalmark, except to the extent of his pecuniary interest therein ultimately realized. Metalmark Capital does not have investment and voting

power with respect to 3,250 shares of Vanguard common stock indirectly owned by Morgan Stanley Capital Investors, L.P. and Morgan Stanley Dean Witter Capital Investors IV, L.P. and these 3,250 shares are not included in the 126,750 shares contained in this table for Mr. Husain.

(9) Mr. Dal Bello and Mr. Muney are employees of Blackstone, but do not have investment or voting control over the shares beneficially owned by Blackstone.

(10) Includes solely 11 options in Vanguard common stock which are vested or vest within 60 days of September 1, 2009.

(11) Includes 13,445 options in Vanguard and 28,574 B units and 24,492 D units in Holdings which have vested or vest within 60 days of September 1, 2009.

Equity Compensation Plan Information

The following table gives information about our common stock that may be issued upon the exercise of options, warrants and rights under all of Vanguard's existing equity compensation plans as of June 30, 2009.

	Equity Compensation Plan Information		
Plan Category	Number of securities to be issued upon exercise of outstanding options, warrants and rights (a)	Weighted-average exercise price of outstanding options, warrants and rights (b)	Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a)) (c)
Equity compensation plans approved by security holders	102,455(1)	$1,643	2,652 (1)
Equity compensation plans not approved by security holders	0	$ 0	0
Total	102,455	$1,643	2,652

(1) The material features of the equity compensation plan under which these options were issued are set forth in this report under "Item 11. Executive Compensation – Our 2004 Stock Incentive Plan."

Item 13. Certain Relationships and Related Transactions, and Director Independence.

Holdings Limited Liability Company Agreement

In the Merger, Blackstone invested, and MSCP, Baptist and the Rollover Management Investors re-invested, in our company by subscribing for and purchasing Class A membership units in Holdings. In addition, at the closing of the Merger, the board of representatives of Holdings issued to certain Rollover Management Investors Class B, C and D membership units in Holdings as part of a new equity incentive program.

Under the limited liability company agreement of Holdings, the board of representatives of Holdings consists of the same five individuals who constitute the sole members of our board of directors. At Blackstone's election, the size of the board of representatives may be increased to nine members, with two additional representatives to be designated by Blackstone and two additional representatives to be independent representatives identified by our chief executive officer and acceptable to Blackstone. If at any time our chief executive officer is not Charles N. Martin, Jr., the Rollover Management Investors shall have the right to designate one representative to the board (the "Manager Representative") so long as the Rollover Management Investors continue to own not less than 50% of the Class A units held by them immediately after the completion of the Merger. MSCP will continue to be entitled to nominate and elect one representative so long as MSCP continues to own not less than 50% of the Class A units it held immediately after the completion of the Merger.

The limited liability company agreement of Holdings also has provisions relating to restrictions on transfer of securities, rights of first refusal, tag-along, drag-along, preemptive rights and affiliate transactions. At the

completion of the Merger, the Company issued Class B, C and D warrants to Holdings, exercisable for the proportional percentage of equity represented by the related classes of membership units in Holdings. With respect to the Class B, C and D units only, the limited liability company agreement also has call provisions applicable in the event of certain termination events relating to a Rollover Management Investor's employment.

Stockholders Agreement

Recipients of options to purchase the Company's common stock are required to enter into a stockholders agreement governing such grantees' rights and obligations with respect to the common stock underlying such options. The provisions of the stockholders agreement are, with limited exceptions, similar to those set forth in the limited liability company agreement of Holdings, including certain restrictions on transfer of shares of common stock, rights of first refusal, call rights, tag-along rights and drag-along rights. The transfer restrictions apply until the earlier of the fifth anniversary of the date the stockholder becomes a party to the stockholders agreement, or a change in control of the Company. The right of first refusal provision gives the Company a right of first refusal at any time after the fifth anniversary of the date the stockholder became a party to the stockholders agreement and prior to the earlier of a change in control of the Company or a registered public offering of our common stock meeting certain specified criteria. The call provisions provide rights with respect to the shares of our common stock held by the stockholder, whether or not such shares were acquired upon the exercise of a New Option, except for shares received upon conversion of or in redemption for Class A membership units in Holdings pursuant to the limited liability company agreement of Holdings. Such call rights are applicable in the event of certain termination events relating to the grantee's employment with the Company.

Transaction and Monitoring Fee Agreement

In connection with the Merger, Vanguard entered into a transaction and monitoring fee agreement with affiliates of Blackstone and with Metalmark Subadvisor LLC ("Metalmark SA") pursuant to which these entities provide certain structuring, advisory and management services to Vanguard. Under this agreement, Vanguard paid to Blackstone Management Partners IV L.L.C. ("BMP") upon the closing of the Merger a transaction fee of $20.0 million. In consideration for ongoing consulting and management advisory services, Vanguard is required to pay to BMP an annual fee of $4.0 million. In consideration for on-going consulting and management services Vanguard is required to pay to Metalmark SA an annual fee of $1.2 million for the first five years and thereafter an annual fee of $600,000. In the event or in anticipation of a change of control or initial public offering, BMP may elect at any time to have Vanguard pay to BMP and Metalmark SA lump sum cash payments equal to the present value (using a discount rate equal to the yield to maturity on the date of notice of such event of the class of outstanding U.S. government bonds having a final maturity closest to the tenth anniversary of such written notice) of all then-current and future fees payable to each of BMP and Metalmark SA under the agreement (assuming that the agreement terminates on the tenth anniversary of the closing of the Merger). In the event that BMP receives any additional fees in connection with an acquisition or disposition involving Vanguard, Metalmark SA will receive an additional fee equal to 15.0% of such fees paid to BMP or, if both parties provide equity financing in connection with the transaction, Metalmark SA will receive a portion of the aggregate fees payable by Vanguard, if any, based upon the amount of equity financing provided by Metalmark SA. The transaction and monitoring fee agreement also requires Vanguard to pay or reimburse BMP and Metalmark SA for reasonable out-of-pocket expenses in connection with, and indemnify them for liabilities arising from, the engagement of BMP and Metalmark SA of independent professionals pursuant to and the performance by BMP and Metalmark SA of the services contemplated by the transaction and monitoring fee agreement. The transaction and monitoring fee agreement will remain in effect with respect to each of BMP and Metalmark SA until the earliest of (1) BMP and Metalmark SA, as the case may be, beneficially owning less than 5.0% of Vanguard's common equity on a fully diluted basis, (2) the completion of a lump-sum payout as described above or (3) termination of the agreement upon the mutual consent of BMP and/or Metalmark SA, as the case may be, and Vanguard. Upon termination of Metalmark SA as a party to the agreement, Metalmark SA will be entitled to the excess, if any, of 15.0% of the aggregate amount of fees paid to date to BMP under the agreement minus any monitoring fees already paid to Metalmark SA.

Under the transaction and monitoring fee agreement during fiscal year 2009, Vanguard paid to BMP the annual $4.0 million fee referred to above. BMP is an affiliate of the Blackstone Funds which own 66.0% of the equity of Vanguard. Four of our seven directors, Messrs. Dal Bello, Muney, Quella and Simpkins, are employed by affiliates of BMP.

Under the transaction and monitoring fee agreement during fiscal year 2009, Vanguard paid to Metalmark SA the annual $1.2 million fee referred to above. Metalmark SA is an affiliate of Metalmark Capital LLC which manages the MSCP Funds and the MSCP Funds own 17.3% of the equity of Vanguard.

Registration Rights Agreement

In connection with the Merger, the Company entered into a registration rights agreement with Blackstone, MSCP and other investors and the Rollover Management Investors, pursuant to which Blackstone and MSCP are entitled to certain demand registration rights and pursuant to which Blackstone, MSCP and other investors and the Rollover Management Investors are entitled to certain piggyback registration rights.

Employer Health Program Agreement with a Blackstone Affiliate, Equity Healthcare LLC

Effective July 1, 2008, the Company entered into an Employer Health Program Agreement with Equity Healthcare LLC ("Equity Healthcare"). Equity Healthcare negotiates with providers of standard administrative services for health benefit plans as well as other related services for cost discounts and quality of service monitoring capability by Equity Healthcare. Because of the combined purchasing power of its client participants, Equity Healthcare is able to negotiate pricing terms for providers that are believed to be more favorable than the companies could obtain for themselves on an individual basis.

In consideration for Equity Healthcare's provision of access to these favorable arrangements and its monitoring of the contracted third parties' delivery of contracted services to the Company, Equity Healthcare receives from the Company a fee of $2 per employee per month ("PEPM Fee"). As of June 30, 2009, the Company has approximately 11,750 employees enrolled in its health and welfare benefit plans.

Equity Healthcare may also receive a fee from one or more of the health plans contracted with Equity Healthcare ("Health Plan Fees") if the total number of employees from Blackstone portfolio companies joining such health plans exceeds specified thresholds. If and when Equity Healthcare reaches the point at which the aggregate of its receipts from the PEPM Fee and the Health Plan Fees have covered all of its allocated costs, it will apply the incremental revenues derived from all such fees to (a) reduce the PEPM Fee; (b) avoid or reduce an increase in the PEPM Fee that might otherwise have occurred on contract renewal; or (c) arrange for additional services to the Company at no cost or reduced cost.

Equity Healthcare is an affiliate of Blackstone, with whom Michael A. Dal Bello, Alan M. Muney, James A. Quella and Neil P. Simpkins, members of our Board, are affiliated and in which they may have an indirect pecuniary interest.

Commercial Transactions with Sponsor Portfolio Companies

Blackstone, MSCP and Metalmark each sponsor private equity funds which have ownership interests in a broad range of companies. We have entered into commercial transactions in the ordinary course of our business with some of these companies, including the sale of goods and services and the purchase of goods and services. None of these transactions or arrangements is of great enough value to be considered material to us.

Policy on Transactions with Related Persons

The Vanguard board of directors recognizes the fact that transactions with related persons present a heightened risk of conflicts of interests and/or improper valuation (or the perception thereof). In February 2007, the board of directors adopted a written policy reflecting existing practices to be followed in connection with any transaction between the Company and a "related person."

Any transaction with the Company in which a director, executive officer or beneficial holder of more than 5% of the total equity of the Company, or any immediate family member of the foregoing (each, a "related person") has a direct or indirect material interest, and where the amount involved exceeds $120,000, must be specifically disclosed by the Company in its public filings. Any such transaction would be subject to the Company's written policy respecting the review, approval or ratification of related person transactions.

Under this policy:

- the Company or any of its subsidiaries may employ a related person in the ordinary course of business consistent with the Company's policies and practices with respect to the employment of non-related persons in similar positions; and

- any other related person transaction that would be required to be publicly disclosed must be approved or ratified by the board of directors, a committee thereof or if it is impractical to defer consideration of the matter until a board or committee meeting, by a non-management director who is not involved in the transaction.

If the transaction involves a related person who is a director or an immediate family member of a director, that director may not participate in the deliberations or vote. In approving or ratifying a transaction under this policy, the board of directors, the committee or director considering the matter must determine that the transaction is fair to the Company and may take into account, among other factors deemed appropriate, whether the transaction is on terms not less favorable than terms generally available to an unaffiliated third-party under the same or similar circumstances and the extent of the related person's interest in the transaction.

During fiscal year 2009, there were no transactions between the Company and a related person requiring approval under this policy, except for the Employer Health Program Agreement with Equity Healthcare.

Director Independence

Our board of directors has not made a formal determination as to whether each director is "independent" because we have no equity securities listed for trading on a national securities exchange or in an automated inter-dealer quotation system of a national securities association, which has requirements that a majority of its board of directors be independent. Six of our seven directors have either been appointed by our equity Sponsors or are employed by us (Mr. Martin, our chairman and chief executive officer). Our seventh director (Michael J. Parsons) is neither our employee or otherwise affiliated with us in any significant way. Thus, we do not believe any of our directors would be considered independent under the New York Stock Exchange's definition of independence, except for Mr. Parsons.

Item 14. Principal Accounting Fees and Services.

Fees Paid to the Independent Auditor

The following table presents fees for professional services rendered by Ernst & Young LLP for the audit of Vanguard's annual financial statements for 2008 and 2009, and fees billed for audit-related services, tax services and all other services rendered by Ernst & Young LLP for 2008 and 2009.

	2008	2009
Audit fees[1]	$ 856,929	$ 852,712
Audit-related fees	1,500	1,995
Audit and audit-related fees	858,429	854,707
Tax fees[2]	64,263	133,384
All other fees[3]	1,108,072	1,002,563
Total fees[4]	$ 2,030,764	$ 1,990,654

(1) Audit fees for 2008 and 2009 include fees for the audit of the annual consolidated financial statements, reviews of the condensed consolidated financial statements included in Vanguard's quarterly reports and statutory audits.

(2) Tax fees for 2008 and 2009 consisted principally of fees for tax advisory services.

(3) All other fees for 2008 and 2009 consisted of assistance in identification of Medicaid eligible days for inclusion in the Medicare cost reports for Medicare disproportionate share reimbursement; assistance in validating average wage rates in our markets used in Medicare reimbursement; assistance in preparing reports for us relating to payer matters; and assistance in preparing occupational mix survey data in accordance with CMS requirements.

(4) Ernst & Young LLP full time, permanent employees performed all of the professional services described in this chart.

Pre-Approval Policies and Procedures

In February 2004, our board of directors first adopted an audit and non-audit services pre-approval policy and in November 2004 and May 2006 the board amended and restated this policy. This policy sets forth the Board's procedures and conditions pursuant to which services proposed to be performed by the Company's regular independent auditor (and those other independent auditors for whom pre-approvals are legally necessary) are presented to the Board for pre-approval. Normally, the policy would have been approved by the audit committee and ratified by the board of directors, but in February 2004, November 2004 and May 2006 we had no audit committee and, as a result, the full board of directors has the responsibility for all matters that are usually the responsibility of the audit committee.

The policy provides that the board of directors shall pre-approve audit services, audit-related services, tax services and those other services that it believes to be routine and recurring services that do not impair the independence of the auditor. Under the policy, our Chief Accounting Officer is responsible for determining whether services provided by the independent auditor are included as part of those services already pre-approved or whether separate approval from the board of directors is required. All services performed for us by Ernst & Young LLP, our independent registered public accounting firm, subsequent to the adoption of the policy have been pre-approved by the board of directors. The board of directors has concluded that the audit-related services, tax services and other non-audit services provided by Ernst & Young LLP in fiscal year 2009 were compatible with the maintenance of the firm's independence in the conduct of its auditing functions. In addition, to safeguard the continued independence of the independent auditors, the policy prevents our independent auditors from providing services to us that are prohibited under Section 10A(g) of the Securities Exchange Act of 1934, as amended.

PART IV

Item 15. Exhibits and Financial Statement Schedules.

(a) List of documents filed as part of this report.

(1) Financial Statements. The accompanying index to financial statements on page **XX** of this report is provided in response to this item.

(2) Financial Statement Schedules. All schedules are omitted because the required information is either not present, not present in material amounts or presented within the consolidated financial statements.

(3) Exhibits. The exhibits filed as part of this report are listed in the Exhibit Index which is located at the end of this report.

(b) Exhibits.
See Item 15(a)(3) of this report.

(c) Financial Statement Schedules.
See Item 15(a)(2) of this report.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

VANGUARD HEALTH SYSTEMS, INC. — Date

By: /s/ Charles N. Martin, Jr. — September 2, 2009
Charles N. Martin, Jr.
Chairman of the Board & Chief Executive Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/s/ Charles N. Martin, Jr. Charles N. Martin, Jr.	Chairman of the Board & Chief Executive Officer; Director (Principal Executive Officer)	September 2, 2009
/s/ Phillip W. Roe Phillip W. Roe	Executive Vice President, Chief Financial Officer & Treasurer (Principal Financial Officer)	September 2, 2009
/s/ Gary D. Willis Gary D. Willis	Senior Vice President, Controller & Chief Accounting Officer (Principal Accounting Officer)	September 2, 2009
/s/ Michael A. Dal Bello Michael A. Dal Bello	Director	September 2, 2009
/s/ M. Fazle Husain M. Fazle Husain	Director	September 2, 2009
_____ Alan M. Muney, M.D.	Director	September 2, 2009
/s/ Michael J. Parsons Michael J. Parsons	Director	September 2, 2009
_____ James A. Quella	Director	September 2, 2009
/s/ Neil P. Simpkins Neil P. Simpkins	Director	September 2, 2009

Supplemental Information to be Furnished With Reports Filed Pursuant to Section 15(d) of the Act by Registrants Which Have Not Registered Securities Pursuant to Section 12 of the Act.

No annual report or proxy material has been sent to security holders.

EXHIBIT INDEX

Exhibit No.	Description
2.1	Agreement and Plan of Merger, dated as of July 23, 2004, among VHS Holdings LLC, Health Systems Acquisition Corp. and Vanguard Health Systems, Inc.(1)
2.2	First Amendment to the Agreement and Plan of Merger, dated as of September 23, 2004, among VHS Holdings LLC, Health Systems Acquisition Corp. and Vanguard Health Systems, Inc.(1)
2.3	Indemnification Agreement, dated as of July 23, 2004, among VHS Holdings LLC, Vanguard Health Systems, Inc., and the stockholders and holders of options set forth therein(1)(3)
3.1	Amended and Restated Certificate of Incorporation of Vanguard Health Systems, Inc.(1)
3.2	By-Laws of Vanguard Health Systems, Inc.(7)
4.1	Indenture, relating to the 9% Senior Subordinated Notes, dated as of September 23, 2004, among Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the Guarantors party thereto and the Trustee(1)
4.2	First Supplemental Indenture, dated as of November 5, 2004, among Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the Guarantors party thereto and the Trustee(1)
4.3	Indenture, relating to the 11 1/4% Senior Discount Notes, dated as of September 23, 2004, among Vanguard Health Holding Company I, LLC, Vanguard Holding Company I, Inc, Vanguard Health Systems, Inc. and the Trustee(1)
4.4	Registration Rights Agreement relating to the 9% Senior Subordinated Notes, dated as of September 23, 2004, among Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the Guarantors party thereto, Citigroup Global Markets Inc., Banc of America Securities LLC, Bear Stearns & Co., Inc., J.P. Morgan Securities Inc., Merrill Lynch, Pierce, Fenner & Smith Incorporated, Wachovia Capital Markets, LLC and ABN AMRO Incorporated(1)
4.5	Registration Rights Agreement, relating to the 11 1/4% Senior Discount Notes, dated as of September 23, 2004, among Vanguard Health Holding Company I, LLC, Vanguard Holding Company I, Inc., Vanguard Health Systems, Inc., Citigroup Global Markets Inc., Banc of America Securities LLC, Bear Stearns & Co., Inc., J.P. Morgan Securities Inc., Merrill Lynch, Pierce, Fenner & Smith Incorporated, Wachovia Capital Markets, LLC and ABN AMRO Incorporated(1)
4.6	Registration Rights Agreement, concerning Vanguard Health Systems, Inc., dated as of September 23, 2004(1)
4.7	Second Supplemental Indenture, dated as of March 28, 2005, among Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the Guarantors party thereto and the Trustee (5)
4.8	Third Supplemental Indenture, dated as of July 13, 2006, among Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the Guarantors party thereto and the Trustee (11)
4.9	Fourth Supplemental Indenture, dated as of June 25, 2007, among Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the Guarantors party thereto and the Trustee(13)

4.10	Fifth Supplemental Indenture, dated as of July 1, 2007, among Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the Guarantors party thereto and the Trustee(13)
4.11	Sixth Supplemental Indenture, dated as of October 2, 2007, among Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the Guarantors party thereto and the Trustee (14)
4.12	Seventh Supplemental Indenture, dated as of November 3, 2008, among Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the Guarantors party thereto and the Trustee (18)
4.13	Eighth Supplemental Indenture, dated as of March 24, 2009, among Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the Guarantors party thereto and the Trustee (19)
10.1	Credit Agreement, dated as of September 23, 2004, among Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., Vanguard Health Holding Company I, LLC, the lenders party thereto, Bank of America, N.A. as administrative agent, Citicorp North America, Inc., as syndication agent, the other agents named therein, and Banc of America Securities LLC and Citigroup Global Markets Inc., as joint lead arrangers and book runners(1)
10.2	Security Agreement, dated as of September 23, 2004, made by each assignor party thereto in favor of Bank of America, N.A., as collateral agent(1)
10.3	Vanguard Guaranty, dated as of September 23, 2004, made by and among Vanguard Health Systems, Inc. in favor of Bank of America, N.A., as administrative agent(1)
10.4	Subsidiaries Guaranty, dated as of September 23, 2004, made by and among each of the guarantors party thereto in favor of Bank of America, N.A., as administrative agent(1)
10.5	Pledge Agreement, dated as of September 23, 2004, among each of the pledgors party thereto and Bank of America, N.A., as collateral agent(1)
10.6	Transaction and Monitoring Fee Agreement, dated as of September 23, 2004, among Vanguard Health Systems, Inc., Blackstone Management Partners IV L.L.C., and Metalmark Management LLC(1)
10.7	Amended and Restated Limited Liability Company Operating Agreement of VHS Holdings LLC, dated as of September 23, 2004(1)
10.8	Vanguard Health Systems, Inc. 2004 Stock Incentive Plan(1)(3)
10.9	VHS Holdings LLC 2004 Unit Plan(1)(3)
10.10	Vanguard Health Systems, Inc. 2001 Annual Incentive Plan(2)(3)
10.11	Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Charles N. Martin, Jr., dated as of September 23, 2004(1)(3)
10.12	Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Joseph D. Moore, dated as of September 23, 2004(1)(3)
10.13	Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Ronald P. Soltman, dated as of September 23, 2004(1)(3)

10.14	Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Keith B. Pitts, dated as of September 23, 2004(1)(3)
10.15	Form of Amended and Restated Severance Protection Agreement of Vanguard Health Systems, Inc. dated as of September 23, 2004 for Vice Presidents and above (1)(3)
10.16	Amended and Restated Agreement Between the Shareholders of VHS Acquisition Subsidiary Number 5, Inc. executed on September 8, 2004, but effective as of September 1, 2004(1)
10.17	Certificate of Designations, Preferences and Rights of Series A Preferred Stock of VHS Acquisition Subsidiary Number 5, Inc., dated as of September 8, 2004(1)
10.18	License Agreement between Baptist Health System and VHS San Antonio Partners, L.P. dated as of January 1, 2003(4)
10.19	Form of Performance Option Under 2004 Stock Incentive Plan(1)(3)
10.20	Form of Time Option Under 2004 Stock Incentive Plan(1)(3)
10.21	Form of Liquidity Event Option Under 2004 Stock Incentive Plan(1)(3)
10.22	Stockholders Agreement Concerning Vanguard Health Systems, Inc., dated as of November 4, 2004, by and among Vanguard Health Systems, Inc., VHS Holdings LLC, Blackstone FCH Capital Partners IV L.P. and its affiliates identified on the signature pages thereto and the employees identified on the signature pages thereto(1)
10.23	Amendment No. 1 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Charles N. Martin, Jr., dated as of December 1, 2004(1)(3)
10.24	Amendment No. 1 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Joseph D. Moore, dated as of December 1, 2004(1)(3)
10.25	Amendment No. 1 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Ronald P. Soltman, dated as of December 1, 2004(1)(3)
10.26	Amendment No. 1 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Keith B. Pitts, dated as of December 1, 2004(1)(3)
10.27	First Amendment of VHS Holdings LLC 2004 Unit Plan(3)(7)
10.28	First Amendment to Credit Agreement, dated as of August 15, 2005, among Vanguard Health Holding Company I, LLC, Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the lenders party to the Credit Agreement referred to therein, and Bank of America, N.A. as administrative agent(6)
10.29	First Amendment to Credit Agreement, dated as of August 15, 2005, among Vanguard Health Holding Company I, LLC, Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the lenders party to the Credit Agreement referred to therein, and Bank of America, N.A. as administrative agent(8)
10.30	Amendment No. 2 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Charles N. Martin, Jr., dated as of December 1, 2005(3)(9)
10.31	Amendment No. 2 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Joseph D. Moore , dated as of December 1, 2005(3)(9)

10.32	Amendment No. 2 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Ronald P. Soltman, dated as of December 1, 2005(3)(9)
10.33	Amendment No. 2 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Keith B. Pitts, dated as of December 1, 2005(3)(9)
10.34	Amendment No. 1, dated as of November 3, 2005, to Amended and Restated Limited Liability Company Operating Agreement of VHS Holdings LLC(9)
10.35	Amendment Number 1 to the Vanguard Health Systems, Inc. 2004 Stock Incentive Plan, effective November 28, 2005(3)(9)
10.36	Amendment Number 2 to the Vanguard Health Systems, Inc. 2004 Stock Incentive Plan, effective February 15, 2006(3)(10)
10.37	Amendment Number 3 to the Vanguard Health Systems, Inc. 2004 Stock Incentive Plan, effective April 15, 2006(3)(10)
10.38	Amendment Number 4 to the Vanguard Health Systems, Inc. 2004 Stock Incentive Plan, effective November 13, 2006(3)(12)
10.39	Amendment No. 3 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Charles N. Martin, Jr., dated as of October 1, 2007(3)(15)
10.40	Amendment No. 3 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Keith B. Pitts, dated as of October 1, 2007(3)(15)
10.41	Amendment No. 3 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Joseph D. Moore, dated as of October 1, 2007(3)(15)
10.42	Amendment No. 4 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Joseph D. Moore, dated as of November 7, 2007(3)(15)
10.43	Amendment No. 3 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Ronald P. Soltman, dated as of October 1, 2007(3)(15)
10.44	Employment Agreement between Vanguard Health Systems, Inc. and Kent H. Wallace dated as of November 15, 2007(3)(15)
10.45	Employment Agreement between Vanguard Health Systems, Inc. and Phillip W. Roe dated as of November 15, 2007(3)(15)
10.46	Form of Amendment No. 1 to Severance Protection Agreement dated as of October 1, 2007, entered into between Vanguard Health Systems, Inc. and each of its executive officers (other than Messrs. Martin, Pitts, Moore, Soltman, Wallace and Roe who each have entered into employment agreements with the registrant)(3)(15)
10.47	Amendment Number 5 to the Vanguard Health Systems, Inc. 2004 Stock Incentive Plan, effective May 6, 2008(3)(16)
10.48	Letter dated May 13, 2008, from the Arizona Health Care Cost Containment System to VHS Phoenix Health Plan, LLC, countersigned by VHS Pboenix Health Plan, LLC on May 13, 2008 awarding Contract No. YH09-0001-07(17)

10.49 Waiver No. 1 dated as of May 22, 2008, to Amended and Restated Limited Liability Company Operating Agreement of VHS Holdings LLC, dated as of September 23, 2004, as amended by Amendment No. 1, dated as of November 3, 2005(20)

10.50 Amendment No. 5 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Joseph D. Moore, dated as of June 30, 2008(3)(20)

10.51 Form of Severance Protection Agreement of Vanguard Health Systems, Inc. in current use for Vice Presidents and above(3)(20)

10.52 Arizona Health Care Cost Containment System Administration RFP re Contract No. YH09-0001-07 with VHS Phoenix Health Plan, LLC awarded May 13, 2008(20)

10.53 Solicitation Amendments to RFP numbers One, Two, Three, Four and Five dated February 29, 2008, March 14, 2008, March 26, 2008, March 28, 2008 and April 10, 2008, respectively, to Arizona Health Care Cost Containment System Administration Contract No. YH09-0001-07 with VHS Phoenix Health Plan, LLC(20)

10.54 Contract Amendment Number 1, executed on September 23, 2008, but effective as of October 1, 2008, to the Arizona Health Care Cost Containment System Administration Contract No. YH09-0001-07 between VHS Phoenix Health Plan, LLC and the Arizona Health Care Cost Containment System(21)

10.55 Contract Amendment Number 2, executed on January 16, 2009, but effective as of January 15, 2009, to the Arizona Health Care Cost Containment System Administration Contract No. YH09-0001-07 between VHS Phoenix Health Plan, LLC and the Arizona Health Care Cost Containment System(18)

10.56 Contract Amendment Number 3, executed on April 6, 2009, but effective as of May 1, 2009, to the Arizona Health Care Cost Containment System Administration Contract No. YH09-0001-07 between VHS Phoenix Health Plan, LLC and the Arizona Health Care Cost Containment System(19)

10.57 Contract Amendment Number 4, executed on July 7, 2009, but effective as of August 1, 2009, to the Arizona Health Care Cost Containment System Administration Contract No. YH09-0001-07 between VHS Phoenix Health Plan, LLC and the Arizona Health Care Cost Containment System

10.58 Contract Amendment Number 5, executed on July 7, 2009, but effective as of August 1, 2009, to the Arizona Health Care Cost Containment System Administration Contract No. YH09-0001-07 between VHS Phoenix Health Plan, LLC and the Arizona Health Care Cost Containment System

10.59 Amendment Number 6 to the Vanguard Health Systems, Inc. 2004 Stock Incentive Plan, effective February 13, 2009(3)(19)

10.60 Form of Indemnification Agreement between the Company and each of its directors and executive officers (3)(22)

10.61 Amendment No. 4 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Charles N. Martin, Jr., dated as of May 5, 2009(3)

10.62 Amendment No. 4 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Keith B. Pitts, dated as of May 5, 2009(3)

10.63 Amendment No. 4 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Ronald P. Soltman, dated as of May 5, 2009(3)

10.64	Amendment No. 1 to Employment Agreement between Vanguard Health Systems, Inc. and Kent H. Wallace, dated as of May 5, 2009(3)
10.65	Amendment No. 1 to Employment Agreement between Vanguard Health Systems, Inc. and Phillip W. Roe, dated as of May 5, 2009(3)
10.66	Employment Agreement between Vanguard Health Systems, Inc. and Mark R. Montoney, M.D. dated as of December 31, 2008(3)
10.67	Amendment No. 1 to Employment Agreement between Vanguard Health Systems, Inc. and Mark R. Montoney, M.D. dated as of May 5, 2009(3)
10.68	Employment Agreement between Vanguard Health Systems, Inc. and Bradley A. Perkins dated as of July 1, 2009(3)
10.69	Vanguard Health Systems, Inc. 2009 Long Term Incentive Plan (3)(23)
10.70	Amendment No. 7 to Vanguard Health Systems, Inc. 2004 Stock Incentive Plan (3)(23)
12.1	Computation of Ratios of Earnings to Fixed Charges
21.1	Subsidiaries of Vanguard Health Systems, Inc.
31.1	Certification of CEO pursuant to Rule 13a-14(a)/15d-14(a) as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
31.2	Certification of CFO pursuant to Rule 13a-14(a)/15d-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
32.1	Certification of CEO pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
32.2	Certification of CFO pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002

(1) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Registration Statement on Form S-4 first filed on November 12, 2004 (Registration No. 333-120436).

(2) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Registration Statement on Form S-1 first filed on October 19, 2001 (Registration No. 333-71934).

(3) Management compensatory plan or arrangement.

(4) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Current Report on Form 8-K dated January 14, 2003, File No. 333-71934.

(5) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended March 31, 2005, File No. 333-71934.

(6) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Current Report on Form 8-K dated August 26, 2005, File No. 333-71934.

(7) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Annual Report on Form 10-K for the annual period ended June 30, 2005, File No. 333-71934.

(8) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Current Report on Form 8-K dated September 27, 2005, File No. 333-71934.

(9) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended December 31, 2005, File No. 333-71934.

(10) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended March 31, 2006, File No. 333-71934.

(11) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Annual Report on Form 10-K for the annual period ended June 30, 2006, File No. 333-71934.

(12) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended December 31, 2006, File No. 333-71934.

(13) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Annual Report on Form 10-K for the annual period ended June 30, 2007, File No. 333-71934.

(14) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended September 30, 2007, File No. 333-71934.

(15) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended December 31, 2007, File No. 333-71934.

(16) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Current Report on Form 8-K dated May 9, 2008, File No. 333-71934.

(17) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Current Report on Form 8-K dated May 16, 2008, File No. 333-71934.

(18) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended December 31, 2008, File No. 333-71934.

(19) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended March 31, 2009, File No. 333-71934.

(20) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Annual Report on Form 10-K for the annual period ended June 30, 2008, File No. 333-71934.

(21) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended September 30, 2008, File No. 333-71934.

(22) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Current Report on Form 8-K dated May 6, 2009, File No. 333-71934.

(23) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Current Report on Form 8-K dated August 21, 2009, File No. 333-71934.

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, D.C. 20549

FORM 10-K

(Mark One)

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the fiscal year ended June 30, 2008

OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from _____ to _____

Commission File Number: 333-71934

VANGUARD
HEALTH SYSTEMS

VANGUARD HEALTH SYSTEMS, INC.

(Exact name of registrant as specified in its charter)

Delaware	**62-1698183**
(State or other jurisdiction of incorporation or organization)	*(I.R.S. Employer Identification No.)*

20 Burton Hills Boulevard, Suite 100
Nashville, TN 37215
(Address and zip code of principal executive offices)

(615) 665-6000
(Registrant's telephone number, including area code)

Securities Registered Pursuant to Section 12(b) of the Act: None
Securities Registered Pursuant to Section 12(g) of the Act: None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. ☐Yes ☒No

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. ☒Yes ☐No

Indicate by check mark whether the registrant (1) has filed all reports required to be filed under Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports) and (2) has been subject to such filing requirements for the past 90 days. ☒Yes ☐No

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer or a smaller reporting company. See the definitions of "large accelerated filer", "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☐	Accelerated filer ☐
Non-accelerated filer ☒ (Do not check if a smaller reporting company)	Smaller reporting company ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). ☐Yes ☒No

There were 749,550 shares of registrant's common stock outstanding as of September 15, 2008 (all of which are privately owned and not traded on a public market).

Documents incorporated by reference: None

VANGUARD HEALTH SYSTEMS, INC.
ANNUAL REPORT ON FORM 10-K
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VANGUARD HEALTH SYSTEMS, INC.

CAUTIONARY STATEMENT REGARDING FORWARD-LOOKING STATEMENTS

This annual report on Form 10-K contains "forward-looking statements" within the meaning of the federal securities laws that are intended to be covered by safe harbors created thereby. Forward-looking statements are those statements that are based upon management's plans, objectives, goals, strategies, future events, future revenue or performance, capital expenditures, financing needs, plans or intentions relating to acquisitions, business trends and other information that is not historical information. These statements are based upon estimates and assumptions made by the Company's management that, although believed to be reasonable, are subject to numerous factors, risks and uncertainties that could cause actual outcomes and results to be materially different from those projected. When used in this annual report on Form 10-K, the words "estimates," "expects," "anticipates," "projects," "plans," "intends," "believes," "forecasts," "continues," or future or conditional verbs, such as "will," "should," "could" or "may," and variations of such words or similar expressions are intended to identify forward-looking statements.

These factors, risks and uncertainties include, among other things, statements relating to:

- Our high degree of leverage
- Our ability to incur substantially more debt
- Operating and financial restrictions in our debt agreements
- Our ability to successfully implement our business strategies
- Our ability to successfully integrate our recent and any future acquisitions
- The highly competitive nature of the healthcare industry
- Governmental regulation of the industry, including Medicare and Medicaid reimbursement levels
- Pressures to contain costs by managed care organizations and other insurers and our ability to negotiate acceptable terms with these third party payers
- Our ability to attract and retain qualified management and healthcare professionals, including physicians and nurses
- Potential federal or state reform of healthcare
- Future governmental investigations
- Potential management information systems failures and the significant costs of systems integrations
- The availability of capital to fund our corporate growth strategy
- Potential lawsuits or other claims asserted against us
- Our ability to maintain or increase patient membership and control costs of our managed healthcare plans
- Changes in general economic conditions including risks associated with investments we may hold from time to time
- Our exposure to the increased amounts of and collection risks associated with uninsured accounts and the co-pay and deductible portions of insured accounts
- Cost of professional and general liability insurance and increases in the quantity and severity of professional liability claims
- Our ability to maintain and increase patient volumes and control the costs of providing services, including salaries and benefits, supplies and bad debts
- Our failure to comply, or allegations of our failure to comply, with applicable laws and regulations
- The geographic concentration of our operations
- Technological and pharmaceutical improvements that increase the cost of providing, or reduce the demand for, healthcare services
- Potential substantial liabilities arising from unfavorable retrospective reviews by governmental or other payers of the medical necessity of medical procedures performed at our hospitals
- Lost future revenues from payer contract terminations resulting from their unfavorable retrospective reviews of the medical necessity of medical procedures performed at our hospitals

See "Item 1A – Risk Factors" for further discussion. We assume no obligation to update any forward-looking statements.

PART I

Item 1. Business.

Company Overview

We own and operate acute care hospitals and complementary outpatient facilities principally located in urban and suburban markets. We currently operate 15 acute care hospitals which, as of June 30, 2008, had a total of 4,181 beds in the following four locations:

- San Antonio, Texas
- metropolitan Phoenix, Arizona
- metropolitan Chicago, Illinois
- Massachusetts

Historically, we have concentrated our operations in markets with high population growth and median income in excess of the national average. Our objective is to provide high-quality, cost effective healthcare services through an integrated delivery platform serving the needs of the communities in which we operate. During the year ended June 30, 2008, we generated revenues from continuing operations of $2,790.7 million. During this period 83.9% of our total revenues were derived from acute care hospitals and complementary outpatient facilities.

Our general acute care hospitals offer a variety of medical and surgical services including emergency services, general surgery, internal medicine, cardiology, obstetrics, orthopedics and neurology. In addition, certain of our facilities provide on-campus and off-campus services including outpatient surgery, physical therapy, radiation therapy, diagnostic imaging and laboratory services. We also own three strategically important managed care health plans: a Medicaid managed health plan, Phoenix Health Plan, that served approximately 103,400 members as of June 30, 2008 in Arizona; Abrazo Advantage Health Plan, a managed Medicare and dual-eligible health plan that served approximately 3,200 members as of June 30, 2008 in Arizona; and MacNeal Health Providers a preferred provider network that served approximately 43,000 member lives in metropolitan Chicago as of June 30, 2008 under capitated contracts covering only outpatient and physician services.

We are a Delaware corporation formed in July 1997. Our principal executive offices are located at 20 Burton Hills Boulevard, Suite 100, Nashville, Tennessee, 37215 and our telephone number at that address is (615) 665-6000. Our corporate website address is www.vanguardhealth.com. Information contained on our website does not constitute part of this Annual Report on Form 10-K. The terms "we", "our", "the Company", "us", "registrant" and "Vanguard" as used in this report refer to Vanguard Health Systems, Inc. and its subsidiaries as a consolidated entity, except where it is clear from the context that such terms mean only Vanguard Health Systems, Inc. "Subsidiaries" means direct and indirect corporate subsidiaries of Vanguard Health Systems, Inc. and partnerships, joint ventures and limited liability companies in which such subsidiaries are partners or members.

The Merger

On July 23, 2004, Vanguard executed an agreement and plan of merger (the "Merger Agreement") with VHS Holdings LLC ("Holdings") and Health Systems Acquisition Corp., a newly formed Delaware corporation ("Acquisition Corp."), pursuant to which on September 23, 2004 Acquisition Corp. merged with and into Vanguard, with Vanguard being the surviving corporation (the "Merger"). In the Merger, holders of the outstanding Vanguard capital stock, options to acquire Vanguard common stock and other securities convertible into Vanguard common stock received aggregate consideration of approximately $1,248.6 million.

The Blackstone Group, together with its affiliates (collectively, "Blackstone"), funded the Merger in part by subscribing for and purchasing approximately $494.9 million aggregate amount of (1) Class A membership units in Holdings and (2) common stock of Acquisition Corp. (merged with and into Vanguard), in an amount equal to $125.0 million of such common stock. In addition, Morgan Stanley Capital Partners, together with its affiliates

(collectively, "MSCP"), subscribed for and purchased Class A membership units in Holdings by contributing to Holdings a number of shares of Vanguard common stock equal to (1) $130.0 million divided by (2) the per share consideration payable for each share of Vanguard common stock in connection with the Merger. Certain senior members of management and certain other stockholders of Vanguard (the "Rollover Management Investors") subscribed for and purchased Class A membership units in Holdings, having an aggregate purchase price of approximately $119.1 million, by (a) paying cash using the proceeds of consideration received in connection with the Merger and/or (b) contributing shares of Vanguard common stock in the same manner as MSCP. Baptist Health Services ("Baptist"), the former owner of our division, Baptist Health System of San Antonio, also purchased $5.0 million of Class A membership units in Holdings. Immediately after completion of the Merger in September 2004, Blackstone, MSCP (together with Baptist) and the Rollover Management Investors held approximately 66.1%, 18.0% and 15.9%, respectively, of the common equity of Vanguard (most of which is indirectly held through the ownership of the Class A membership units in Holdings). Certain members of senior management also purchased $5.7 million of the equity incentive units in Holdings.

Our Competitive Strengths

Concentrated Local Market Positions in Attractive Markets

We believe that our markets are attractive because of their favorable demographics, competitive landscape, payer mix and opportunities for expansion. Ten of our 15 hospitals are located in markets with population growth rates in excess of the national average and all of our acute care hospitals are located in markets in which the median household income is above the national average. For the fiscal year ended June 30, 2008, we derived approximately 65% of our total revenues from the high-growth markets of San Antonio and metropolitan Phoenix, in which we own five hospitals each. Our facilities in these markets primarily serve Bexar County, Texas, which encompasses most of the metropolitan San Antonio area and Maricopa County, Arizona, which encompasses most of the metropolitan Phoenix area. Our strong market positions provide us with opportunities to offer integrated services to patients, receive more favorable reimbursement terms from a broader range of third party payers and realize regional operating efficiencies. The U.S. Census Bureau projects that the number of individuals aged 65 and older will increase by an average of 3.0% each year during the years 2010 to 2020 so that those individuals aged 65 and older would represent approximately 18.6% of the total U.S. population by 2020. Our presence in high growth markets combined with the general aging of the United States population and expected longer life expectancies should result in higher demand for healthcare services and provide growth opportunities for us well into the future.

Strong Management Team with Significant Equity Investment

Our senior management has an average of more than 20 years of experience in the healthcare industry at various organizations, including OrNda Healthcorp, HCA Inc. and HealthTrust, Inc. Many of our senior managers have been with Vanguard since its founding in 1997, and 12 of our 18 members of senior management have worked together managing healthcare companies for up to 20 years, either continuously or from time to time. In connection with consummation of the Merger, the Rollover Management Investors purchased Class A membership units in Holdings having an aggregate purchase price of approximately $119.1 million which then represented approximately 15.9% of our equity interests.

Proven Ability to Complete and Integrate Acquisitions

Including our first acquisition in 1998, we have selectively acquired 18 hospitals, 12 of which were formerly not-for-profit hospitals. We have subsequently sold 3 of these hospitals and ceased acute care operations in another. We believe our success in completing acquisitions is due in large part to our disciplined approach to making acquisitions. Prior to completing an acquisition, we carefully review the operations of the target facility and develop a strategic plan to improve performance. We have routinely rejected acquisition candidates that did not meet our financial and operational criteria.

We believe our historical performance demonstrates our ability to identify underperforming facilities and improve the operations of acquired facilities. When we acquire a hospital, we generally implement a number of measures to lower costs, and we often make significant investments in the facility to expand existing services and introduce new services, strengthen the medical staff and improve our overall market position. We expect to continue

to grow revenues and profitability in the markets in which we operate by improving quality of care, increasing the depth and breadth of services provided and through the implementation of additional operational enhancements.

Our Business Strategy

The key elements of our business strategy include the following:

Continue our Commitment to Quality of Care

We have implemented and continue to implement various programs to improve the quality of care we provide. Our quality of care initiatives focus on engaging all of the stakeholders in the healthcare delivery process – the physicians, nurses, payers and most importantly the patients themselves. Establishing a commitment to quality of care that starts at the top and spreads down through the entire hospital organization is the first step in achieving a culture of quality. This culture fosters successful outcomes through continuous communication with physicians, discussing treatment plans with patients and reporting quality measurements with payers.

We have invested significant resources to develop clinical information systems to allow us to standardize compliance reporting of multiple quality indicators across our facilities, and we currently conduct a monthly review of 30 quality indicators set forth by CMS. We have developed training programs for our staff and share information among our hospital management teams to implement best practices and assist in complying with regulatory requirements. Corporate support is provided to each hospital to assist with accreditation reviews.

All hospitals conduct patient, physician and staff satisfaction surveys to help identify methods of improving the quality of care. We have appointed licensed physicians in each of our markets to the position of chief medical officer charged with driving best practices and clinical quality to improve the level of satisfaction among physicians and patients and promote cost-efficient provision of care. We have established rapid response teams and hourly nursing rounds in all of our hospitals to improve patient care. By the end of our fiscal year 2008, we had established Physician Advisory Councils at most of our hospitals to align the quality goals of our hospitals with the physicians who practice at our hospitals.

We believe quality of care has become an increasingly important factor in governmental and managed care reimbursement. We continuously review patient care evaluations and maintain other quality assurance programs to support and monitor quality of care standards and to meet and exceed Medicare and Medicaid accreditation and regulatory requirements. Many payers, including Medicare and several large managed care organizations, currently require providers to report certain quality measures in order to receive the full amount of payment increases that were awarded automatically in the past. For federal fiscal year 2009, Medicare expanded the number of quality measures to be reported to 42 from 30 during federal fiscal year 2008 and from 21 during federal fiscal year 2007. These measures include risk-adjusted outcomes measures such as 30-day mortality measures for patients who suffered a heart attack, heart failure or pneumonia; additional measures related to patients who undergo surgical procedures such as hospital-acquired infections data; and several patient satisfaction indicators. Many large managed care organizations have developed quality measurement criteria that are similar to or even more stringent than these Medicare requirements. We have invested and will continue to invest significant capital to upgrade our clinical information systems to enable us to report these quality measures.

We believe that pay for performance reimbursement will continue to evolve, and that the quality measures themselves will determine reimbursement as evidenced by CMS' new reforms effective October 1, 2008 that would take the first steps toward preventing Medicare from making additional payments to hospitals for treating patients that acquire one of eleven identified hospital-acquired conditions during a hospital stay. Our ability to meet our quality goals requires not only information systems to monitor compliance with quality indicators, but more importantly requires clinical programs and physician integration to improve quality.

Expand Services to Increase Revenues and Profitability

We will continue to invest in our facilities to expand the range and improve the quality of services provided based on our understanding of the needs of the communities we serve. Our local management teams work closely with patients, payers, physicians and other medical personnel to identify and prioritize the healthcare needs of individual communities. We intend to increase our revenues and profitability by expanding the range of services we offer at certain of our hospitals. We plan to:

- expand emergency room and operating room capacity;
- improve the convenience, quality and breadth of our outpatient services;
- upgrade and expand select specialty services, including cardiology, oncology, neurosurgery, orthopedics, and women's services;
- update our medical equipment technology, including diagnostic and imaging equipment and robotics; and
- continue evaluating the construction of new facilities in underserved areas of the community.

We believe that our disciplined expansion strategy will grow volumes, increase acuity mix, improve managed care pricing and enhance operating margins at our existing facilities, and at the same time reduce patient out-migration and satisfy unmet demand within our existing markets.

Improve Operating Margins and Efficiency

We seek to position ourselves as a cost effective provider of healthcare services in each of our markets. We intend to generate operational efficiencies and improve operating margins by:

- implementing more efficient care management, supply utilization and inventory management
- improving our billing and collection processes;
- capitalizing on purchasing efficiencies;
- targeting our capital expenditures on high demand service lines that will achieve higher returns; and
- implementing programs to reduce nurse turnover to minimize utilization of contract labor.

Recruit New Physicians and Maintain Strong Relationships with Existing Physicians

We recruit both primary care and specialty physicians who can provide services that we believe are currently underserved and in demand in the communities we serve. A core group of primary care physicians serves as the initial contact point for members of those communities. Having a quality group of specialty physicians available to provide such services as general surgery, cardiovascular services, orthopedics and obstetrics/gynecology, among others, enables members of the community to obtain necessary healthcare services locally without traveling to other communities. We increased the number of employed physicians at our hospitals by more than 50 during fiscal 2008, primarily through our physician recruiting initiatives. During fiscal 2009, we plan to further increase the number of primary care and specialty physicians who practice in our communities by more than 140 physicians through both employment and non-employment initiatives. We added significant corporate resources during fiscal 2008 in order to implement our physician recruiting strategies and to manage the practices of our employed physicians. We believe our hospitals provide an attractive setting for physicians to practice based on the following strategies and initiatives we have in place:

- continually seeking to improve quality of care and engaging physicians in these programs;
- providing physicians with access to efficiently designed facilities and modern technologies;
- providing a broad array of services within the integrated health network;
- offering quality training programs;
- obtaining physician support for the long-term vision of our hospitals;
- providing remote access to clinical information; and
- arranging for convenient medical office space adjacent to our facilities.

Continue to Develop Favorable Managed Care Relationships

We plan to increase the number of patients at our facilities and improve our profitability by negotiating more favorable terms with managed care plans. We believe that we are attractive to managed care plans because of the geographic and demographic coverage of our facilities in their respective markets, the quality and breadth of our services and the expertise of our physicians. Further, we believe that as we increase our presence and improve our competitive position in our markets, particularly as we develop our networks of hospitals, we will be even better positioned to negotiate more favorable managed care contracts.

Grow Through Selective Acquisitions

We will continue to pursue acquisitions and enter into partnerships or affiliations with other healthcare service providers that either expand our network and presence in our existing markets or allow us to enter new urban and suburban markets. We intend to selectively pursue acquisitions of networks of hospitals and other complementary facilities or single-well positioned facilities where we believe we can improve operating performance and profitability and increase market share. We maintain a disciplined approach whereby we ensure that potential acquisition targets fit within our corporate mission and long-term strategic goals while also providing benefit in the short-term. We believe that we will continue to have substantial acquisition opportunities as other healthcare providers choose to divest facilities and as independent hospitals, particularly not-for-profit hospitals, seek to capitalize on the benefits of becoming part of a larger hospital company.

The Markets We Serve

San Antonio, Texas

In the San Antonio market, as of June 30, 2008, we owned and operated 5 hospitals with a total of 1,741 licensed beds and related outpatient service locations complementary to the hospitals. We acquired these hospitals in January 2003 from the non-profit Baptist Health Services (formerly known as Baptist Health System) and continue to operate the hospitals as the Baptist Health System. The acquisition followed our strategy of acquiring a significant market share in a growing market, San Antonio, Texas. Our facilities primarily serve the residents of Bexar County which encompasses most of the metropolitan San Antonio area. According to estimates by the U.S. Census Bureau, the population in Bexar County grew by 11.7% from 2000 to 2006 and is expected to grow by another 13.9% by 2020. These growth rates are well above the national average.

During the years ended June 30, 2007 and 2008, we generated approximately 31.2% and 32.1% of our total revenues, respectively, in this market. In our acquisition agreement for the Baptist Health System we committed to fund not less than $200.0 million in capital expenditures in respect of the acquired businesses in the San Antonio metropolitan area during the first six years of our ownership, with $75.0 million of such expenditures being required in the first two years. By the end of our fiscal year ended June 30, 2005, we had funded or committed to fund all $200.0 million of this capital commitment.

Metropolitan Phoenix, Arizona

In the Phoenix market, as of June 30, 2008, we owned and operated 5 hospitals with a total of 996 licensed beds and related outpatient service locations complementary to the hospitals, a prepaid Medicaid managed health plan, Phoenix Health Plan ("PHP"), and a managed Medicare and dual-eligible health plan, Abrazo Advantage Health Plan ("AAHP"). Phoenix is the fifth largest city in the U.S. and has been one of the fastest growing major metropolitan areas in recent years. Our facilities primarily serve the residents of Maricopa County, which encompasses most of the metropolitan Phoenix area. According to estimates by the U.S. Census Bureau, the population in Maricopa County grew by 22.7% from 2000 to 2006 and is expected to grow by another 38.3% by 2020. These growth rates are also well above the national average.

During the years ended June 30, 2007 and 2008, exclusive of PHP and AAHP, we generated approximately 19.5% and 18.8% of our total revenues, respectively, in this market. Three of our hospitals in this market were formerly not-for-profit hospitals. We believe that payers will choose to contract with us in order to give their enrollees a comprehensive choice of providers in the western and northern Phoenix areas. Recently, we have

negotiated improvements in our payer rates at our Phoenix hospitals generally, and Arizona's state Medicaid program remains strong. We believe our network strategy will position us to continue to negotiate favorable rate increases with managed care payers and to build upon our network's comprehensive range of integrated services. In addition, our ownership of PHP and AAHP will allow us to enroll eligible patients, who would not otherwise be able to pay for healthcare services, into our health plan or into other state-approved plans.

Metropolitan Chicago, Illinois

In the Chicago metropolitan area, as of June 30, 2008, we owned and operated 2 hospitals with 784 licensed beds, and related outpatient service locations complementary to the hospitals. These hospitals, MacNeal Hospital and Weiss Hospital, are located in areas serving relatively well-insured populations. Weiss Hospital is operated by us in a consolidated joint venture corporation in which we own 80.1% and the University of Chicago Hospitals owns 19.9% of the equity interests. During the years ended June 30, 2007 and 2008, we generated approximately 15.6% and 14.9%, respectively, of our total revenues in this market.

We chose MacNeal and Weiss Hospitals, both former not-for-profit facilities, as our first two entries into the largely not-for-profit metropolitan Chicago area. Both MacNeal and Weiss Hospitals are large, well-equipped, university-affiliated hospitals with strong reputations and medical staffs. We believe we have captured a large share of the patients in MacNeal Hospital's immediate surrounding service area, which encompasses the cities of Berwyn and Cicero, Illinois. MacNeal offers tertiary services such as open heart surgery that patients would otherwise have to travel outside the local community to receive. We have also established a fully-integrated healthcare system at MacNeal and Weiss Hospitals by operating free-standing primary care and occupational medicine centers and a large commercial reference laboratory and by employing 68 physicians on our medical staffs there, including 30 primary care physicians. Our network of 17 primary care and occupational medicine centers allows us to draw patients to MacNeal and Weiss Hospital from around the metropolitan Chicago area. Both hospitals partner with various medical schools, the most significant being the University of Chicago Medical School and the University of Illinois Medical School, to provide medical training through residency programs in multiple specialties. In addition, MacNeal Hospital runs a successful free-standing program in family practice, one of the oldest such programs in the state of Illinois, and Weiss Hospital also runs a successful free-standing residency program in internal medicine. Our medical education programs help us to attract quality physicians to both the hospitals and our network of primary care and occupational medicine centers.

Massachusetts

In Massachusetts, as of June 30, 2008, we owned and operated 3 hospitals with a total of 660 licensed beds and related healthcare services complementary to the hospitals. These hospitals include Saint Vincent Hospital located in Worcester and MetroWest Medical Center, a two-campus hospital system comprised of Framingham Union Hospital in Framingham and Leonard Morse Hospital in Natick. These hospitals were acquired by us on December 31, 2004. We believe that opportunities for growth through increased market share exist in the Massachusetts area through the possible addition of new services, partnerships and the implementation of a strong primary care physician strategy. During the years ended June 30, 2007 and 2008, the Massachusetts facilities represented 19.8% and 19.7% of our total revenues, respectively.

Saint Vincent Hospital, located in Worcester, is a 321-bed teaching hospital with a strong residency program. Worcester is located in central Massachusetts and is the second largest city in Massachusetts. The service area is characterized by a patient base that is older, more affluent and well-insured. Saint Vincent Hospital is focused on strengthening its payer relationships, developing its primary care physician base and expanding its offerings in cardiology, orthopedics, radiology and minimally-invasive surgery capabilities.

MetroWest Medical Center's two campus system has a combined total of 339 licensed beds with locations in Framingham and Natick, in the suburbs west of Boston. These facilities serve communities that are generally well-insured. We are seeking to develop strong ambulatory care capabilities in these service areas, as well as expansion of oncology, radiology, women's services and cardiology services.

Our Facilities

We owned and operated 15 acute care hospitals as of June 30, 2008. The following table contains information concerning our hospitals:

Hospital	City	Licensed Beds	Date Acquired
Texas			
Baptist Medical Center	San Antonio	636	January 1, 2003
Northeast Baptist Hospital	San Antonio	367	January 1, 2003
North Central Baptist Hospital	San Antonio	268	January 1, 2003
Southeast Baptist Hospital	San Antonio	175	January 1, 2003
St. Luke's Baptist Hospital	San Antonio	295	January 1, 2003
Arizona			
Maryvale Hospital	Phoenix	232	June 1, 1998
Arrowhead Hospital	Glendale	220	June 1, 2000
Phoenix Baptist Hospital	Phoenix	236	June 1, 2000
Paradise Valley Hospital	Phoenix	151	November 1, 2001
West Valley Hospital (1)	Goodyear	157	September 4, 2003
Illinois			
MacNeal Hospital	Berwyn	427	February 1, 2000
Louis A. Weiss Memorial Hospital (2)	Chicago	357	June 1, 2002
Massachusetts			
MetroWest Medical Center – Leonard Morse Hospital	Natick	141	December 31, 2004
MetroWest Medical Center - Framingham Union Hospital	Framingham	198	December 31, 2004
Saint Vincent Hospital at Worcester Medical Center	Worcester	321	December 31, 2004
Total Licensed Beds		4,181	

(1) This hospital was constructed, not acquired.

(2) This hospital is operated by us in a consolidated joint venture corporation in which we own 80.1% of the equity interests and the University of Chicago Hospitals owns 19.9% of the equity interests.

In addition to the hospitals listed in the table above, as of June 30, 2008, we owned certain outpatient service locations complementary to our hospitals and two surgery centers in California. We also own and operate a limited number of medical office buildings in conjunction with our hospitals which are primarily occupied by physicians practicing at our hospitals.

Our Hospital Operations

Acute Care Services

Our hospitals typically provide the full range of services commonly available in acute care hospitals, such as internal medicine, general surgery, cardiology, oncology, neurosurgery, orthopedics, obstetrics, diagnostic and emergency services, as well as select tertiary services such as open-heart surgery and level II and III neonatal intensive care. Our hospitals also generally provide outpatient and ancillary healthcare services such as outpatient surgery, laboratory, radiology, respiratory therapy and physical therapy. We also provide outpatient services at our

imaging centers and ambulatory surgery centers. Certain of our hospitals have a limited number of psychiatric, skilled nursing and rehabilitation beds.

Management and Oversight

Our senior management team has extensive experience in operating multi-facility hospital networks and focuses on strategic planning for our facilities. A hospital's local management team is generally comprised of a chief executive officer, chief operating officer, chief financial officer and chief nursing officer. Local management teams, in consultation with our corporate staff, develop annual operating plans setting forth revenue growth strategies through the expansion of offered services and the recruitment of physicians in each community, as well as plans to improve operating efficiencies and reduce costs. We believe that the ability of each local management team to identify and meet the needs of our patients, medical staffs and the community as a whole is critical to the success of our hospitals. We base the compensation for each local management team in part on its ability to achieve the goals set forth in the annual operating plan, including both quality of care and financial measures.

Boards of trustees at each hospital, consisting of local community leaders, members of the medical staff and the hospital administrator, advise the local management teams. Members of each board of trustees are identified and recommended by our local management teams and serve three-year staggered terms. The boards of trustees establish policies concerning medical, professional and ethical practices, monitor these practices and ensure that they conform to our high standards. We have recently formed Physician Advisory Councils at each of our hospitals that focus on quality of care and other issues important to physicians and make recommendations to the boards of trustees as neeessary. We maintain company-wide compliance and quality assurance programs and use patient care evaluations and other assessment methods to support and monitor quality of care standards and to meet accreditation and regulatory requirements.

We also provide support to the local management teams through our corporate resources including areas such as revenue cycle, business office, legal, managed care, case management, physician services and other administrative functions. These resources also allow for sharing best practices and standardization of policies and processes among all of our hospitals.

Attracting Patients

We believe that the most important factors affecting a patient's choice in hospitals are the reputation of the hospital's nursing staff for delivering quality carc, the availability and expertise of physicians caring for patients at the facility and the location and convenience of the hospital. Other factors that affect utilization include local demographics and population growth, local economic conditions and the hospital's success in contracting with a wide range of local payers.

Operating Statistics

The following table sets forth certain operating statistics from continuing operations for the periods indicated. Acute care hospital operations are subject to fluctuations due to seasonal cycles of illness and weather, ineluding increased patient utilization during the cold weather months and decreases during holiday periods.

	Year Ended June 30,				
	2004	2005	2006	2007	2008
Number of hospitals at end of period (a)	12	15	15	15	15
Number of licensed beds at end of period (b)	3,133	3,907	3,937	4,143	4,181
Discharges (c)	126,356	147,798	162,446	166,873	169,668
Adjusted discharges - hospitals (d)	186,464	231,322	261,056	264,698	270,076
Average length of stay (days) (e)	4.1	4.2	4.3	4.3	4.3
Average daily census (f)	1,420	1,708	1,921	1,978	2,008
Net patient revenue per adjusted hospital discharge (g)	$ 6,455	$ 6,859	$ 7,319	$ 7,766	$ 8,110
Total surgeries (h)	83,996	101,368	113,043	113,833	110,877
Member lives (i)	142,200	146,700	146,200	145,600	149,600

(a) The number of hospitals at the end of each period represents hospitals included in continuing operations.

(b) Licensed beds are those beds for which a facility has been granted approval to operate from the applicable state licensing agency.

(c) Represents the total number of patients discharged (in the facility for an overnight stay) from our hospitals and is used by management and certain investors as a general measure of inpatient volumes.

(d) Adjusted discharges-hospitals is used by management and certain investors as a general measure of combined inpatient and outpatient volumes and is computed by multiplying discharges by the sum of gross hospital inpatient and outpatient revenues and then dividing the result by gross hospital inpatient revenues. This computation enables management to assess hospital volumes by a combined measure of inpatient and outpatient volumes.

(e) Average length of stay represents the average number of days admitted patients stay in our hospitals.

(f) Average daily census represents the average number of patients in our hospitals each day during our ownership.

(g) Net revenue per adjusted hospital discharge is calculated by dividing hospital net patient revenues by hospital adjusted discharges and measures the average net payment expected to be received for a patient's hospital stay.

(h) Total surgeries represent the sum of inpatient surgeries and outpatient surgeries performed at our hospitals or ambulatory surgery centers.

(i) Member lives represents the total number of enrollees in our Arizona prepaid managed health plans and our Chicago capitated health plan as of the end of the respective period.

Outpatient Services

The healthcare industry has experienced a general shift during the past few years from inpatient services to outpatient services as Medicare, Medicaid and managed care payers have sought to reduce costs by shifting lower-acuity cases to an outpatient setting. Advances in medical equipment technology and pharmacology have supported the shift to outpatient utilization, which has resulted in an increase in the acuity of inpatient admissions. However, we expect inpatient admissions to recover over the long-term as the baby boomer population reaches ages where inpatient admissions become more prevalent. We have responded to the shift to outpatient services through our ambulatory surgery centers in Orange County, California, our interests in diagnostic imaging centers in San Antonio, Texas, our outpatient diagnostic imaging centers in metropolitan Phoenix, Arizona and our network of primary care and occupational medicine centers in metropolitan Chicago, Illinois, along with continued expansion of emergency and outpatient services at our acute hospitals. We continually upgrade our resources, including quality physicians and nursing staff and technologically advanced equipment, to support our comprehensive service offerings to capture inpatient volumes from the baby boomers and have focused on core services including cardiology, neurology, oncology, orthopedics and women's services. We also operate sub-acute units such as rehabilitation, skilled nursing facilities and psychiatric services, where appropriate, to meet the needs of our patients while increasing volumes and increasing care management efficiencies.

Our Health Plan Operations

Phoenix Health Plan

In addition to our hospital operations, we own three health plans. PHP is a prepaid Medicaid managed health plan that currently serves Maricopa, Pinal and Gila counties in the Phoenix, Arizona area. We acquired PHP in May 2001. We are able to enroll eligible patients in our hospitals into PHP or other local Medicaid managed health plans who otherwise would not be able to pay for their hospital expenses. We believe the volume of patients generated through our health plans will help attract quality physicians to the communities our hospitals serve.

For the year ended June 30, 2008, we derived approximately $353.3 million of our total revenues from PHP. PHP had approximately 103,400 enrollees as of June 30, 2008, and derives substantially all of its revenues through a contract with the Arizona Health Care Cost Containment System ("AHCCCS"), which is Arizona's state Medicaid program. The contract requires PHP to arrange for healthcare services for enrolled Medicaid patients in exchange for monthly capitation payments and supplemental payments from AHCCCS. PHP subcontracts with physicians, hospitals and other healthcare providers to provide services to its enrollees. These services are provided regardless of the actual costs incurred to provide these services. We receive reinsurance and other supplemental payments from AHCCCS to cover certain costs of healthcare services that exceed certain thresholds.

As part of its contract with AHCCCS, PHP is required to maintain a performance guarantee in the amount of $22.0 million. Vanguard maintains this performance guarantee on behalf of PHP in the form of surety bonds totaling $22.0 million with independent third party insurers that expire on October 1, 2008. We were also required to arrange for $2.9 million in letters of credit to collateralize our $22.0 million in surety bonds with the third party insurers. The amount of the performance guaranty that AHCCCS requires is based upon the membership in the health plan and the related capitation amounts paid to us. As a result of PHP's new AHCCCS contract which commences on October 1, 2008, as discussed below, we currently expect a significant increase in the amount of the performance guarantee during our fiscal year ending June 30, 2009.

Our current contract with AHCCCS commenced on October 1, 2003 and covers members in three Arizona counties: Gila, Maricopa and Pinal. In September 2007, AHCCCS executed its final one-year renewal option that effectively extended the contract through September 30, 2008. In May 2008, PHP was awarded a new contract with AHCCCS effective for the three-year period beginning October 1, 2008 and ending September 30, 2011. AHCCCS has the option to renew the new contract, in whole or in part, for two additional one-year periods commencing on October 1, 2011 and on October 1, 2012. The new contract will cover the existing three counties under the current contract plus an additional six Arizona counties: Apache, Coconino, Mohave, Navajo, Pima and Yavapai. We expect a significant increase in PHP membership under the new contract but are unable to determine the impact of the new contract on our future operations and cash flows at this time.

Abrazo Advantage Health Plan

Effective January 1, 2006, AAHP became a Medicare Advantage Prescription Drug Special Needs Plan provider under a contract with the Centers for Medicare & Medicaid Services ("CMS"). This allows AAHP to offer Medicare and Part D drug benefit coverage for Medicare members and dual-eligible members (those that are eligible for Medicare and Medicaid). PHP has historically served dual-eligible members through its AHCCCS contract. As of June 30, 2008, approximately 3,200 members were enrolled in AAHP, most of whom were previously enrolled in PHP. For the year ended June 30, 2008, we derived approximately $39.2 million of our total revenues from AAHP.

MacNeal Health Providers

The operations of MHP are somewhat integrated with our MacNeal Hospital in Berwyn, Illinois. For the year ended June 30, 2008, we derived approximately $57.7 million of our total revenues from MHP. MHP generates revenues from its contracts with health maintenance organizations from whom it took assignment of capitated member lives as well as third party administration services for other providers. As of June 30, 2008, MHP had contracts in effect covering approximately 43,000 capitated member lives. Such capitation is limited to physician services and outpatient ancillary services and does not cover inpatient hospital services. We try to utilize MacNeal Hospital and its medical staff as much as possible for the physician and outpatient ancillary services that are

required by such capitation arrangements. Revenues of MHP are dependent upon health maintenance organizations in the metropolitan Chicago area continuing to assign capitated-member lives to health plans like MHP as opposed to entering into direct fee-for-service arrangements with healthcare providers.

Competition

The hospital industry is highly competitive. We currently face competition from established, not-for-profit healthcare companies, investor-owned hospital companies, large tertiary care centers, specialty hospitals and outpatient service providers. In the future, we expect to encounter increased competition from companies, like ours, that consolidate hospitals and healthcare companies in specific geographic markets. Continued consolidation in the healthcare industry will be a leading factor contributing to increased competition in our current markets and markets we may enter in the future. Due to the shift to outpatient care and more stringent payer-imposed pre-authorization requirements during the past few years, most hospitals have significant unused capacity resulting in increased competition for patients. Many of our competitors are larger than us and have more financial resources available than we do. Other not-for-profit competitors have endowment and charitable contribution resources available to them and can purchase equipment and other assets on a tax-free basis.

One of the most important factors in the competitive position of a hospital is its location, including its geographic coverage and access to patients. A location convenient to a large population of potential patients or a wide geographic coverage area through hospital networks can make a hospital significantly more competitive. Another important factor is the scope and quality of services a hospital offers, whether at a single facility or a network of facilities, compared to the services offered by its competitors. A hospital or network of hospitals that offers a broad range of services and has a strong local market presence is more likely to obtain favorable managed care contracts. We intend to evaluate changing circumstances in the geographic areas in which we operate on an ongoing basis to ensure that we offer the services and have the access to patients necessary to compete in these managed care markets and, as appropriate, to form our own, or join with others to form, local hospital networks.

A hospital's competitive position also depends in large measure on the quality and scope of the practices of physicians associated with the hospital. Physicians refer patients to a hospital primarily on the basis of the quality and scope of services provided by the hospital, the quality of the medical staff and employees affiliated with the hospital, the hospital's location and the availability of modern equipment and facilities. Although physicians may terminate their affiliation with our hospitals, we seek to retain physicians of varied specialties on our medical staffs and to recruit other qualified physicians by maintaining and improving our level of care and providing quality facilities, equipment, employees and services for physicians and their patients.

Another major factor in the competitive position of a hospital is the ability of its management to obtain contracts with managed care plans and other group payers. The importance of obtaining managed care contracts has increased in recent years due primarily to consolidations of health plans and is expected to continue to increase as private and government payers and others increasingly turn to managed care organizations to help control rising healthcare costs. Our markets have experienced significant managed care penetration. The revenues and operating results of our hospitals are significantly affected by our hospitals' ability to negotiate favorable contracts with managed care plans. Health maintenance organizations and preferred provider organizations use managed care contracts to encourage patients to use certain hospitals in exchange for discounts from the hospitals' established charges. Traditional health insurers and large employers also are interested in containing costs through similar contracts with hospitals.

The hospital industry and our hospitals continue to have significant unused capacity. Inpatient utilization, average lengths of stay and average occupancy rates have historically been negatively affected by payer-required pre-admission authorization, utilization review and payer pressure to maximize outpatient and alternative healthcare delivery services for less acutely ill patients. Admissions constraints, payer pressures and increased competition are expected to continue. We endeavor to meet these challenges by expanding many of our facilities to include outpatient centers, offering discounts to private payer groups, upgrading facilities and equipment and offering new or expanded programs and services.

Employees and Medical Staff

As of June 30, 2008, we had approximately 18,500 employees, including approximately 2,000 part-time employees. Approximately 1,600 of our full-time employees at our three Massachusetts hospitals are unionized. Overall, we consider our employee relations to be good. While some of our non-unionized hospitals experience union organizing activity from time to time, we do not expect these efforts to materially affect our future operations. Our hospitals, like most hospitals, have experienced labor costs rising faster than the general inflation rate.

In the industry as a whole, and particularly in our Phoenix and San Antonio service areas, there is currently a shortage of nurses and other medical support personnel. Often these nursing shortages result in our using more contract labor resources to meet increased demand especially during the peak winter months. To address the nursing shortage, we have implemented comprehensive recruiting and retention plans for nurses. As part of this plan, we have expanded our nursing school in San Antonio to attract new students and to provide options for current nurses to advance their careers. We also increased our involvement with other colleges, participated in more job fairs and recruited nurses from abroad. Our recruiting and retention plan also focuses on mentoring, flexible work hours, performance leadership training, quality of care and patient safety and competitive pay and benefits. We anticipate that demand for nurses will continue to exceed supply especially as the baby boomer population reaches the ages where inpatient stays become more frequent. However, we expect our initiatives to help stabilize our nursing resources over time.

Our hospitals grant staff privileges to licensed physicians who may serve on the medical staffs of multiple hospitals, including hospitals not owned by us. A physician who is not an employee can terminate his or her affiliation with our hospital at any time. Although we employ a limited number of physicians, a physician does not have to be an employee of ours to be a member of the medical staff of one of our hospitals. Any licensed physician may apply to be admitted to the medical staff of any of our hospitals, but admission to the staff must be approved by each hospital's medical staff and board of trustees in accordance with established credentialing criteria.

Compliance Program

We voluntarily maintain a company-wide compliance program designed to ensure that we maintain high standards of ethics and conduct in the operation of our business and implement policies and procedures so that all our employees act in compliance with all applicable laws, regulations and company policies. The organizational structure of our compliance program includes oversight by our board of directors and a high-level corporate management compliance committee. The board of directors and compliance committee are responsible for ensuring that the compliance program meets its stated goals and remains up-to-date to address the current regulatory environment and other issues affecting the healthcare industry. Our Senior Vice President of Compliance and Ethics reports jointly to our Chairman and Chief Executive Officer and to our board of directors, serves as Chief Compliance Officer and is charged with direct responsibility for the day-to-day management of our compliance program. Other features of our compliance program include Regional Compliance Officers who report to our Chief Compliance Officer in all four of our operating regions, initial and periodic ethics and compliance training and effectiveness reviews, a toll-free hotline for employees to report, without fear of retaliation, any suspected legal or ethical violations, annual "fraud and abuse" audits to examine all of our payments to physicians and other referral sources and annual "coding audits" to make sure our hospitals bill the proper service codes for reimbursement from the Medicare program.

Our compliance program also oversees the implementation and monitoring of the standards set forth by the Health Insurance Portability and Accountability Act ("HIPAA") for privacy and security. To facilitate reporting of potential HIPAA compliance concerns by patients, family or employees, we established a second toll-free hotline dedicated to HIPAA and other privacy matters. Corporate HIPAA compliance staff monitors all reports to the privacy hotline and each phone call is responded to appropriately. Ongoing HIPAA compliance also includes self-monitoring of HIPAA policy and procedure implementation by each of our healthcare facilities and corporate compliance oversight.

Our Information Systems

We believe that our information systems must cost-effectively meet the needs of our hospital management, medical staff and nurses in the following areas of our business operations:

- patient accounting, including billing and collection of revenues;
- accounting, financial reporting and payroll;
- coding and compliance;
- laboratory, radiology and pharmacy systems;
- medical records and document storage;
- remote physician access to patient data;
- quality indicators;
- materials and asset management; and
- negotiating, pricing and administering our managed care contracts.

Although we map the financial information systems from each of our hospitals to one centralized database, we do not automatically standardize our financial information systems among all of our hospitals. We carefully review existing systems at the hospitals we acquire and, if a particular information system is unable to cost-effectively meet the operational needs of the hospital, we will convert or upgrade the information system at that hospital to one of several standardized information systems that can cost-effectively meet these needs.

Professional and General Liability Insurance

As is typical in the healthcare industry, we are subject to claims and legal actions by patients and others in the ordinary course of business. For claims incurred on or after June 1, 2002 through May 31, 2006, our wholly owned captive subsidiary insured our professional and general liability risks at a $10.0 million retention level. For professional and general liability claims incurred on or after June 1, 2006, we self-insure the first $9.0 million of each claim, and the captive subsidiary insures the next $1.0 million. We maintain excess coverage from independent third-party carriers for individual claims exceeding $10.0 million per occurrence up to $75.0 million, but limited to total annual payments of $65.0 million in the aggregate. The captive insurance subsidiary funds its portion of claims costs from proceeds of premium payments received from us.

The malpractice insurance environment remains volatile. Some states in which we operate, including Texas and Illinois, have passed in recent years tort reform legislation to place limits on non-economic damages. However, in November 2007 a judge in the Illinois Cook County Circuit Court declared that these Illinois malpractice limits were unconstitutional under state law. While such ruling is being considered in an appeal to the Illinois Supreme Court, we understand that the trial courts are not enforcing the non-economic damages limits under that Illinois tort reform statute. Additionally, in Texas an action has been brought to declare its tort reform legislation unconstitutional under federal law. Thus, while we have taken multiple steps at our facilities to reduce our professional liability exposures, absent significant legislation (not later declared unconstitutional) to curb the size of malpractice judgments in the states in which we operate, our insurance costs may increase in the future.

Sources of Revenues

Hospital revenues depend upon inpatient occupancy levels, the medical and ancillary services ordered by physicians and provided to patients, the volume of outpatient procedures and the charges or payment rates for such services. Charges and reimbursement rates for inpatient services vary significantly depending on the type of payer, the type of service (e.g., acute care, intensive care or subacute) and the geographic location of the hospital. Inpatient occupancy levels fluctuate for various reasons, many of which are beyond our control.

We receive payment for patient services from:

- the federal government, primarily under the Medicare program;
- state Medicaid programs; and
- health maintenance organizations, preferred provider organizations, managed Medicare providers, managed Medicaid providers, other private insurers and individual patients.

The table below presents the approximate percentage of net patient revenues we received from the following sources for the periods indicated:

Payer Source	Year ended June 30, 2006	2007	2008
Medicare	28%	26%	26%
Medicaid	7	9	8
Managed Medicare[1]	N/A	13	14
Managed Medicaid[1]	N/A	7	7
Other managed care plans[1]	52	32	35
Self-pay	9	10	9
Commercial	4	3	1
Total	100%	100%	100%

(1) For the year ended June 30, 2006, managed care revenues include revenues from managed Medicare, managed Medicaid and other governmental managed plans in addition to commercial managed care plans.

Medicare is a federal program that provides certain hospital and medical insurance benefits to persons age 65 and over, some disabled persons and persons with end-stage renal disease. Medicaid is a federal-state program, administered by the states, which provides hospital and medical benefits to qualifying individuals who are unable to afford health care. All of our general, acute care hospitals located in the United States are certified as health care services providers for persons covered under the Medicare and Medicaid programs. Amounts received under the Medicare and Medicaid programs are generally significantly less than established hospital gross charges for the services provided.

Our hospitals offer discounts from established charges to certain group purchasers of healthcare services, including private insurance companies, employers, health maintenance organizations, preferred provider organizations and other managed care plans. These discount programs limit our ability to increase net revenues in response to increasing costs. Patients generally are not responsible for any difference between established hospital charges and amounts reimbursed for such services under Medicare, Medicaid, some private insurance plans, health maintenance organizations or preferred provider organizations, but are generally responsible for exclusions, deductibles and coinsurance features of their coverages. Due to rising healthcare costs, many payers have increased the number of excluded services and the levels of deductibles and coinsurance resulting in a higher portion of the contracted rate due from the individual patients. Collecting amounts due from individual patients is typically more difficult than collecting from governmental or private managed care plans.

Medicare

Inpatient Acute Care

Under a prospective payment system, a hospital receives a fixed payment based on the patient's assigned diagnosis related group ("DRG") for acute care hospital inpatient services. The DRG classifies categories of illnesses according to the estimated intensity of hospital resources necessary to furnish care for each principal diagnosis. The DRG rates for acute care hospitals are based upon a statistically normal distribution of severity. When treatments for patients fall well outside the normal distribution, providers may receive additional payments known as outlier payments. The DRG payments do not consider a specific hospital's actual costs but are adjusted for geographic area wage differentials. Inpatient capital costs for acute care hospitals are reimbursed on a prospective system based on DRG weights multiplied by geographically adjusted federal weights.

Pursuant to regulation, the DRG rates are supposed to be adjusted each federal fiscal year for inflation, but such adjustment has often been affected by new federal legislation. The index used to adjust the DRG rates, known as the "market basket index," gives consideration to the inflation experienced by hospitals and entities outside of the healthcare industry in purchasing goods and services, but the percentage increases in the DRG rates have generally been lower than the actual projected increase in the cost of goods and services purchased by hospitals. Moreover,

often federal legislation has lowered or potentially lowered the annual percentage increase to the DRG rates below the annual amount indicated by the "market basket index" for the year. Thus, while federal legislation provided for DRG rate increases for federal fiscal years 2007, 2008 and 2009 at the full market basket, the increases were or will be paid only if the facility has submitted data for 21 patient care quality indicators to the Secretary of Health and Human Services in federal fiscal year 2007, 30 in federal fiscal year 2008 and 42 in federal fiscal year 2009. We currently have the ability to monitor our compliance with the quality indicators and have submitted or intend to submit the quality data required to receive the full market basket pricing updates during federal fiscal years 2007, 2008 and 2009. Those hospitals not submitting data on the quality indicators received or will receive an increase equal to the market basket rate minus 2% in federal fiscal years 2007, 2008 or 2009. Consistent with federal law, CMS issued final rules in August 2006, 2007 and 2008 that increased the hospital DRG payment rates by the full market basket of 3.40% for federal fiscal year 2007, the full market basket of 3.30% for federal fiscal year 2008 and the full market basket of 3.60% for federal fiscal year 2009 for those hospitals submitting data on the required quality indicators. While we will endeavor to comply with all data submission requirements as additional requirements continue to be added, our submissions may not be deemed timely or sufficient to entitle us to the full market basket adjustment for all of our hospitals.

In August 2006, CMS changed the methodology used to recalibrate the DRG weights from charge-based weights to cost relative weights under a three-year transition period beginning in federal fiscal year 2007. The adoption of the cost relative weights is not anticipated to have a material financial impact on us. On August 22, 2007, CMS published a final rule which adopts a two-year implementation of Medicare-Severity Diagnostic-Related Groups ("MS-DRGs"), a severity-adjusted DRG system. This change represents a refinement to the existing DRG system, and its impact on our revenues has not been significant. Additionally, CMS has imposed a documentation and coding adjustment to account for changes in payments under the new MS-DRG system that are not related to changes in case mix. Through legislative refinement, the documentation and coding adjustments for federal fiscal years 2008 and 2009 are reductions to the base payment rate of 0.6% and 0.9%, respectively. However, Congress has given CMS the ability to retrospectively determine if the documentation and coding adjustment levels for federal fiscal years 2008 and 2009 were adequate to account for changes in payments not related to changes in case mix. If the levels are found to have been inadequate, CMS can impose an adjustment to payments for federal fiscal years 2010, 2011 and 2012.

Beginning in federal fiscal year 2009, Medicare will not pay hospitals additional amounts for the treatment of certain preventable adverse events, also know as hospital-acquired conditions. The Deficit Reduction Act of 2005 required CMS to select at least two hospital-acquired conditions for which hospitals will not receive additional payment unless the conditions were present on admission to the hospital. In a final rule published on August 22, 2007, CMS selected eight such hospital-acquired conditions, three of which are classified as "serious preventable events" or "never events." Effective October 1, 2008, cases with any of these eight hospital-acquired conditions will not be paid at a higher DRG unless the condition was present at admission. The Act also provides that CMS may revise the list of conditions from time to time, and, thus, CMS sought comment in April 2008 on adding nine additional proposed conditions. In a final rule announced on July 31, 2008, CMS selected only three of the nine proposed additional hospital-acquired conditions to be added to the eight previously selected, bringing the total to 11 hospital-acquired conditions for which, effective October 1, 2008, it will not make additional payments to hospitals. Additionally, CMS has recently issued a report proposing a value-based purchasing system, which would phase out the current quality reporting system, making a portion of hospital payments contingent on actual performance against specified measures. It is uncertain whether such a program will be implemented.

Further realignments in the DRG system could also reduce the payments we receive for certain specialties, including cardiology and orthopedics. The greater proliferation of specialty hospitals in recent years has caused CMS to focus on payment levels for such specialties. Changes in the payments received for specialty services could have an adverse effect on our revenues.

In addition to DRG inpatient payments, in certain high-cost situations CMS makes additional payments to acute care hospitals, commonly referred to as "outlier payments", for those DRG cases where the cost of the case exceeds the total DRG payments plus a fixed threshold amount. Historically, the Medicare program has set aside 5.1% of Medicare inpatient payments to pay for outlier cases. During federal fiscal years 2001, 2002 and 2003, the CMS payments for outlier cases far exceeded the 5.1% set aside. As a result CMS increased the threshold amount from $16,350 at the end of federal fiscal year 2001 to as high as $33,560 for 2003. Additionally, on June 9, 2003,

CMS published a final rule substantially modifying the methodology for determining Medicare outlier payments in order to ensure that only the highest cost cases are entitled to receive additional payments under the inpatient prospective payment system. For discharges occurring on or after October 1, 2003, outlier payments are based on either a provider's most recent tentatively settled cost report or the most recent settled cost report, whichever is from the latest cost reporting period. Previously, outlier payments had been based on the most recent settled cost report, resulting in excessive outlier payments for some hospitals. The final rule requires, in most cases, the use of hospital-specific cost to charge ratios instead of a statewide ratio. Further, outlier payments may be adjusted retroactively to recoup any past outlier overpayments plus interest or to return any underpayments plus interest. We believe that these 2003 changes to the outlier payment methodology have not and will not have a material adverse effect on our business, financial position or results of operations. Indeed, we believe that as a result of these 2003 changes to the outlier payment methodology, CMS bas generally reduced the outlier threshold amounts in each year after 2003. Thus, CMS decreased the threshold in federal fiscal year 2008 to $22,650 and decreased it in federal fiscal year 2009 to $20,185. Decreasing the outlier threshold amounts has and will increase both the number of our cases that qualify for outlier payments and the amount of payments for qualifying outlier cases, compared to the "peak" year of federal fiscal year 2003 when the threshold amount was $33,560. The most recent cost reports filed for each of our facilities as of June 30, 2006, 2007 and 2008 reflected outlier payments of $5.9 million, $5.8 million and $4.3 million for those respective cost report periods.

Outpatient

CMS reimburses hospital outpatient services and certain Medicare Part B services furnished to hospital inpatients who have no Part A coverage on a prospective payment system basis. CMS has continued to use existing fee schedules to pay for physical, occupational and speech therapies, durable medical equipment, clinical diagnostic laboratory services and nonimplantable orthotics and prosthetics. Freestanding surgery centers and independent diagnostic testing facilities are also reimbursed on a fee schedule.

All services paid under the prospective payment system for hospital outpatient services are classified into groups called ambulatory payment classifications ("APCs"). Services in each APC are similar clinically and in terms of the resources they require. A payment rate is established for each APC. Depending on the services provided, a hospital may be paid for more than one APC for a patient visit. The APC payment rates were updated for calendar years 2006 and 2007 by the full market baskets of 3.70% and 3.40%, respectively. However, as a result of the expiration of additional payments for drugs that were being paid in calendar year 2005, for calendar year 2006 there was an effective 2.25% reduction to the market basket of 3.70%, resulting in a net market basket of 1.45%. This reduction was not applied in calendar years 2007 and 2008. In November 2007, CMS published a final rule to update outpatient prospective payment system payments for calendar year 2008 by 3.30%, which is the full market basket. In this final rule, CMS outlined the requirements for hospitals to submit quality data relating to outpatient care in order to receive the full market basket increase under the outpatient prospective payment system beginning in calendar year 2009. CMS requires that data on seven quality measures be submitted according to a data submission schedule. Hospitals that fail to submit such data will receive the market basket update minus two percentage points for the outpatient prospective payment system. We intend to submit the necessary quality data to qualify to receive the full market basket update in 2009.

Disproportionate Share Payments

Hospitals that treat a disproportionately large number of low-income patients (Medicare and Medicaid patients eligible to receive supplemental Social Security income) currently receive additional payments from the federal government in the form of disproportionate share payments. CMS has recommended changes to the present formula used to calculate these payments. One recommended change would give greater weight to the amount of uncompensated care provided by a hospital than it would to the number of low-income patients treated. During fiscal year 2008 all of our hospitals qualified for disproportionate share payments. During the year ended June 30, 2008, we recognized revenues of approximately $59.4 million or 2.1% of total revenues from Medicare disproportionate share reimbursement.

Rehabilitation Units

CMS reimburses inpatient rehabilitation hospitals and designated units pursuant to a prospective payment system. Under this prospective payment system, patients are classified into case mix groups based upon impairment, age, comorbidities and functional capability. Inpatient rehabilitation facilities and units are paid a predetermined amount per discharge that reflects the patient's case mix group and is adjusted for area wage levels, low-income patients, rural areas and high-cost outliers. For federal fiscal year 2008, CMS originally updated the payment rate for inpatient rehabilitation facilities and units by the full market basket rate of 3.2%. However, subsequently, Congress passed the Medicare, Medicaid, and SCHIP Extension Act of 2007 which set the inflation update for inpatient rehabilitation facilities and units at zero percent for federal fiscal years 2008 and 2009, effective for discharges beginning on or after April 1, 2008. As of June 30, 2008, we operated three inpatient rehabilitation units within our acute care hospitals.

Skilled Nursing Units

Medicare has established a prospective payment system for Medicare skilled nursing units, under which the units are paid a federal per diem rate for virtually all covered services. The effect of the new payment system generally has been to significantly reduce reimbursement for skilled nursing services, which has led many hospitals to close such units. We will monitor closely and evaluate the few remaining skilled nursing units in our hospitals and related facilities to determine whether it is feasible to continue to offer such services under this reimbursement system. For federal fiscal years 2008 and 2009, CMS updated the payment rate for skilled nursing units by the full market basket of 3.3% and 3.4%, respectively. As of June 30, 2008, we operated two skilled nursing units within our acute care hospitals.

Psychiatric Units

On November 15, 2004 CMS published a final regulation to implement a new Medicare prospective payment system for inpatient psychiatric hospitals and units. The new system replaced a cost-based payment system with a per diem prospective payment system for reporting periods beginning on or after January 1, 2005. The new system is a per diem prospective payment system with adjustments to account for certain patient and facility characteristics. The final rule included several provisions to ease the transition to the new payment system. For example, CMS phased in the new system over a three-year period so that full payment under the new system did not begin until cost report periods beginning on or after January 1, 2008. Additionally, CMS has included in the final rule a stop-loss provision, an "outlier" policy authorizing additional payments for extraordinarily costly cases and an adjustment to the base payment if the facility maintains a full-service emergency department which all of our units qualified for. CMS increased payments to our units by 3.2% for each of the psychiatric rate years of July 1, 2007 to June 30, 2008 and July 1, 2008 to June 30, 2009.

At the current time we continue to believe that the new psychiatric payment system will not materially negatively impact our Medicare reimbursement in respect of our psychiatric units. As of June 30, 2008, we operated seven psychiatric units within our acute care hospitals.

Home Health

CMS reimburses home health agencies through a prospective payment system. Home health payment rates have been historically updated annually by either the full home health market basket, or by the home health market basket as adjusted by Congress. The increase in payment rates for calendar year 2008 was the full home health market basket increase of 3.0%. The 2008 increase, however, provides for an adjustment to the payment rates for the non-reporting of certain quality data. Home health agencies that submit the quality data as required will receive payments based on the full home health market basket update of 3.0% for calendar year 2008. If a home health agency does not submit the required quality data, the home health market basket percentage increase will be reduced by 2.0% and the home health agency will only receive a 1.0% update during calendar year 2008. We currently submit, and plan to continue to submit, the necessary quality data to receive the full market basket update. As of June 30, 2008, we operated two entities providing home health services.

Contractor Reform

CMS has a significant initiative underway that could affect the administration of the Medicare program and impact how hospitals bill and receive payment for covered Medicare services. In accordance with the Medicare Modernization Act, CMS has begun implementation of contractor reform whereby CMS will competitively bid the Medicare fiscal intermediary and Medicare carrier functions to 15 Medicare Administrative Contractors ("MACs"). Hospital management companies like Vanguard will have the option to work with the selected MAC in the jurisdiction where a given hospital is located or to use the MAC in the jurisdiction where our home office is located. For hospital management companies, either all hospitals in the system must choose to stay with the MAC chosen for their locality or all hospitals must opt to use the home office MAC. We have filed a request for our single home office MAC to serve all of our hospitals. CMS awarded one MAC contract in 2006, and from August 2007 to June 2008 CMS awarded seven MAC contracts.

The remaining seven MAC contracts are expected to be awarded in the second half of calendar 2008 with all implementations occurring by July 2009. All of these changes could impact claims processing functions and the resulting cash flow; however, we are unable to predict the impact that these changes could have, if any, to our cash flows.

Wage Index

Under Medicare's prospective payment system, the payment rates are adjusted for the area differences in wage levels by a factor ("wage index") reflecting the relative wage level in the geographic area compared to the national average wage level. In federal fiscal years 2007 and 2008, CMS adjusted 100% of the wage index factor for occupational mix. The redistributive impact of wage index changes was not materially adverse to our results of operations in our fiscal year ended June 30, 2008.

Recovery Audit Contractors

In 2005, CMS began using recovery audit contractors ("RACs") to detect Medicare overpayments not identified through existing claims review mechanisms. The RAC program relies on private auditing firms to examine Medicare claims filed by healthcare providers. Fees to the RACs are paid on a contingency basis. The RAC program began as a demonstration project in 2005 in three states (New York, California and Florida) which was expanded into the three additional states of Arizona, Massachusetts and South Carolina in July 2007. No RAC audits, however, were initiated at our Arizona or Massachusetts hospitals during the demonstration project. The program was made permanent by the Tax Relief and Health Care Act of 2006 enacted in December 2006. CMS announced in March 2008 the end of the demonstration project and the commencement of the permanent program by the expansion of the RAC program to additional states beginning in the summer and fall 2008 and its plans to have RACs in place in all 50 states by 2010. Also, in March 2008 CMS initiated a process for selecting the four permanent RACs for the permanent program which are expected to be selected by CMS by September or October 2008.

In a report issued in July 2008 CMS reported that the RACs corrected over $1 billion of Medicare improper payments from 2005 through March 2008. Roughly 96% of the improper payments ($992.7 million) were overpayments collected from providers, while the remaining 4% ($37.8 million) were underpayments repaid to providers. Of the overpayments, 85% were collected from inpatient hospital providers, and the other principal collections were 6% from inpatient rehabilitation facilities, and 4% from outpatient hospital providers.

RACs perform post-discharge audits of medical records to identify Medicare overpayments resulting from incorrect payment amounts, non-covered services, incorrectly coded services, and duplicate services. CMS has given RACs the authority to look back at claims up to three years old, provided that the claim was paid on or after October 1, 2007. Claims identified as overpayments will be subject to the Medicare appeals process.

RACs are paid a contingency fee based on the overpayments they identify and collect. Therefore, we expect that the RACs will look very closely at claims submitted by our facilities in an attempt to identify possible overpayments. Although we believe the claims for reimbursement submitted to the Medicare program by our facilities have been accurate, we cannot predict whether, once our facilities are subject to RAC audits in the future,

what the result of such audits might be, but it is reasonably possible that the aggregate payments that our facilities are required to return to the Medicare program pursuant to these RAC audits may have a material adverse effect on our business, financial position, results of operations or cash flows.

Managed Medicare

Managed Medicare plans relate to situations where a private company contracts with CMS to provide members with Medicare benefits. Managed Medicare plans can be structured as health maintenance organizations, preferred provider organizations or private fee-for-service plans. The Medicare Modernization Act increased reimbursement to managed Medicare plans and included provisions limiting, to some extent, the financial risk to the companies offering the plans. Following these changes, the number of beneficiaries choosing to receive their Medicare benefits through such plans has increased significantly.

Medicaid

Medicaid programs are funded jointly by the federal government and the states and are administered by states under approved plans. Most state Medicaid program payments are made under a prospective payment system or are based on negotiated payment levels with individual hospitals. Medicaid reimbursement is less than Medicare reimbursement for the same services and is often less than a hospital's cost of services. The federal government and many states have recently adopted or are currently considering reducing the level of Medicaid funding (including upper payment limits) or program eligibility that could adversely affect future levels of Medicaid reimbursement received by our hospitals. As permitted by law, certain states in which we operate have adopted broad-based provider taxes to fund their Medicaid programs. Since states must operate with balanced budgets and since the Medicaid program is often the state's largest program, states can be expected to adopt or consider adopting legislation designed to reduce their Medicaid expenditures.

As to recent federal action, the Deficit Reduction Act of 2005 included Medicaid cuts in federal funding of approximately $4.8 billion over five years. Additionally, on May 29, 2007, CMS published a final rule entitled "Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership" which is estimated to reduce federal Medicaid funding from $12 to $20 billion over five years. Congress has enacted two moratoria in respect of this rule. First, Congress delayed its implementation totally until May 2008. Secondly, in June 2008 Congress delayed six of seven proposed Medicaid regulations in this final CMS rule until April 1, 2009, with only the seventh regulation concerning certain outpatient services and imposing severe restrictions on states covering children with family income levels beyond 250% of the federal poverty level under the Children's Health Insurance Program not being delayed by this second moratorium. As a result of the moratorium on implementing the final rule, the impact on us of the final rule has not been quantified.

Certain states in which we operate provide disproportionate share payments to hospitals that treat a disproportionately large number of low-income patients as part of their state Medicaid programs, similar to disproportionate share payments received from Medicare. During the year ended June 30, 2008, we recognized revenues of approximately $20.2 million or 0.7% of total revenues related to Medicaid disproportionate share reimbursement. These states continually assess the level of expenditures for disproportionate share reimbursement and may reduce these payments or restructure this portion of their Medicaid programs.

The states have also adopted, or are considering, legislation designed to reduce coverage and program eligibility, enroll Medicaid recipients in managed care programs and/or impose additional taxes on hospitals to help finance or expand the states' Medicaid systems.

Future federal or state legislation or other changes in the administration or interpretation of government health programs by the federal government or by the states in which we operate could have a material, adverse effect on our financial position and results of operations.

Managed Medicaid

Managed Medicaid programs relate to situations where states contract with one or more entities for patient enrollment, care management and claims adjudication. The states usually do not give up program responsibilities for financing, eligibility criteria and core benefit plan design. We generally contract directly with one of the designated entities, usually a managed care organization. The provisions of these programs are state-specific.

Annual Cost Reports

All hospitals participating in the Medicare and Medicaid programs are required to meet specific 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. Moreover, annual cost reports required under the Medicare and Medicaid programs are subject to routine audits, which may result in adjustments to the amounts ultimately determined to be due to us under these reimbursement programs. The audit process takes several years to reach the final determination of allowable amounts under the programs. Providers also have the right of appeal, and it is common to contest issues raised in audits of prior years' reports.

Many prior year cost reports of our facilities are still open. If any of our facilities are found to have been in violation of federal or state laws relating to preparing and filing of Medicare or Medicaid cost reports, whether prior to or after our ownership of these facilities, we and our facilities could be subject to substantial monetary fines, civil and criminal penalties and exclusion from participation in the Medicare and Medicaid programs. If an allegation is lodged against one of our facilities for a violation occurring during the time period before we acquired the facility, we may have indemnification rights against the seller of the facility to us. In each of our acquisitions, we have negotiated customary indemnification and hold harmless provisions for any damages we may incur in these areas.

Managed Care and Other Private Insurers

Managed care providers, including health maintenance organizations, preferred provider organizations, other private insurance companies and employers, are organizations that provide insurance coverage and a network of healthcare providers to members for a fixed monthly premium. To attract additional volume, most of our hospitals offer discounts from established charges or prospective payment systems to these large group purchasers of healthcare services. These discount programs often limit our ability to increase charges in response to increasing costs. However, as part of our business strategy, we have been able to renegotiate payment rates on many of our managed care contracts to improve our operating margin. While we generally received annual average payment rate increases of 5 to 16 percent from non-governmental managed care payers during fiscal year 2008, there can be no assurance that we will continue to receive increases in the future and that patient volumes from these payers will not be adversely affected by rate negotiations. While the majority of our admissions and revenues are generated from patients covered by managed care plans, the percentage may decrease in the future due to increased Medicare utilization associated with the aging U.S. population. We experienced a slight increase in managed care utilization of inpatient days as a percentage of total inpatient days during the year ended June 30, 2008 compared to the year ended June 30, 2007.

Self-Pay Patients

Self-pay patients are patients who do not qualify for government programs payments, such as Medicare and Medicaid, and who do not have some form of private insurance, and are, therefore, responsible for their own medical bills. We also include in our self-pay accounts those unpaid coinsurance and deductible amounts for which payment has been received from the primary payer. A significant portion of our self-pay patients are admitted through our hospitals' emergency departments and often require high-acuity treatment. High-acuity treatment is more costly to provide and, therefore, results in higher billings, which are the least collectible of all accounts. We believe self-pay patient volumes and revenues have been impacted during the last two years due to a combination of broad economic factors, including reductions in state Medicaid budgets, increasing numbers of individuals and employers who choose not to purchase insurance and an increased burden of coinsurance and deductibles to be made by patients instead of insurers.

Self-pay accounts pose significant collectibility problems. At June 30, 2008, approximately 23.5% of our accounts receivable, prior to the allowance for doubtful accounts, contractual allowances and the charity care allowance, was comprised of self-pay accounts. The majority of our provision for doubtful accounts relates to self-pay patients. While our allowance for doubtful accounts and charity care allowance cover over 95% of our collecibility risks associated with self-pay receivables, we remain vulnerable to further increased self-pay utilization. We are taking multiple actions in an effort to mitigate the effect on us of the high number of uninsured patients and the related economic impact. These initiatives include conducting detailed reviews of intake procedures in hospitals facing the greatest pressures and enhancing and updating intake best practices for all of our hospitals. We developed hospital-specific reports detailing collection rates by type of patient to help the hospital management teams better identify areas of vulnerability and opportunities for improvement. Also, we completely redesigned our self-pay collection workflows, enhanced technology and improved staff training in an effort to increase collections.

We do not pursue collection of amounts due from uninsured patients that qualify for charity care under our guidelines (currently those uninsured patients whose incomes are equal to or less than 200% of the current federal poverty guidelines set forth by the Department of Health and Human Services). We exclude charity care accounts from revenues when we determine that the account meets our charity care guidelines. We provide expanded discounts from billed charges and alternative payment structures for uninsured patients who do not qualify for charity care but meet certain other minimum income guidelines, primarily those uninsured patients with incomes between 200% and 500% of the federal poverty guidelines. During the fiscal years ended June 30, 2006, 2007 and 2008, we deducted $71.1 million, $86.1 million and $86.1 million of charity care from gross charges, respectively.

Government Regulation and Other Factors

Overview

All participants in the healthcare industry are required to comply with extensive government regulation at the federal, state and local levels. In addition, these laws, rules and regulations are extremely complex and the healthcare industry has had the benefit of little or no regulatory or judicial interpretation of many of them. Although we believe we are in compliance in all material respects with such laws, rules and regulations, if a determination is made that we were in material violation of such laws, rules or regulations, our business, financial condition or results of operations could be materially adversely affected. 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 their ability to participate in the Medicare and Medicaid programs.

Licensing, Certification and Accreditation

Healthcare facility construction and operation is subject to federal, state and local regulations relating to the adequacy of medical care, equipment, personnel, operating policies and procedures, fire prevention, rate-setting and compliance with building codes and environmental protection laws. Our facilities also are subject to periodic inspection by governmental and other authorities to assure continued compliance with the various standards necessary for licensing and accreditation. We believe that all of our operating healthcare facilities are properly licensed under appropriate state healthcare laws.

All of our operating hospitals are certified under the Medicare program and are accredited by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"), the effect of which is to permit the facilities to participate in the Medicare and Medicaid programs. If any facility loses its accreditation by JCAHO, or otherwise loses its certification under the Medicare program, then the facility will be unable to receive reimbursement from the Medicare and Medicaid programs. We intend to conduct our operations in compliance with current applicable federal, state, local and independent review body regulations and standards. The requirements for licensure, certification and accreditation are subject to change and, in order to remain qualified, we may need to make changes in our facilities, equipment, personnel and services.

Certificates of Need

In some states, the construction of new facilities, acquisition of existing facilities or addition of new beds or services may be subject to review by state regulatory agencies under a Certificate of Need program. Illinois and

Massachusetts are the only states in which we currently operate that require approval under a Certificate of Need program. These laws generally require appropriate state agency determination of public need and approval prior to the addition of beds or services or other capital expenditures. Failure to obtain necessary state approval can result in the inability to expand facilities, add services, acquire a facility or change ownership. Further, violation of such laws may result in the imposition of civil sanctions or the revocation of a facility's license.

Utilization Review

Federal law contains numerous provisions designed to ensure that services rendered by hospitals to Medicare and Medicaid patients meet professionally recognized standards and are medically necessary and that claims for reimbursement are properly filed. These provisions include a requirement that a sampling of admissions of Medicare and Medicaid patients be reviewed by quality improvement organizations that analyze the appropriateness of Medicare and Medicaid patient admissions and discharges, quality of care provided, validity of diagnosis related group classifications and appropriateness of cases of extraordinary length of stay or cost. Quality improvement organizations may deny payment for services provided, assess fines and recommend to the Department of Health and Human Services that a provider not in substantial compliance with the standards of the quality improvement organization be excluded from participation in the Medicare program. Most non-governmental managed care organizations also require utilization review.

Federal Healthcare Program Statutes and Regulations

Participation in any federal healthcare program, such as the Medicare and Medicaid programs, is regulated heavily by statute and regulation. If a hospital provider fails to substantially comply with the numerous conditions of participation in the Medicare or Medicaid program or performs specific prohibited acts, the hospital's participation in the Medicare program may be terminated or civil or criminal penalties may be imposed upon it under provisions of the Social Security Act and other statutes.

Anti-Kickback Statute

A section of the Social Security Act known as the federal Anti-Kickback Statute prohibits providers and others from soliciting, receiving, offering or paying, directly or indirectly, any remuneration with the intent of generating referrals or orders for services or items covered by a federal healthcare program. Violation of this statute is a felony, including criminal penalties of imprisonment or criminal fines up to $25,000 for each violation, but it also includes civil money penalties of up to $50,000 per violation, damages up to three times the total amount of the improper payment to the referral source and exclusion from participation in Medicare, Medicaid or other federal healthcare programs.

The Office of the Inspector General of the Department of Health and Human Services (the "OIG") has published final safe harbor regulations that outline categories of activities that are deemed protected from prosecution under the Anti-Kickback Statute. Currently there are safe harbors for various activities, including the following: investment interests, space rental, equipment rental, practitioner recruitment, personal services and management contracts, sale of practice, referral services, warranties, discounts, employees, group purchasing organizations, waiver of beneficiary coinsurance and deductible amounts, managed care arrangements, obstetrical malpractice insurance subsidies, investments in group practices, ambulatory surgery centers and referral agreements for specialty services.

The fact that conduct or a business arrangement does not fall within a safe harbor does not automatically render the conduct or business arrangement illegal under the Anti-Kickback Statute. The conduct or business arrangement, however, does increase the risk of scrutiny by government enforcement authorities. We may be less willing than some of our competitors to take actions or enter into business arrangements that do not clearly satisfy the safe harbors. As a result, this unwillingness may put us at a competitive disadvantage.

The OIG, among other regulatory agencies, is responsible for identifying and eliminating fraud, abuse and waste. The OIG carries out this mission through a nationwide program of audits, investigations and inspections. In order to provide guidance to healthcare providers, the OIG has from time to time issued "fraud alerts" that, although they do not have the force of law, identify features of a transaction that may indicate that the transaction could

violate the Anti-Kickback Statute or other federal healthcare laws. The OIG has identified several incentive arrangements as potential violations, including:

- 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;
- guarantees that 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 or a physician's continuing education courses;
- coverage on the hospital's group health insurance plans at an inappropriately low cost to the physician;
- rental of space in physician offices, at other than fair market value terms, by persons or entities to which physicians refer;
- 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
- "gain sharing," the practice of giving physicians a share of any reduction in a hospital's costs for patient care attributable in part to the physician's efforts.

Also, the OIG has encouraged persons having information about hospitals who offer the above types of incentives to physicians to report such information to the OIG.

The OIG also issues "Special Advisory Bulletins" as a means of providing guidance to healthcare providers. These bulletins, along with other "fraud alerts", have focused on certain arrangements between physicians and providers that could be subject to heightened scrutiny by government enforcement authorities, including, "suspect" joint ventures where physicians may become investors with the provider in a newly formed joint venture entity where the investors refer their patients to this new entity, and are paid by the entity in the form of "profit distributions." These subject joint ventures may be intended not so much to raise investment capital legitimately to start a business, but to lock up a stream of referrals from the physician investors and to compensate them indirectly for these referrals. Because physician investors can benefit financially from their referrals, unnecessary procedures and tests may be ordered or performed, resulting in unnecessary Medicare expenditures.

Similarly, in a Special Advisory Bulletin issued in April 2003, the OIG focused on "questionable" contractual arrangements where a healthcare provider in one line of business (the "Owner") expands into a related healthcare business by contracting with an existing provider of a related item or service (the "Manager/Supplier") to provide the new item or service to the Owner's existing patient population, including federal healthcare program patients (so called "suspect Contractual Joint Ventures"). The Manager/Supplier not only manages the new line of business, but may also supply it with inventory, employees, space, billing, and other services. In other words, the Owner contracts out substantially the entire operation of the related line of business to the Manager/Supplier – otherwise a potential competitor – receiving in return the profits of the business as remuneration for its federal program referrals. The Bulletin lists the following features of these "questionable" contractual relationships. First, the Owner expands into a related line of business, which is dependent on referrals from, or other business generated by, the Owner's existing business. Second, the Owner neither operates the new business itself nor commits

substantial financial, capital or human resources to the venture. Instead, it contracts out substantially all the operations of the new business. The Manager/Supplier typically agrees to provide not only management services, but also a range of other services, such as the inventory necessary to run the business, office and healthcare personnel, billing support, and space. Third, the Manager/Supplier is an established provider of the same services as the Owner's new line of business. In other words, absent the contractual arrangement, the Manager/Supplier would be a competitor of the new line of business, providing items and services in its own right, billing insurers and patients in its own name, and collecting reimbursement. Fourth, the Owner and the Manager/Supplier share in the economic benefit of the Owner's new business. The Manager/Supplier takes its share in the form of payments under the various contracts with the Owner; the Owner receives its share in the form of the residual profit from the new business. Fifth, aggregate payments to the Manager/Supplier typically vary with the value or volume of business generated for the new business by the Owner. We monitor carefully our contracts with other healthcare providers and attempt to not allow our facilities to enter into these suspect Contractual Joint Ventures.

In addition to issuing fraud alerts and Special Advisory Bulletins, the OIG from time to time issues compliance program guidance for certain types of healthcare providers. In January 2005, the OIG published a Supplemental Compliance Guidance for Hospitals, supplementing its 1998 guidance for the hospital industry. In the supplemental guidance, the OIG identifies a number of risk areas under federal fraud and abuse statutes and regulations. These areas of risk include compensation arrangements with physicians, recruitment arrangements with physicians and joint venture relationships with physicians.

We have a variety of financial relationships with physicians who refer patients to our hospitals. As of June 30, 2008, physicians owned interests in two of our free-standing surgery centers in California and seven of our diagnostic imaging centers in Texas. We may sell ownership interests in certain other of our facilities to physicians and other qualified investors in the future. We also have contracts with physicians providing for a variety of financial arrangements, including employment contracts, leases and professional service agreements. We have provided financial incentives to recruit physicians to relocate to communities served by our hospitals, including income and collection guarantees and reimbursement of relocation costs, and will continue to provide recruitment packages in the future. Although we have established policies and procedures to ensure that our arrangements with physicians comply with current law and available interpretations, we cannot assure you that regulatory authorities that enforce these laws will not determine that some of these arrangements violate the Anti-Kickback Statute or other applicable laws. An adverse determination could subject us to liabilities under the Social Security Act, including criminal penalties, civil monetary penalties and exclusion from participation in Medicare, Medicaid or other federal healthcare programs, any of which could have a material adverse effect in our business, financial condition or results of operations.

Other Fraud and Abuse Provisions

The Social Security Act also imposes criminal and civil penalties for submitting false claims to Medicare and Medicaid. False claims include, but are not limited to, billing for services not rendered, misrepresenting actual services rendered in order to obtain higher reimbursement and cost report fraud. Like the Anti-Kickback Statute, these provisions are very broad. Further, the Social Security Act contains civil penalties for conduct including improper coding and billing for unnecessary goods and services. Careful and accurate preparation and submission of claims for reimbursement must be performed in order to avoid liability.

The Health Insurance Portability and Accountability Act of 1996 broadened the scope of the fraud and abuse laws by adding several criminal provisions for healthcare fraud offenses that apply to all health benefit programs. This act also created new enforcement mechanisms to combat fraud and abuse, including the Medicaid Integrity Program and an incentive program under which individuals can receive up to $1,000 for providing information on Medicare fraud and abuse that leads to the recovery of at least $100 of Medicare funds. In addition, federal enforcement officials now have the ability to exclude from Medicare and Medicaid any investors, officers and managing employees associated with business entities that have committed healthcare fraud. Additionally, this Act establishes a violation for the payment of inducements to Medicare or Medicaid beneficiaries in order to influence those beneficiaries to order or receive services from a particular provider or practitioner.

Some of these provisions, including the federal Civil Monetary Penalty Law, require a lower burden of proof than other fraud and abuse laws, including the Anti-kickback Statute. Civil monetary penalties that may be

imposed under the federal Civil Monetary Penalty Law range from $10,000 to $50,000 per act, and in some cases may result in penalties of up to three times the remuneration offered, paid, solicited or received. In addition, a violator may be subject to exclusion from federal and state healthcare programs. Federal and state governments increasingly use the federal Civil Monetary Penalty Law, especially where they believe they cannot meet the higher burden of proof requirements under the Anti-kickback Statute.

The Stark Law

The Social Security Act also includes a provision commonly known as the "Stark Law." This law prohibits physicians from referring Medicare and (to an extent) Medicaid patients to entities with which they or any of their immediate family members have a financial relationship for the provision of certain designated health services that are reimbursable by Medicare or Medicaid, including inpatient and outpatient hospital services. The law also prohibits the entity from billing the Medicare program for any items or services that stem from a prohibited referral. Sanctions for violating the Stark Law include denial of payment, refunding amounts received for services provided pursuant to prohibited referrals, civil money penalties up to $15,000 per item or service improperly billed and exclusion from the federal healthcare programs. The statute also provides for a penalty of up to $100,000 for a circumvention scheme. There are a number of exceptions to the self-referral prohibition, including an exception for a physician's ownership interest in an entire hospital as opposed to an ownership interest in a hospital department. There are also exceptions for many of the customary financial arrangements between physicians and providers, including employment contracts, leases, professional services agreements, non-cash gifts having an annual value of no more than $338 in calendar 2008 and recruitment agreements. Unlike safe harbors under the Anti-kickback Statute with which compliance is voluntary, an arrangement must comply with every requirement of a Stark Law exception or the arrangement is in violation of the Stark Law.

CMS has issued three phases of final regulations implementing the Stark Law, which became effective on January 4, 2002, July 26, 2004 and December 4, 2007, respectively, and which created several additional exceptions and many technical changes and nuanced details. Also, as part of its annual physician fee schedule update, on July 2, 2007, CMS released a number of proposed and potentially far-reaching changes to the Stark Law regulations apparently resulting from CMS's frustration with what it perceived as a growing number of hospital/physician joint venture arrangements that permitted physicians to profit from their referrals of ancillary services, while side-stepping or working around existing Stark Law restrictions. On July 31, 2008, CMS issued the final hospital inpatient prospective payment system rule for federal fiscal year 2009 which, in part, finalized and responded to public comments regarding some of its July 2007 proposed major changes to the Stark Law regulations to undermine many common hospital/physician joint venture models. The most far-reaching of the changes made in this final July 2008 rule will effectively prohibit, as of a delayed effective date of October 1, 2009, both "under arrangements" ventures between a hospital and any of its physicians and unit-of-service-based "per click" compensation and percentage-based compensation in office space and equipment leases between a hospital and its physicians. Hospitals will need to examine all of their "under arrangements" ventures and their space and equipment leases with physicians to identify those arrangements which violate these new Stark regulations and restructure or terminate those arrangements so identified prior to October 1, 2009. In addition, in this July 2008 final rule CMS indicated that it will continue to enact further regulations tightening aspects of the Stark Law that it perceives allow for Medicare program abuse, especially those regulations that still permit physicians to profit from their referrals of ancillary services. There can be no assurance that the arrangements entered into by us and our facilities will be found to be in compliance with the Stark Law, as it ultimately may be implemented or interpreted.

Similar State Laws, etc.

Many of the states in which we operate also have adopted laws that prohibit payments to physicians in exchange for referrals similar to the federal Anti-Kickback Statute or that otherwise prohibit fraud and abuse activities. Many states also have passed self-referral legislation, similar to the Stark Law, prohibiting the referral of patients to entities with which the physician has a financial relationship. Often these state laws are broad in scope and they may apply regardless of the source of payment for care. These statutes typically provide criminal and civil penalties, as well as loss of licensure. Little precedent exists for the interpretation or enforcement of these state laws.

Certain Implications of these Fraud and Abuse Laws or New Laws

Our operations could be adversely affected by the failure of our arrangements to comply with the Anti-Kickback Statute, the Stark Law, billing laws and regulations, current state laws or other legislation or regulations in these areas adopted in the future. We are unable to predict whether other legislation or regulations at the federal or state level in any of these areas will be adopted, what form such legislation or regulations may take or how they may impact our operations. We are continuing to enter into new financial arrangements with physicians and other providers in a manner structured to comply in all material respects with these laws. We cannot assure you, however, that governmental officials responsible for enforcing these laws will not assert that we are in violation of them or that such statutes or regulations ultimately will be interpreted by the courts in a manner consistent with our interpretation.

The Federal False Claims Act and Similar Laws

Another trend affecting the healthcare industry today is the increased use of the federal False Claims Act, and, in particular, actions being brought by individuals on the government's behalf under the False Claims Act's "*qui tam*" or whistleblower provisions. Whistleblower provisions allow private individuals to bring actions on behalf of the government alleging that the defendant has defrauded the federal government. If the government intervenes in the action and prevails, the party filing the initial complaint may share in any settlement or judgment. If the government does not intervene in the action, the whistleblower plaintiff may pursue the action independently, and may receive a larger share of any settlement or judgment. When a private party brings a *qui tam* action under the False Claims Act, the defendant generally will not be made aware of the lawsuit until the government makes a determination whether it will intervene.

When a defendant is determined by a court of law to be liable under the False Claims Act, the defendant must pay three times the actual damages sustained by the government, plus mandatory civil penalties of between $5,500 to $11,000 for each separate false claim. Settlements entered into prior to litigation usually involve a less severe calculation of damages. There are many potential bases for liability under the False Claims Act. Although liability often arises when an entity knowingly submits a false claim for reimbursement to the federal government, the False Claims Act defines the term "knowingly" broadly. Thus, simple negligence will not give rise to liability under the False Claims Act, but submitting a claim with reckless disregard to its truth or falsity can constitute "knowingly" submitting a false claim and result in liability. In some cases, whistleblowers or the federal government have taken the position that providers who allegedly have violated other statutes, such as the Anti-Kickback Statute or the Stark Law, have thereby submitted false claims under the False Claims Act.

A number of states, including states in which we operate, have adopted their own false claims provisions as well as their own whistleblower provisions whereby a private party may file a civil lawsuit in state court. From time to time, companies in the healthcare industry, including ours, may be subject to actions under the False Claims Act or similar state laws.

Provisions in the Deficit Reduction Act of 2005 ("DRA") that went into effect on January 1, 2007 give states significant financial incentives to enact false claims laws modeled on the federal False Claims Act. Additionally, the DRA requires every entity that receives annual payments of at least $5 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 health care providers. We have complied with the written policy requirements.

Corporate Practice of Medicine and Fee Splitting

The states in which we operate have laws that prohibit unlicensed persons or business entities, including corporations, from employing physicians or laws that prohibit certain 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 that may violate these restrictions. These statutes vary from state to state, are often vague and seldom have been interpreted by the courts or regulatory agencies. Although we exercise care to structure our arrangements

with healthcare providers to comply with the relevant state law, and believe these arrangements comply with applicable laws in all material respects, we cannot assure you that governmental officials responsible for enforcing these laws will not assert that we, or transactions in which we are involved, are in violation of such laws, or that such laws ultimately will be interpreted by the courts in a manner consistent with our interpretations.

The Health Insurance Portability and Accountability Act of 1996

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires the use of uniform electronic data transmission standards for healthcare claims and payment transactions submitted or received electronically. These provisions are intended to encourage electronic commerce in the healthcare industry. On August 17, 2000, the Department of Health and Human Services published final regulations establishing electronic data transmission standards that all healthcare providers must use when submitting or receiving certain healthcare transactions electronically. Compliance with these standards became mandatory on October 16, 2003. However, the Department of Health and Human Services agreed to accept noncompliant Medicare claims until October 1, 2005 to assist providers that were not yet able to process compliant transactions. Thus, commencing on October 1, 2005, fee-for-service Medicare claims that did not meet the standards required by HIPAA were returned to the filer for resubmission as compliant claims and non-compliant claims were not processed by Medicare. As of October 1, 2005, all of our facilities were filing compliant Medicare claims and continue doing so as of the date of this report.

HIPAA also requires the Department of Health and Human Services to adopt standards to protect the security and privacy of health-related information. The Department of Health and Human Services released final regulations containing privacy standards in December 2000 and published revisions to the final regulations in August 2002. Compliance with these regulations became mandatory on April 14, 2003. The privacy regulations extensively regulate the use and disclosure of individually identifiable health-related information. The privacy regulations also provide patients with significant new rights related to understanding and controlling how their health information is used or disclosed. The Department of Health and Human Services released final security regulations on February 20, 2003. The security regulations became mandatory on April 20, 2005 and require healthcare providers to implement administrative, physical and technical practices to protect the security of individually identifiable health information that is electronically maintained or transmitted.

Violations of HIPAA could result in civil penalties of up to $25,000 per type of violation in each calendar year and criminal penalties of up to $250,000 per violation. In addition, our facilities will continue to remain subject to any privacy-related federal or state laws that are more restrictive than the privacy regulations issued under HIPAA. These laws vary by jurisdiction and could impose additional penalties.

Compliance with these standards has and will continue to require significant commitment and action by us. We have appointed members of our management team to direct our compliance with these standards. Implementation has and will continue to require us to engage in extensive preparation and make significant expenditures. At this time we have appointed a corporate privacy officer and a privacy officer at each of our facilities, prepared privacy policies, trained our workforce on these policies and entered into business associate agreements with the appropriate vendors. However, failure by us or third parties on which we rely, including payers, to resolve HIPAA-related implementation or operational issues could have a material adverse effect on our results of operations and our ability to provide healthcare services. Consequently, we can give you no assurance that issues related to the full implementation of, or our operations under, HIPAA will not have a material adverse effect on our financial condition or future results of operations.

Conversion Legislation

Many states have enacted laws affecting the conversion or sale of not-for-profit hospitals. These laws generally include provisions relating to attorney general approval, advance notification and community involvement. In addition, attorneys general in states without specific conversion legislation may exercise authority over these transactions based upon existing law. In many states, there has been an increased interest in the oversight of not-for-profit conversions. The adoption of conversion legislation and the increased review of not-for-profit hospital conversions may increase the cost and difficulty or prevent the completion of transactions with or acquisitions of not-for-profit organizations in various states.

The Emergency Medical Treatment and Active Labor Act

The Federal Emergency Medical Treatment and Active Labor Act ("EMTALA") was adopted by Congress in response to reports of a widespread hospital emergency room practice of "patient dumping." At the time of the enactment, patient dumping was considered to have occurred when a hospital capable of providing the needed care sent a patient to another facility or simply turned the patient away based on such patient's inability to pay for his or her care. The law imposes requirements upon physicians, hospitals and other facilities that provide emergency medical services. Such requirements pertain to what care must be provided to anyone who comes to such facilities seeking care before they may be transferred to another facility or otherwise denied care. The government broadly interprets the law to cover situations in which patients do not actually present to a hospital's emergency department, but present to a hospital-based clinic that treats emergency medical conditions on an urgent basis or are transported in a hospital-owned ambulance, subject to certain exceptions. EMTALA does not generally apply to patients admitted for inpatient services. Sanctions for violations of this statute include termination of a hospital's Medicare provider agreement, exclusion of a physician from participation in Medicare and Medicaid programs and civil monetary penalties. In addition, the law creates private civil remedies that enable an individual who suffers personal harm as a direct result of a violation of the law, and a medical facility that suffers a financial loss as a direct result of another participating hospital's violation of the law, to sue the offending hospital for damages and equitable relief. Although we believe that our practices are in substantial compliance with the law, we cannot assure you that governmental officials responsible for enforcing the law will not assert from time to time that our facilities are in violation of this statute.

Antitrust Laws

The federal government and most states have enacted antitrust laws that prohibit certain types of conduct deemed to be anti-competitive. These laws prohibit price fixing, agreements to fix wages, concerted refusal to deal, market monopolization, price discrimination, tying arrangements, acquisitions of competitors and other practices that have, or may have, an adverse effect on competition. Violations of federal or state antitrust laws can result in various sanctions, including criminal and civil penalties. Antitrust enforcement in the healthcare industry is currently a priority of the Federal Trade Commission. We believe we are in compliance with such federal and state laws, but there can be no assurance that a review of our practices by courts or regulatory authorities will not result in a determination that could adversely affect our operations.

Healthcare Reform

The healthcare industry, as one of the largest industries in the United States, continues to attract much legislative interest and public attention. Changes in Medicare, Medicaid and other programs, hospital cost-containment initiatives by public and private payers, proposals to limit payments and healthcare spending and industry-wide competitive factors are highly significant to the healthcare industry. In addition, a framework of extremely complex federal and state laws, rules and regulations governs the healthcare industry and, for many provisions, there is little history of regulatory or judicial interpretation on which to rely.

Both the federal government and many states have enacted or are considering enacting measures designed to reduce their Medicaid expenditures and change private healthcare insurance. Most states, including the states in which we operate, have applied for and been granted federal waivers from current Medicaid regulations to allow them to serve some or all of their Medicaid participants through managed care providers. We are unable to predict the future course of federal, state or local healthcare legislation. Further changes in the law or regulatory framework that reduce our revenues or increase our costs could have a material adverse effect on our business, financial condition or results of operations.

Healthcare Industry Investigations

Significant media and public attention has focused in recent years on the hospital industry. In recent years, increased attention has been paid to hospitals with high Medicare outlier payments and to recruitment arrangements with physicians. Further, there are numerous ongoing federal and state investigations regarding multiple issues. These investigations have targeted hospital companies as well as their executives and managers. Like other hospital companies, we have substantial Medicare, Medicaid and other governmental billings and we engage in various

arrangements with physicians, which could result in scrutiny of our operations. We continue to monitor these and all other aspects of our business and have developed a compliance program to assist us in gaining comfort that our business practices are consistent with both legal principles and current industry standards. However, because the law in this area is complex and constantly evolving, we cannot assure you that government investigations will not result in interpretations that are inconsistent with industry practices, including ours. In public statements surrounding current investigations, governmental authorities have taken positions on a number of issues, including some for which little official interpretation previously has been available, that appear to be inconsistent with practices that have been common within the industry and that previously have not been challenged in this manner. In some instances, government investigations that have in the past been conducted under the civil provisions of federal law may now be conducted as criminal investigations.

Many current healthcare investigations are national initiatives in which federal agencies target an entire segment of the healthcare industry. One example is the federal government's initiative regarding hospital providers' improper requests for separate payments for services rendered to a patient on an outpatient basis within three days prior to the patient's admission to the hospital, where reimbursement for such services is included as part of the reimbursement for services furnished during an inpatient stay. In particular, the government has targeted all hospital providers to ensure conformity with this reimbursement rule. The federal government also has undertaken a national investigative initiative targeting the billing of claims for inpatient services related to bacterial pneumonia, as the government has found that many hospital providers have attempted to bill for pneumonia cases under more complex and higher reimbursed diagnosis related groups codes. Further, the federal government continues to investigate Medicare overpayments to prospective payment hospitals that incorrectly report transfers of patients to other prospective payment system hospitals as discharges. We are aware that prior to our acquisition of them, several of our hospitals were contacted in relation to certain government investigations relating to their operations. Although we take the position that, under the terms of the acquisition agreements, the prior owners of these hospitals retained any liability resulting from these government investigations, we cannot assure you that the prior owners' resolution of these matters or failure to resolve these matters, in the event that any resolution was deemed necessary, will not have a material adverse effect on our operations. Further, under the federal False Claims Act, private parties have the right to bring *"qui tam"* whistleblower lawsuits against companies that submit false claims for payments to the government. Some states have adopted similar state whistleblower and false claims provisions.

In addition to national enforcement initiatives, federal and state investigations commonly relate to a wide variety of routine healthcare operations such as: cost reporting and billing practices; financial arrangements with referral sources; physician recruitment activities; physician joint ventures; and hospital charges and collection practices for self-pay patients. We engage in many of these routine healthcare operations and other activities that could be the subject of governmental investigations or inquiries from time to time. For example, we have significant Medicare and Medicaid billings, we have numerous financial arrangements with physicians who are referral sources to our hospitals and we have joint venture arrangements involving physician investors.

While we are not currently aware of any material investigation of us under federal or state health care laws or regulations, it is possible that governmental entities may conduct investigations at facilities operated by us and that such investigations could result in significant penalties to us, as well as adverse publicity. It is also possible that our executives and managers, many of whom have worked at other healthcare companies that are or may become the subject of federal and state investigations and private litigation, could be included in governmental investigations or named as defendants in private litigation. The positions taken by authorities in any future investigations of us, our executives or managers or other healthcare providers and the liabilities or penalties that may be imposed could have a material adverse effect on our business, financial condition and results of operations.

Health Plan Regulatory Matters

Our health plans are subject to state and federal laws and regulations. CMS has the right to audit our health plans to determine the plans' compliance with such standards. In addition, AHCCCS has the right to audit PHP to determine PHP's compliance with such standards. Also, PHP is required to file periodic reports with AHCCCS, meet certain financial viability standards, provide its enrollees with certain mandated benefits and meet certain quality assurance and improvement requirements. Our health plans also have to comply with the standardized formats for electronic transmissions and privacy and security standards set forth in the Administrative

Simplifications Provisions of HIPAA. Our health plans have implemented the necessary policies and procedures to comply with the final federal regulations on these matters and were in compliance with them by their deadlines.

The Anti-Kickback Statute has been interpreted to prohibit the payment, solicitation, offering or receipt of any form of remuneration in return for the referral of federal health program patients or any item or service that is reimbursed, in whole or in part, by any federal healthcare program. Similar statutes have been adopted in Illinois and Arizona that apply regardless of the source of reimbursement. The Department of Health and Human Services has adopted safe harbor regulations specifying certain relationships and activities that are deemed not to violate the Anti-Kickback Statute which specifically relate to managed care including:

- waivers by health maintenance organizations of Medicare and Medicaid beneficiaries' obligations to pay cost-sharing amounts or to provide other incentives in order to attract Medicare and Medicaid enrollees;
- certain discounts offered to prepaid health plans by contracting providers;
- certain price reductions offered to eligible managed care organizations; and
- certain price reductions offered by contractors with substantial financial risk to managed care organizations.

We believe that the incentives offered by our health plans to their enrollees and the discounts they receive contracting with healthcare providers satisfy the requirements of the safe harbor regulations. However, the failure to satisfy each criterion of the applicable safe harbor does not mean that the arrangement constitutes a violation of the law; rather, the safe harbor regulations provide that an arrangement which does not fit within a safe harbor must be analyzed on the basis of its specific facts and circumstances. We believe that our health plans' arrangements comply in all material respects with the federal Anti-Kickback Statute and similar state statutes.

Environmental Matters

We are subject to various federal, state and local laws and regulations relating to environmental protection. Our hospitals are not highly regulated under environmental laws because we do not engage in any industrial activities at those locations. The principal environmental requirements and concerns applicable to our operations relate to:

- the proper handling and disposal of hazardous and low level medical radioactive waste;
- ownership or historical use of underground and above-ground storage tanks;
- management of impacts from leaks of hydraulic fluid or oil associated with elevators, chiller units or incinerators;
- appropriate management of asbestos-containing materials present or likely to be present at some locations; and
- the potential acquisition of, or maintenance of air emission permits for, boilers or other equipment.

We do not expect our compliance with environmental laws and regulations to have a material effect on us. We may also be subject to requirements related to the remediation of substances that have been released into the environment at properties owned or operated by us or at properties where substances were sent for off-site treatment or disposal. These remediation requirements may be imposed without regard to fault and whether or not we owned or operated the property at the time that the relevant releases or discharges occurred. Liability for environmental remediation can be substantial.

Item 1A. Risk Factors.

If any of the following events discussed in the following risks were to occur, our business, results of operations, financial condition, cash flows or prospects could be materially adversely affected. Additional risks and uncertainties not presently known, or currently deemed immaterial by us, may also constrain our business and operations.

Risks Relating to our Capital Structure

Our high level of debt and significant leverage may adversely affect our operations and our ability to grow and otherwise execute our business strategy.

We have a substantial amount of debt. As of June 30, 2008, we had $1,537.5 million of outstanding debt, excluding letters of credit and guarantees. This represented 73.0% of our total capitalization as of June 30, 2008. The amount of our outstanding indebtedness is large compared to the net book value of our assets, and we have significant repayment obligations under our outstanding indebtedness.

Our substantial indebtedness could:

- limit our ability to obtain additional financing to fund future capital expenditures, working capital, acquisitions or other needs;
- increase our vulnerability to general adverse economic, market and industry conditions and limit our flexibility in planning for, or reacting to, these conditions;
- make us vulnerable to increases in interest rates since $324.1 million of our borrowings under our senior credit facilities as of September 1, 2008 are, and additional borrowings may be, at variable interest rates;
- our flexibility to adjust to changing market conditions and ability to withstand competitive pressures could be limited, and we may be more vulnerable to a downturn in general economic or industry conditions or be unable to carry out capital spending that is necessary or important to our growth strategy and our efforts to improve operating margins;
- limit our ability to use operating cash in other areas of our business because we must use a substantial portion of these funds to make principal and interest payments; and
- limit our ability to compete with others who are not as highly-leveraged.

Our ability to make scheduled payments of principal and interest or to satisfy our other debt obligations, to refinance our indebtedness or to fund capital expenditures will depend on our future operating performance. Prevailing economic conditions (including interest rates) and financial, business and other factors, many of which are beyond our control, will also affect our ability to meet these needs. We may not be able to generate sufficient cash flows from operations or realize anticipated revenue growth or operating improvements, or obtain future borrowings in an amount sufficient to enable us to pay our debt, or to fund our other liquidity needs. We may need to refinance all or a portion of our debt on or before maturity. We may not be able to refinance any of our debt when needed on commercially reasonable terms or at all.

Despite our current significant leverage, we may still be able to incur substantially more debt. This could further exacerbate the risks that we and our subsidiaries face.

We and our subsidiaries may be able to incur substantial additional indebtedness in the future. The terms of the indentures and the senior credit facilities do not fully prohibit us or our subsidiaries from doing so. Our revolving credit facility provides commitments of up to $250.0 million (not giving effect to any outstanding letters of credit, which would reduce the amount available under our revolving credit facility), of which $222.0 million was available for future borrowings as of September 1, 2008. In addition, upon the occurrence of certain events, we may request an incremental term loan facility or facilities be added to our current senior credit facilities in an amount not to exceed $300.0 million in the aggregate, subject to receipt of commitments by existing lenders or other financing institutions and to the satisfaction of certain other conditions. We may in the future borrow all available amounts under the revolving credit facility, under the incremental term loan facility and in addition, we may borrow substantial additional indebtedness in the future under new debt agreements. If new debt is added to our current debt levels, the related risks that we and our subsidiaries now face could intensify.

Operating and financial restrictions in our debt agreements limit our operational and financial flexibility.

The senior credit facilities and the indentures under which $575.0 million aggregate principal amount of our 9.0% senior subordinated notes due 2014 and $216.0 million aggregate principal amount of our 11.25% senior discount notes due 2015 were issued (collectively, the "Public Notes") contain a number of significant covenants that, among other things, restrict our ability to:

- incur additional indebtedness or issue preferred stock;
- pay dividends on or make other distributions or repurchase our capital stock or make other restricted payments;
- make investments;
- enter into certain transactions with affiliates;
- limit dividends or other payments by restricted subsidiaries to our restricted subsidiaries;
- create liens on *pari passu* or subordinated indebtedness without securing the Public Notes;
- designate our subsidiaries as unrestricted subsidiaries; and
- sell certain assets or merge with or into other companies or otherwise dispose of all or substantially all of our assets.

In addition, under the senior credit facilities, we are required to satisfy and maintain specified financial ratios and tests. Events beyond our control may affect our ability to comply with those provisions, and we may not be able to meet those ratios and tests. The breach of any of these covenants would result in a default under the senior credit facilities. In the event of default, the lenders could elect to declare all amounts borrowed under the senior credit facilities, together with accrued interest, to be due and payable and could proceed against the collateral securing that indebtedness. Borrowings under the senior credit facilities are senior in right of payment to the Public Notes. If any of our indebtedness were to be accelerated, our assets may not be sufficient to repay in full that indebtedness and the Public Notes.

Our capital expenditure and acquisition strategies require substantial capital resources. The building of new hospitals and the operations of our existing hospitals and newly acquired hospitals require ongoing capital expenditures for construction, renovation, expansion and the addition of medical equipment and technology. More specifically, we may in the future be contractually obligated to make significant capital expenditures relating to the facilities we acquire. Also, construction costs to build new hospitals are substantial and continue to increase. Our debt agreements may restrict our ability to incur additional indebtedness to fund these expenditures.

A breach of any of the restrictions or covenants in our debt agreements could cause a cross-default under other debt agreements. A significant portion of our indebtedness then may become immediately due and payable. We are not certain whether we would have, or be able to obtain, sufficient funds to make these accelerated payments. If any senior debt is accelerated, our assets may not be sufficient to repay in full such indebtedness and our other indebtedness.

We may not be able to generate sufficient cash to service all of our indebtedness and 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 certain financial, business and other factors beyond our control. We may not be able to 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. In addition, the indentures governing the Public Notes allow us to make significant dividend payments, investments and other

restricted payments. The making of these payments could decrease available cash and adversely affect our ability to make principal and interest payments on our indebtedness.

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, seek additional capital or seek to restructure or refinance our indebtedness. These alternative measures may not be successful and may not permit us to meet our scheduled debt service obligations. In the absence of such operating results and resources, we could face substantial liquidity problems and might be required to sell material assets or operations to attempt to meet our debt service and other obligations. The senior credit facilities and the indentures restrict our ability to use the proceeds from asset sales. We may not be able to consummate those asset sales to raise capital or sell assets at prices that we believe are fair and proceeds that we do receive may not be adequate to meet any debt service obligations then due.

An increase in interest rates would increase the cost of servicing our debt and could reduce our profitability.

A significant portion of the borrowings under our Senior Credit Facilities bear interest at variable rates. As a result, an increase in interest rates, whether because of an increase in market interest rates or an increase in our own cost of borrowing, would increase the cost of servicing our debt and could materially reduce our profitability. The impact of such an increase would be more significant than it would be for some other companies because of our substantial debt. For a discussion of how we manage our exposure to changes in interest rates through the use of interest rate swap agreements on certain portions of our outstanding debt, see "Item 7A. – Quantitave and Qualitative Disclosure About Market Risks."

We are controlled by a small number of stockholders and they may have conflicts of interest with us in the future.

We are controlled by our principal equity sponsors, and they have the ability to control our policies and operations. The interests of our principal equity sponsors may not in all cases be aligned with our interests. For example, our principal equity sponsors could cause us to make acquisitions, divestitures and other transactions that, in their judgment, could enhance their equity investment in us, even though such transactions might reduce cash flows or capital reserves available to fund our debt service obligations. Additionally, our controlling shareholders are in the business of making investments in companies and may from time to time acquire and hold interests in businesses that compete directly or indirectly with us. Accordingly, our principal equity sponsors may also pursue acquisitions that may be complementary to our business, and as a result, those acquisition opportunities may not be available to us. So long as our principal equity sponsors continue to own a significant amount of our equity interests, even if such amount is less than 50%, they will continue to be able to strongly influence or effectively control our decisions.

Risks Related to our Business

If we are unable to enter into favorable contracts with managed care plans, our operating revenues may be reduced.

Our ability to negotiate favorable contracts with health maintenance organizations, insurers offering preferred provider arrangements and other managed care plans significantly affects the revenues and operating results of our hospitals. Revenues derived from health maintenance organizations, insurers offering preferred provider arrangements and other managed care plans, including managed Medicare and managed Medicaid plans, accounted for approximately 57% of our net patient revenues for the year ended June 30, 2008. Managed care organizations offering prepaid and discounted medical services packages represent an increasing portion of our admissions, a general trend in the industry which has limited hospital revenue growth nationwide and a trend that may continue if the Medicare Modernization Act increases enrollment in Medicare managed care plans. In addition, private payers are increasingly attempting to control healthcare costs through direct contracting with hospitals to provide services on a discounted basis, increased utilization review, including the use of hospitalists, and greater enrollment in managed care programs such as health maintenance organizations and preferred provider organizations. Additionally, the trend towards consolidation among private managed care payers tends to increase their bargaining prices over fee structures. In most cases, we negotiate our managed care contracts annually as they

come up for renewal at various times during the year. Our future success will depend, in part, on our ability to renew existing managed care contracts and enter into new managed care contracts on terms favorable to us. Other healthcare companies, including some with greater financial resources, greater geographic coverage or a wider range of services, may compete with us for these opportunities. If we are unable to contain costs through increased operational efficiencies or to obtain higher reimbursements and payments from managed care payers, our results of operations and cash flows will be materially adversely affected.

Our revenues may decline if federal or state programs reduce our Medicare or Medicaid payments or managed care companies reduce our reimbursements.

Approximately 55% of our net patient revenues for the year ended June 30, 2008 came from the Medicare and Medicaid programs, including Medicare and Medicaid managed plans. In recent years, federal and state governments have made significant changes in the Medicare and Medicaid programs. Some of those changes adversely affect the reimbursement we receive for certain services. In addition, due to budget deficits in many states, significant decreases in state funding for Medicaid programs have occurred or are being proposed.

On August 22, 2007, CMS issued a final rule for federal fiscal year 2008 for the hospital inpatient prospective payment system. This rule adopts a two-year implementation of MS-DRGs, a severity-adjusted DRG system. This change represents a refinement to the existing DRG system, and its impact on our revenues has not been significant. Realignments in the DRG system could impact the margins we receive for certain services. This rule provides for a 3.3% market basket update for hospitals that submit certain quality patient care indicators and a 1.3% update for hospitals that do not submit this data. While we will endeavor to comply with all quality data submission requirements, our submissions may not be deemed timely or sufficient to entitle us to the full market basket adjustment for all our hospitals. Medicare payments to hospitals in federal fiscal year 2008 will be reduced by 0.6% to eliminate what CMS estimates will be the effect of coding or classification changes as a result of hospitals implementing the MS-DRG system. This "documentation and coding adjustment" will increase to 0.9% for federal fiscal year 2009. However, Congress has given CMS the ability to retrospectively determine if the documentation and coding adjustment levels for federal fiscal years 2008 and 2009 were adequate to account for changes in payments not related to changes in case mix. If the levels are found to have been inadequate, CMS can impose an adjustment to payments for federal fiscal years 2010, 2011 and 2012. This evaluation of changes in case-mix based on actual claims data may yield a higher documentation and coding adjustment thereby potentially reducing our revenues and impacting our results of operations in ways that cannot be quantified at this time. Additionally, Medicare payments to hospitals are subject to a number of other adjustments, and the actual impact on payments to specific hospitals may vary. In some cases, commercial third-party payers and other payers such as some state Medicaid programs rely on all or portions of the Medicare DRG system to determine payment rates. The change from traditional Medicare DRGs to MS-DRGs could adversely impact those payment rates if any other payers adopt MS-DRGs.

DRG rates are updated and DRG weights are recalibrated each federal fiscal year. The index used to update the market basket gives consideration to the inflation experienced by hospitals and entities outside the healthcare industry in purchasing goods and services. Congressional legislation provides for DRG increases using the full market basket if data for certain patient care quality indicators is submitted quarterly to CMS, and using the market basket minus two percentage points if such data is not submitted. While we will endeavor to comply with all data submission requirements, our submissions may not be deemed timely or sufficient to entitle us to the full market basket adjustment for all of our hospitals.

The federal government and many states have recently adopted or are currently considering reducing the level of Medicaid funding (including upper payment limits) or program eligibility that could adversely affect future levels of Medicaid reimbursement received by our hospitals. Since states must operate with balanced budgets and since the Medicaid program is often a state's largest program, a number of states have adopted, or are considering adopting, legislation designed to reduce their Medicaid expenditures. The Deficit Reduction Act of 2005 includes federal Medicaid cuts of approximately $4.8 billion over five years. Additionally, on May 29, 2007, CMS published a final rule entitled "Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership" which is estimated to reduce federal Medicaid funding from $12 to $20 billion over five years. Congress has enacted two moratoria in respect of this rule. First, Congress delayed its implementation totally until May 2008. Secondly, in June 2008 Congress delayed six of seven

proposed Medicaid regulations in this final CMS rule until April 1, 2009, with only the seventh regulation concerning certain outpatient services and imposing severe restrictions on states covering children with family income levels beyond 250% of the federal poverty level under the Children's Health Insurance Program not being delayed by this second moratorium. As a result of the moratorium on implementing the final rule, the impact on us of the final rule has not been quantified. States have also adopted, or are considering adopting, legislation designed to reduce coverage and program eligibility, enroll Medicaid recipients in managed care programs and/or impose additional taxes on hospitals to help finance or expand the states' Medicaid systems. Future legislation or other changes in the administration or interpretation of government health programs could have a material adverse effect on our financial position and results of operations.

Our ability to negotiate favorable contracts with managed care plans significantly affects the revenues and operating results of most of our hospitals. Approximately, 56% of our net patient revenues for the year ended June 30, 2008 came from managed care plans including managed Medicare and managed Medicaid plans. Managed care payers increasingly are demanding discounted fee structures, and the trend toward consolidation among managed care plans tends to increase their bargaining power over fee structures. Reductions in price increases or the amounts received from managed care plans could have a material adverse effect on our financial position and results of operations.

In recent years, both the Medicare program and several large managed care companies have changed our reimbursement to link some of their payments, especially their annual increases in payments, to performance of quality of care measures. We expect this trend to "pay-for-performance" to increase in the future. If we are unable to meet these performance measures, our results of operations and cash flow will be materially adversely affected.

We conduct business in a heavily regulated industry, and changes in regulations or violations of regulations may result in increased costs or sanctions that could reduce our revenues and profitability.

The healthcare industry is subject to extensive federal, state and local laws and regulations relating to licensing, the conduct of operations, the ownership of facilities, the addition of facilities and services, financial arrangements with physicians and other referral sources, confidentiality, maintenance and security issues associated with medical records, billing for services and prices for services. If a determination were made that we were in material violation of such laws or regulations, our operations and financial results could be materially adversely affected.

In many instances, the industry does not have the benefit of significant regulatory or judicial interpretations of these laws and regulations. This is particularly true in the case of Medicare and Medicaid statute codified under section 1128B(b) of the Social Security Act and known as the "Anti-Kickback Statute." This law prohibits providers and other person or entities from soliciting, receiving, offering or paying, directly or indirectly, any remuneration with the intent to generate referrals of orders for services or items reimbursable under Medicare, Medicaid and other federal healthcare programs. As authorized by Congress, the United States Department of Health and Human Services has issued regulations which describe some of the conduct and business relationships immune from prosecution under the Anti-Kickback Statute. The fact that a given business arrangement does not fall within one of these "safe harbor" provisions does not render the arrangement illegal, but business arrangements of healthcare service providers that fail to satisfy the applicable safe harbor criteria risk increased scrutiny by enforcement authorities.

Some of the financial arrangements that our facilities maintain with physicians do not meet all of the requirements for safe harbor protection. The regulatory authorities that enforce the Anti-Kickback Statute may in the future determine that one or more of these arrangements violate the Anti-Kickback Statute or other federal or state laws. A determination that a facility has violated the Anti-Kickback Statute or other federal laws could subject us to liability under the Social Security Act, including criminal and civil penalties, as well as exclusion of the facility from participation in government programs such as Medicare and Medicaid or other federal healthcare programs.

In addition, the portion of the Social Security Act commonly known as the "Stark Law" prohibits physicians from referring Medicare and (to an extent) Medicaid patients to providers of certain "designated health services" if the physician or a member of his or her immediate family has an ownership or investment interest in, or compensation arrangement with, that provider. In addition, the provider in such arrangements is prohibited from

billing for all of the designated health services referred by the physician. Many of the services furnished by our facilities are "designated health services" for Stark Law purposes. There are multiple exceptions to the Stark Law, among others, for physicians maintaining an ownership interest in an entire hospital or having a compensation relationship with the facility as a result of employment agreements, leases, physician recruitment and certain other arrangements. However, each of these exceptions applies only if detailed conditions are met. An arrangement subject to the Stark Law must qualify for an exception in order for the services to be lawfully referred by the physician and billed by the provider.

CMS has issued three phases of final regulations implementing the Stark Law. Phases I and II became effective in January 2002 and July 2004, respectively, and Phase III became effective in December 2007. While these regulations help clarify the requirements of the exceptions to the Stark Law, it is unclear how the government will interpret many of these exceptions for enforcement purposes. In addition, in July 2007 CMS proposed far-reaching changes to the regulations implementing the Stark Law that would further restrict the types of arrangements that hospitals and physicians may enter, including additional restrictions on certain leases, percentage compensation arrangements, and agreements under which a hospital purchases services under arrangements. On July 31, 2008, CMS issued a final rule which, in part, finalized and responded to public comments regarding some of its July 2007 proposed major changes to the Stark Law regulations to undermine many common hospital/physician joint venture models. The most far-reaching of the changes made in this final July 2008 rule will effectively prohibit, as of a delayed effective date of October 1, 2009, both "under arrangements" ventures between a hospital and any of its physicians and unit-of-service-based "per click" compensation and percentage-based compensation in office space and equipment leases between a hospital and its physicians. Hospitals will need to examine all of their "under arrangements" ventures and their space and equipment leases with physicians to identify those arrangements which violate these new Stark regulations and restructure or terminate those arrangements so identified prior to October 1, 2009. In addition, in this July 2008 final rule CMS indicated that it will continue to enact further regulations tightening aspects of the Stark Law that it perceives allow for Medicare program abuse, especially those regulations that still permit physicians to profit from their referrals of ancillary services. We cannot assure you that the arrangements entered into by our hospitals will be found to be in compliance with the Stark Law, as it ultimately may be implemented or interpreted.

Additionally, if we violate the Anti-kickback Statute or Stark Law, or if we improperly bill for our services, we may be found to violate the False Claims Act, either under a suit brought by the government or by a private person under a *qui tam*, or "whistleblower," suit.

If we fail to comply with the Anti-kickback Statute, the Stark Law, the False Claims Act or other applicable laws and regulations, or if we fail to maintain an effective corporate compliance program, we could be subjected to liabilities, including civil penalties (including the loss of our licenses to operate one or more facilities), exclusion of one or more facilities from participation in the Medicare, Medicaid and other federal and state health care programs and, for violations of certain laws and regulations, criminal penalties. See Item 1, "Business — Governmental Regulation and Other Factors."

All of the states in which we operate have adopted or have considered adopting similar anti-kickback and physician self-referral legislation, some of which extends beyond the scope of the federal law to prohibit the payment or receipt of remuneration for the referral of patients and physician self-referrals, regardless of the source of payment for the care. Little precedent exists for the interpretation or enforcement of these laws. Both federal and state government agencies have announced heightened and coordinated civil and criminal enforcement efforts.

Government officials responsible for enforcing healthcare laws could assert that one or more of our facilities, or any of the transactions in which we are involved, are in violation of the Anti-Kickback Statute or the Stark Law and related state law exceptions. It is also possible that the courts could ultimately interpret these laws in a manner that is different from our interpretations. Moreover, other healthcare companies, alleged to have violated these laws, have paid significant sums to settle such allegations and entered into "corporate integrity agreements" because of concern that the government might exercise its authority to exclude those providers from governmental payment programs (Medicare, Medicaid, TRICARE). A determination that one or more of our facilities has violated these laws, or the public announcement that we are being investigated for possible violations of these laws, could have a material adverse effect on our business, financial condition, results of operations or prospects, and our business reputation could suffer significantly.

Illinois and Massachusetts require governmental determinations of need ("Certificates of Need") prior to the purchase of major medical equipment or the construction, expansion, closure, sale or change of control of healthcare facilities. We believe our facilities have obtained appropriate certificates wherever applicable. However, if a determination were made that we were in material violation of such laws, our operations and financial results could be materially adversely affected. The governmental determinations, embodied in Certificates of Need, can also affect our facilities' ability to add bed capacity or important services. We cannot predict whether we will be able to obtain required Certificates of Need in the future. A failure to obtain any required Certificates of Need may impair our ability to operate the affected facility profitably.

The laws, rules and regulations described above are complex and subject to interpretation. If we are in violation of any of these laws, rules or regulations, or if further changes in the regulatory framework occur, our results of operations could be significantly harmed. For a more detailed discussion of the laws, rules and regulations described above, see Item 1, "Business – Government Regulation and Other Factors."

Some of our hospitals will be required to submit to CMS information on their relationships with physicians and this submission could subject such hospitals and us to liability.

CMS announced in 2007 that it intends to collect information on ownership, investment and compensation arrangements with physicians from 500 (pre-selected) hospitals by requiring these hospitals to submit to CMS Disclosure of Financial Relationship Reports ("DFRR") from each selected hospital. CMS also indicated that at least 10 of our hospitals will be among these 500 hospitals required to submit a DFRR because these 10 hospitals did not respond to CMS' voluntary survey instrument on this topic purportedly submitted to these hospitals via email by CMS in 2006. CMS intends to use this data to determine whether these hospitals were in compliance with the Stark Law and implementing regulations during the reporting period (currently expected to be the cost reporting periods of these hospitals ending in 2006), and CMS has indicated it may share this information with other government agencies and with Congressional committees. Many of these agencies have not previously analyzed this information and have the authority to bring enforcement actions against the hospitals. However, in July 2008 CMS announced that, based on its further review and expected further public comments on this matter, CMS may decide in the future to decrease (but not increase) the number of hospitals to which it will send the DFRR below the 500 hospitals originally designated.

Once a hospital receives this request for a DFRR, the hospital will have 60 days to compile a significant amount of information relating to its financial relationships with physicians. The hospital may be subject to civil monetary penalties of up to $10,000 per day if it is unable to assemble and report this information within the required timeframe or if CMS or any other government agency determines that the submission is inaccurate or incomplete. The hospital may be the subject of investigations or enforcement actions if a government agency determines that any of the information indicates a potential violation of law.

Also, while in 2007 CMS had announced that it was contemplating proposing a regular financial disclosure process that would apply in the future to all Medicare participating hospitals, in July 2008 CMS announced that, based upon public comments previously received, it was not adopting a regular reporting or disclosure process at that time, and, thus, CMS said the DFRR will initially be used as a one-time collection effort. However, CMS also said in July 2008 that, depending on the information received from the initial DFRR process and other factors, it may propose future rulemaking to use the DFRR or some other instrument as a periodic or regular collection instrument. Thus, even if one of our hospitals does not receive the DFRR survey as part of the initial up to 500 selected hospitals, we expect that all of our hospitals will possibly have to report similar information to CMS in the future.

Any governmental investigation or enforcement action which results from the DFRR process could materially adversely affect the results of our operations.

Providers in the healthcare industry have been the subject of federal and state investigations, whistleblower lawsuits and class action litigation, and we may become subject to investigations, whistleblower lawsuits or class action litigation in the future.

Both federal and state government agencies have heightened and coordinated civil and criminal enforcement efforts as part of numerous ongoing investigations of hospital companies, as well as their executives and managers. These investigations relate to a wide variety of topics, including:

- cost reporting and billing practices;
- laboratory and home healthcare services;
- physician ownership of, and joint ventures with, hospitals;
- physician recruitment activities; and
- other financial arrangements with referral sources

In addition, the federal False Claims Act permits private parties to bring *qui tam*, or whistleblower, lawsuits against companies. Whistleblower provisions allow private individuals to bring actions on behalf of the government alleging that the defendant has defrauded the federal government. Because *qui tam* lawsuits are filed under seal, we could be named in one or more such lawsuits of which we are not aware. Defendants determined to be liable under the False Claims Act may be required to pay three times the actual damages sustained by the government, plus mandatory civil penalties of between $5,500 and $11,000 for each separate false claim. Typically, each fraudulent bill submitted by a provider is considered a separate false claim, and thus the penalties under false claims may be substantial. Liability arises when an entity knowingly submits a false claim for reimbursement to the federal government. In some cases, whistleblowers or the federal government have taken the position that providers who allegedly have violated other statutes and have submitted claims to a governmental payer during the time period they allegedly violated these other statutes, have thereby submitted false claims under the False Claims Act. Some states have adopted similar whistleblower and false claims provisions.

The Office of the Inspector General of the Department of Health and Human Services and the Department of Justice have, from time to time, established national enforcement initiatives that focus on specific billing practices or other suspected areas of abuse. Initiatives include a focus on hospital billing for outpatient charges associated with inpatient services, as well as hospital laboratory billing practices. As a result of these regulations and initiatives, some of our activities could become the subject of governmental investigations or inquiries. For example, we have significant Medicare and Medicaid billings, we provide some durable medical equipment and home healthcare services, and we have joint venture arrangements involving physician investors. We also have a variety of other financial arrangements with physicians and other potential referral sources including recruitment arrangements and leases. In addition, our executives and managers, many of whom have worked at other healthcare companies that are or may become the subject of federal and state investigations and private litigation, could be included in governmental investigations or named as defendants in private litigation. We are aware that several of our hospitals or their related healthcare operations were and may still be under investigation in connection with activities conducted prior to our acquisition of them. Under the terms of our various acquisition agreements, the prior owners of our hospitals are responsible for any liabilities arising from pre-closing violations. The prior owners' resolution of these matters or failure to resolve these matters, in the event that any resolution was deemed necessary, may have a material adverse effect on our business, financial condition or results of operations. Any investigations of us, our executives, managers, facilities or operations could result in significant liabilities or penalties to us, as well as adverse publicity.

We maintain a voluntary compliance program to address health regulatory and other compliance requirements. This program includes initial and periodic ethics and compliance training and effectiveness reviews, a toll-free hotline for employees to report, without fear of retaliation, any suspected legal or ethical violations, annual "fraud and abuse" audits to look at all of our financial relationships with physicians and other referral sources and annual "coding audits" to make sure our hospitals bill the proper service codes in respect of obtaining payment from the Medicare and Medicaid programs.

As an element of our corporate compliance program and our internal compliance audits, from time to time we make voluntary disclosures and repayments to the Medicare and Medicaid programs and/or to the federal and/or state regulators for these programs in the ordinary course of business. At the current time, we know of no active investigations by any of these programs or regulators in respect of our disclosures or repayments. All of these voluntary actions on our part could lead to an investigation by the regulators to determine whether any of our facilities have violated the Stark Law, the Anti-Kickback Statute, the False Claims Act or similar state law. Either an investigation or initiation of administrative or judicial actions could result in a public announcement of possible

violations of the Stark Law, the Anti-Kickback Statute or the False Claims Act or similar state law. Such determination or announcements could have a material adverse effect on our business, financial condition, results of operations or prospects, and our business reputation could suffer significantly.

Additionally, several hospital companies have in recent years been named defendants in class action litigation alleging, among other things, that their charge structures are fraudulent and, under state law, unfair or deceptive practices, insofar as those hospitals charge insurers lower rates than those charged to uninsured patients. We cannot assure you that we will not be named as a defendant in litigation of this type. Furthermore, the outcome of these suits may affect the industry standard for charity care policies and any response we take may have a material adverse effect on our financial results.

In June 2006 we and two other hospital systems operating in San Antonio, Texas had a putative class action lawsuit brought against all of us alleging that we and the other defendants has conspired with each other and with other unidentified San Antonio area hospitals to depress the compensation levels of registered nurses employed at the competing hospitals within the San Antonio area by engaging in certain activities that violated the federal antitrust laws. See "Item 3- Legal Proceedings" for further discussion of this litigation. On the same day that this litigation was brought against us and two other hospital systems in San Antonio, substantially similar class action litigation was brought against multiple hospitals in three other cities.

Competition from other hospitals or healthcare providers (especially specialty hospitals) may reduce our patient volumes and profitability.

The healthcare business is highly competitive and competition among hospitals and other healthcare providers for patients has intensified in recent years. Generally, other hospitals in the local communities served by most of our hospitals provide services similar to those offered by our hospitals. In addition, we believe the number of freestanding specialty hospitals and surgery and diagnostic centers in the geographic areas in which we operate has increased significantly in recent years. As a result, most of our hospitals operate in an increasingly competitive environment. Some of the hospitals that compete with our hospitals are owned by governmental agencies or not-for-profit corporations supported by endowments and charitable contributions and can finance capital expenditures and operations on a tax-exempt basis. Increasingly, we are facing competition from physician-owned specialty hospitals and freestanding surgery centers that compete for market share in high margin services and for quality physicians and personnel. Also, we anticipate that the number of physician-owned specialty hospitals may increase as CMS has ended a moratorium on the Medicare enrollment of such hospitals. If ambulatory surgery centers are better able to compete in this environment than our hospitals, our hospitals may experience a decline in patient volume, and we may experience a decrease in margin, even if those patients use our ambulatory surgery centers. Further, if our competitors are better able to attract patients, recruit physicians, expand services or obtain favorable managed care contracts at their facilities than our hospitals and ambulatory surgery centers, we may experience an overall decline in patient volume. See Item 1, "Business - Competition."

In 2005, CMS began making public performance data related to 10 quality measures that hospitals submit in connection with their Medicare reimbursement. In February 2006, federal legislation was enacted to expand and provide for the future expansion of the number of quality measures that must be reported. For federal fiscal year 2008, CMS requires hospitals to report 30 measures of inpatient quality of care to avoid a 2% point reduction in their market basket update. For the federal fiscal year 2009 payment update, CMS will require hospitals to report 42 inpatient quality measures to avoid a 2% point reduction in their market basket update. CMS is also requiring that seven measures of outpatient quality of care be reported during federal fiscal year 2008 to receive the full market basket update for outpatient services in federal fiscal year 2009. If any of our hospitals achieve poor results (or results that are lower than our competitors) on these quality measures, patient volumes could decline. Also, the additional quality measures and future trends toward clinical transparency may have an unanticipated impact on our competitive position and patient volumes.

PHP also faces competition within the Arizona markets that it serves. As in the case of our hospitals, some of our competitors in these markets are owned by governmental agencies or not-for-profit corporations that have greater financial resources than we do. Other competitors have larger membership bases, are more established and have greater geographic coverage areas that give them an advantage in competing for a limited pool of eligible health plan members. The revenues we derive from PHP could significantly decrease if new plans operating under

AHCCCS enter these markets or other existing AHCCCS plans increase their number of enrollees. Moreover, a failure to attract future enrollees may negatively impact our ability to maintain our profitability in these markets.

We may be subject to liabilities from claims brought against our facilities.

We operate in a highly regulated and litigious industry. As a result, various lawsuits, claims and legal and regulatory proceedings have been instituted or asserted against us, including those outside of the ordinary course of business like class actions and those in the ordinary course of business like malpractice lawsuits. Some of these actions may involve large claims as well as significant defense costs. (See "Item 3, "Legal Proceedings.")

We maintain professional and general liability insurance in amounts we believe are sufficient to cover claims arising out of the operations of our facilities. Some of the claims could exceed the scope of the coverage in effect or coverage of particular claims or damages could be denied.

The relatively high cost of professional liability insurance and, in some cases, the lack of availability of such insurance coverage, for physicians with privileges at our hospitals increases our risk of vicarious liability in cases where both our hospital and the uninsured or underinsured physician are named as co-defendants. As a result, we are subject to greater self-insured risk and may be required to fund claims out of our operating cash flows to a greater extent than during fiscal year 2008. We cannot assure you that we will be able to continue to obtain insurance coverage in the future or that such insurance coverage, if it is available, will be available on acceptable terms.

While we cannot predict the likelihood of future claims or inquiries, we expect that new matters may be initiated against us from time to time. Moreover, the results of current claims, lawsuits and investigations cannot be predicted, and it is possible that the ultimate resolution of these matters, individually or in the aggregate, may have a material adverse effect on our business (both in the near and long term), financial position, results of operations or cash flows.

Our hospitals face a growth in uncompensated care as the result of the inability of uninsured patients to pay for healthcare services and difficulties in collecting patient portions of insured accounts.

Like others in the hospital industry, we have experienced an increase in uncompensated care. Our combined provision for doubtful accounts and charity care deductions as a percentage of patient service revenues increased from 11.2% during fiscal 2006 to 12.0% during fiscal 2007 and to 12.5% during fiscal 2008. Our self pay discharges as a percentage of total discharges have not fluctuated significantly during our past three fiscal years. Our hospitals remain at risk for increases in uncompensated care as a result of price increases, the continuing trend of increases in coinsurance and deductible portions of managed care accounts and increases in uninsured patients as a result of potential state Medicaid funding cuts or general economic weakness. Although we continue to seek ways of improving point of service collection efforts and implementing appropriate payment plans with our patients, if we continue to experience growth in self-pay volumes and revenues, our results of operations could be materially adversely affected. Further, our ability to improve collections for self-pay patients may be limited by regulatory and investigatory initiatives, including private lawsuits directed at hospital charges and collection practices for uninsured and underinsured patients.

Our performance depends on our ability to recruit and retain quality physicians.

Physicians generally direct the majority of hospital admissions. Thus, the success of our hospitals depends in part on the following factors:

- the number and quality of the physicians on the medical staffs of our hospitals;
- the admitting practices of those physicians; and
- the maintenance of good relations with those physicians.

Most physicians at our hospitals also have admitting privileges at other hospitals. Our efforts to attract and retain physicians are affected by our managed care contracting relationships, national shortages in some specialties, such as anesthesiology and radiology, the adequacy of our support personnel, the condition of our facilities and

medical equipment, the availability of suitable medical office space and federal and state laws and regulations prohibiting financial relationships that may have the effect of inducing patient referrals. If facilities are not staffed with adequate support personnel or technologically advanced equipment that meets the needs of patients, physicians may be discouraged from referring patients to our facilities, which could adversely affect our profitability.

In an effort to meet community needs in the markets in which we operate, we have implemented a strategy to employ physicians both in primary care and in certain specialties. As of June 30, 2008, we employed 196 practicing physicians. The deployment of a physician employment strategy includes increased salary costs, physician integration risks and difficulties associated with physician practice management. While we believe this strategy is consistent with industry trends, we cannot be assured of the long-term success of such a strategy.

We may be unable to achieve our acquisition and growth strategies and we may have difficulty acquiring not-for-profit hospitals due to regulatory scrutiny.

An important element of our business strategy is expansion by acquiring hospitals in our existing and in new urban and suburban markets and by entering into partnerships or affiliations with other healthcare service providers. The competition to acquire hospitals is significant, including competition from healthcare companies with greater financial resources than ours, and we may not be able to make suitable acquisitions on favorable terms. We may have difficulty obtaining financing, if necessary, for such acquisitions on satisfactory terms. We sometimes agree not to sell an acquired hospital for some period of time (currently no longer than 10 years) after closing and/or grant the seller a right of first refusal to purchase the hospital if we agree to sell it to a third party. In addition, we may not be able to effectively integrate any acquired facilities with our operations. Even if we continue to acquire additional facilities and/or enter into partnerships or affiliations with other healthcare service providers, federal and state regulatory agencies may constrain our ability to grow.

Additionally, many states, including some where we have hospitals and others where we may in the future attempt to 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 focus primarily on the appropriate valuation of the assets divested and the use of the sale proceeds by the not-for-profit seller. These review and approval processes can add time to the consummation of an acquisition of a not-for profit hospital, and future actions on the state level could seriously delay or even prevent future acquisitions of not-for-profit hospitals. Furthermore, as a condition to approving an acquisition, the attorney general of the state in which the hospital is located may require us to maintain specific services, such as emergency departments, or to continue to provide specific levels of charity care, which may affect our decision to acquire or the terms upon which we acquire one of these hospitals.

Difficulties with integrating our acquisitions may disrupt our ongoing operations.

We may not be able to profitably or effectively integrate the operations of, or otherwise achieve the intended benefits from, any acquisitions we make or partnerships or affiliations we may form. The process of integrating acquired hospitals may require a disproportionate amount of management's time and attention, potentially distracting management from its day-to-day responsibilities. This process may be even more difficult in the case of hospitals we may acquire out of bankruptcy or otherwise in financial distress. In addition, poor integration of acquired facilities could cause interruptions to our business activities, including those of the acquired facilities. As a result, we may incur significant costs related to acquiring or integrating these facilities and may not realize the anticipated benefits.

Moreover, acquired businesses may have unknown or contingent liabilities, including liabilities for failure to comply with healthcare laws and regulations. We could in the future become liable for past activities of acquired businesses and these liabilities could be material.

Our hospitals face competition for staffing, which may increase our labor costs and reduce profitability.

We compete with other healthcare providers in recruiting and retaining qualified management and staff personnel responsible for the day-to-day operations of each of our hospitals, including nurses and other non-

physician healthcare professionals. In the healthcare industry generally, including in our markets, the scarcity of nurses and other medical support personnel has become a significant operating issue. This shortage may require us to increase wages and benefits to recruit and retain nurses and other medical support personnel or to hire more expensive temporary personnel. We have raised on several occasions in the past, and expect to raise in the future, wages for our nurses and other medical support personnel. We also depend on the available labor pool of semi-skilled and unskilled employees in each of the markets in which we operate. In addition, to the extent that a significant additional portion of our employee base unionizes, or attempts to unionize, our labor costs could increase materially. If our labor costs increase, we may not be able to raise rates to offset these increased costs. Because approximately 90% of our net patient revenues for the year ended June 30, 2008, consisted of payments based on fixed or negotiated rates, our ability to pass along increased labor costs is constrained. Our failure to recruit and retain qualified management, nurses and other medical support personnel, or to control our labor costs, could have a material adverse effect on our profitability.

The cost of our malpractice insurance and the malpractice insurance of physicians who practice at our facilities remains volatile. Successful malpractice or tort claims asserted against us, our physicians or our employees could materially adversely affect our financial condition and profitability.

Physicians, hospitals and other healthcare providers are subject to legal actions alleging malpractice, product liability or related legal theories. Many of these actions involve large monetary claims and significant defense costs. Hospitals and physicians have typically maintained a special type of insurance (commonly called malpractice or professional liability insurance) to protect against the costs of these types of legal actions. We created a captive insurance subsidiary on June 1, 2002, to assume a substantial portion of the professional and general liability risks of our facilities. For claims incurred during the period June 1, 2002 to May 31, 2006, we maintained all of our professional and general liability insurance through this captive insurance subsidiary in respect of losses up to $10.0 million per occurrence. For claims incurred subsequent to May 31, 2006, we self-insure the first $9.0 million per occurrence, and our captive subsidiary insures the next $1.0 million per occurrence. We have also purchased an umbrella excess policy for professional and general liability insurance for the period June 1, 2008 to May 31, 2009 with unrelated commercial carriers. This policy covers losses in excess of $10.0 million per occurrence up to $75.0 million, but is limited to total annual payments of $65.0 million in the aggregate. While our premium prices have declined during the past few years, the total cost of professional and general liability insurance remains sensitive to the volume and severity of cases reported. There is no guarantee that excess insurance coverage will continue to be available in the future at a cost allowing us to maintain adequate levels of such insurance. Moreover, due to the increased retention limits insured by us and our captive subsidiary, if actual payments of claims materially exceed our projected estimates of malpractice claims, our financial condition could be materially adversely affected.

Physicians' professional liability insurance costs in certain markets have dramatically increased to the point where some physicians are either choosing to retire early or leave those markets. If physician professional liability insurance costs continue to escalate in markets in which we operate, some physicians may choose not to practice at our facilities, which could reduce our patient volumes and revenues. Our hospitals may also incur a greater percentage of the amounts paid to claimants if physicians are unable to obtain adequate malpractice coverage.

We anticipate employing over 90 additional physicians during our fiscal year 2009. Such a significant increase in employed physicians could significantly increase our professional and general liability risks and related costs in future periods.

We are subject to uncertainties regarding healthcare reform that could materially and adversely affect our business.

In recent years, an increasing number of legislative initiatives have been introduced or proposed in Congress and in state legislatures that would result in major changes in the healthcare system, either nationally or at the state level. Among the proposals that have been introduced are price controls on hospitals, insurance market reforms to increase the availability of group health insurance to small businesses, requirements that all businesses offer health insurance coverage to their employees and the creation of a government health insurance plan or plans that would cover all citizens and increase payments by beneficiaries. Increased regulations, mandated benefits and more oversight, audits and investigations and changes in laws allowing access to federal and state courts to

challenge healthcare decisions may increase our administrative, litigation and healthcare costs. We cannot predict whether any of the above proposals or any other proposals will be adopted, and if adopted, we cannot assure you that the implementation of these reforms will not have a material adverse effect on our business, financial position or results of operations.

Our facilities are concentrated in a small number of regions. If any one of the regions in which we operate experiences a regulatory change, economic downturn or other material change, our overall business results may suffer.

Among our operations as of June 30, 2008, five hospitals and various related healthcare businesses were located in San Antonio, Texas; five hospitals and related healthcare businesses were located in metropolitan Phoenix, Arizona; two hospitals and related healthcare businesses were located in metropolitan Chicago, Illinois; and three hospitals and related healthcare businesses were located in Massachusetts. For the year ended June 30, 2008, our total revenues were generated as follows:

	Year Ended June 30, 2008
San Antonio	32.1 %
Massachusetts	19.7
Metropolitan Phoenix, excluding Phoenix Health Plan and Abrazo Advantage Health Plan	18.8
Phoenix Health Plan and Abrazo Advantage Health Plan	14.1
Metropolitan Chicago (1)	14.9
Other	0.4
	100.0 %

(1) Includes MacNeal Health Providers.

Any material change in the current demographic, economic, competitive or regulatory conditions in any of these regions could adversely affect our overall business results because of the significance of our operations in each of these regions to our overall operating performance. Moreover, due to the concentration of our revenues in only four regions, our business is less diversified and, accordingly, is subject to greater regional risk than that of some of our larger competitors.

If we are unable to control our healthcare costs at Phoenix Health Plan and Abrazo Advantage Health Plan, if the health plans should lose their governmental contracts or if budgetary cuts reduce the scope of Medicaid or dual-eligibility coverage, our profitability may be adversely affected.

For the year ended June 30, 2008, PHP generated approximately 12.7% of our total revenues. PHP derives substantially all of its revenues through a contract with AHCCCS. AHCCCS pays capitated rates to PHP, and PHP subcontracts with physicians, hospitals and other healthcare providers to provide services to its enrollees. If we fail to effectively manage our healthcare costs, these costs may exceed the payments we receive. Many factors can cause actual healthcare costs to exceed the capitated rates paid by AHCCCS, including:

- our ability to contract with cost-effective healthcare providers;
- the increased cost of individual healthcare services;
- the type and number of individual healthcare services delivered; and
- the occurrence of catastrophes, epidemics or other unforeseen occurrences

Our new contract with AHCCCS begins October 1, 2008 and expires September 30, 2011 and could result in significant membership growth in geographic areas in which we did not provide services under our previous AHCCCS contract that could increase our risk. The new contract is terminable without cause on 90 days' written notice from AHCCCS or for cause upon written notice from AHCCCS if we fail to comply with any term or condition of the contract or fail to take corrective action as required to comply with the terms of the contract. AHCCCS may also terminate the contract with PHP in the event of unavailability of state or federal funding. If our AHCCCS contract is terminated, our profitability would be adversely affected by the loss of these revenues and cash

flows. Also, should the scope of the Medicaid program be reduced as a result of state budgetary cuts or other political factors, our results of operations could be adversely affected.

For the year ended June 30, 2008, AAHP generated 1.4% of our total revenues. AAHP began providing healthcare coverage to Medicare and Medicaid dual-eligible enrollees on January 1, 2006. Most of AAHP's members were formerly enrolled in PHP. AAHP's contract with CMS went into effect on January 1, 2006, for a term of one year, with a provision for successive one year renewals, and has currently been renewed through December 31, 2008. If we fail to effectively manage AAHP's healthcare costs, these costs may exceed the payments we receive.

We are dependent on our senior management team and local management personnel, and the loss of the services of one or more of our senior management team or key local management personnel could have a material adverse effect on our business.

The success of our business is largely dependent upon the services and management experience of our senior management team, which includes Charles N. Martin, Jr., our Chairman and Chief Executive Officer; Kent H. Wallace, our President and Chief Operating Officer; Keith B. Pitts, our Vice Chairman, Phillip W. Roe, our Executive Vice President, Chief Financial Officer and Treasurer; and Joseph D. Moore, Executive Vice President. In addition, we depend on our ability to attract and retain local managers at our hospitals and related facilities, on the ability of our senior officers and key employees to manage growth successfully and on our ability to attract and retain skilled employees. We do not maintain key man life insurance policies on any of our officers. If we were to lose any of our senior management team or members of our local management teams, or if we are unable to attract other necessary personnel in the future, it could have a material adverse effect on our business, financial condition and results of operations. If we were to lose the services of one or more members of our senior management team or a significant portion of our hospital management staff at one or more of our hospitals, we would likely experience a significant disruption in our operations and failure of the affected hospitals to adhere to their respective business plans.

Changes in legislation may significantly reduce government healthcare spending and our revenues.

Governmental healthcare programs, principally Medicare and Medicaid, accounted for 55% of our net patient revenues (including managed Medicare and managed Medicaid programs) for both the years ended June 30, 2007 and 2008. In recent years, legislative changes have resulted in limitations on and, in some cases, reductions in levels of, payments to healthcare providers for certain services under many of these government programs. Further, legislative changes have altered the method of payment for various services under the Medicare and Medicaid programs. We believe that hospital operating margins across the country, including ours, have been and may continue to be under pressure because of limited pricing flexibility and growth in operating expenses in excess of the increase in prospective payments under the Medicare program. DRA 2005 passed in February 2006 reduces federal funding for Medicare and Medicaid by approximately $11 billion over the next five years. In addition, a number of states are experiencing budget problems and have adopted or are considering legislation designed to reduce their Medicaid expenditures and to provide universal coverage and additional care, including enrolling Medicaid recipients in managed care programs and imposing additional taxes on hospitals to help finance or expand states' Medicaid systems.

Controls designed to reduce inpatient services may reduce our revenues.

Controls imposed by Medicare and commercial third-party payers designed to reduce admissions and lengths of stay, commonly referred to as "utilization review," have affected and are expected to continue to affect our facilities. Utilization review entails the review of the admission and course of treatment of a patient by managed care plans. Inpatient utilization, average lengths of stay and occupancy rates continue to be negatively affected by payer-required preadmission authorization and utilization review and by payer pressures to maximize outpatient and alternative healthcare delivery services for less acutely ill patients. Efforts to impose more stringent cost controls are expected to continue. Although we are unable to predict the effect these changes will have on our operations, significant limits on the scope of services reimbursed and on reimbursement rates and fees could have a material, adverse effect on our business, financial position and results of operations.

If we fail to continually enhance our hospitals with the most recent technological advances in diagnostic and surgical equipment, our ability to maintain and expand our markets will be adversely affected.

Technological advances with respect to computed axial tomography (CT), magnetic resonance imaging (MRI) and positron emission tomography (PET) equipment, as well as other equipment used in our facilities, are continually evolving. In an effort to compete with other healthcare providers, we must constantly evaluate our equipment needs and upgrade equipment as a result of technological improvements. Such equipment costs typically range from $1.0 million to $3.0 million, exclusive of construction or build-out costs.

Our hospitals face competition for staffing especially as a result of the national shortage of nurses and the increased imposition on us of nurse-staffing ratios, which has in the past and may in the future increase our labor costs and materially reduce our profitability.

We compete with other healthcare providers in recruiting and retaining qualified management and staff personnel responsible for the day-to-day operations of each of our hospitals, including most significantly nurses and other non-physician healthcare professionals. In the healthcare industry generally, including in our markets, the national shortage of nurses and other medical support personnel has become a significant operating issue. This shortage has caused us in the past and may require us in the future to increase wages and benefits to recruit and retain nurses and other medical support personnel or to hire more expensive temporary personnel. We have voluntarily raised on several occasions in the past, and expect to raise in the future, wages for our nurses and other medical support personnel. In addition, union-mandated or state-mandated nurse-staffing ratios significantly affect not only labor costs, but may also cause us to limit patient admissions with a corresponding adverse effect on revenues if we are unable to hire the appropriate number of nurses to meet the required ratios. While we do not currently operate in any states with mandated nurse-staffing ratios, the states in which we operate could adopt mandatory nurse-staffing ratios at any time. In those instances where our nurses are unionized, it is our experience that new union contracts often impose significant new additional staffing ratios by contract on our hospitals. This was the case with the increased staffing ratios imposed on us in our union contract with our nurses at Saint Vincent Hospital in Worcester, Massachusetts negotiated in 2007. In addition, to the extent that a significant additional portion of our employee base unionizes, or attempts to unionize, our labor costs could increase materially, especially if the newly unionized employees are nurses. If our labor costs continue to increase, we may not be able to raise our payer reimbursement levels to offset these increased costs, including the significantly increased costs that we will incur for wage increases and nurse-staffing ratios under our new union contract with our nurses at Saint Vincent Hospital. Because substantially all of our net patient revenues consist of payments based on fixed or negotiated rates, our ability to pass along increased labor costs is materially constrained. Our failure to recruit and retain qualified management, nurses and other medical support personnel, or to control our labor costs, could have a material adverse effect on our profitability.

Compliance with section 404 of the Sarbanes-Oxley Act may negatively impact our results of operations and failure to comply may subject us to regulatory scrutiny and a loss of investors' confidence in our internal control over financial reporting.

Section 404 of the Sarbanes-Oxley Act of 2002 (the "404 Act") requires us to perform an evaluation of our internal control over financial reporting and file management's attestation with our annual report beginning with our fiscal year ended June 30, 2008. The 404 Act also requires our independent auditors to opine on our internal control over financial reporting beginning with our fiscal year ending June 30, 2010. We have evaluated, tested and implemented internal controls over financial reporting to enable management to report on such internal controls under the 404 Act as of June 30, 2008. However, we can not assure you that the conclusions reached by management in its June 30, 2010 report will be the same as those reached by our independent auditors in its report. Failure on our part to comply with the 404 Act may subject us to regulatory scrutiny and a loss of public confidence in our internal control over financial reporting.

A failure of our information systems would adversely affect our ability to properly manage our operations.

We rely on our advanced information systems and our ability to successfully use these systems in our operations. These systems are essential to the following areas of our business operations, among others:

- patient accounting, including billing and collection of patient service revenues;
- financial, accounting, reporting and payroll;
- coding and compliance;
- laboratory, radiology and pharmacy systems;
- remote physician access to patient data;
- negotiating, pricing and administering managed care contracts; and
- monitoring quality of care.

If we are unable to use these systems effectively, we may experience delays in collection of patient service revenues and may not be able to properly manage our operations or oversee the compliance with laws or regulations.

Difficulties with current construction projects or new construction projects such as additional hospitals or major expansion projects may involve significant capital expenditures that could have an adverse impact on our liquidity.

We may decide to construct an additional hospital or hospitals in the future or construct additional major expansion projects to existing hospitals in order to achieve our growth objectives. Our ability to complete construction of new hospitals or new expansion projects on budget and on schedule would depend on a number of factors, including, but not limited to:

- our ability to control construction costs;
- the failure of general contractors or subcontractors to perform under their contracts;
- adverse weather conditions;
- shortages of labor or materials;
- our ability to obtain necessary licensing and other required governmental authorizations; and
- other unforeseen problems and delays.

As a result of these and other factors, we cannot assure you that we will not experience increased construction costs on our construction projects or that we will be able to construct our current or any future construction projects as originally planned. In addition, our current and any future major construction projects has and would involve a significant commitment of capital with no revenues associated with the projects during construction, which also could have in the future an adverse impact on our liquidity.

If the costs for construction materials and labor continue to rise, such increased costs could have an adverse impact on the return on investment relating to our expansion projects.

The cost of construction materials and labor has significantly increased over the past year as a result of global and domestic events. We have experienced significant increases in the cost of steel due to the demand in China for such materials and an increase in the cost of lumber due to multiple factors. Increases in oil and gas prices have increased costs for oil-based products and for transporting materials to job sites. As we continue to invest in modern technologies, emergency rooms and operating room expansions, we expend large sums of cash generated from operating activities. We evaluate the financial viability of such projects based on whether the projected cash flow return on investment exceeds our cost of capital. Such returns may not be achieved if the cost of construction continues to rise significantly or anticipated volumes do not materialize.

State efforts to regulate the construction or expansion of hospitals could impair our ability to operate and expand our operations.

Some states require healthcare providers to obtain prior approval, known as certificates of need, for:

- the purchase, construction or expansion of healthcare facilities;
- capital expenditures exceeding a prescribed amount; or
- changes in services or bed capacity.

In giving approval, these states consider the need for additional or expanded healthcare facilities or services. Illinois and Massachusetts are the only states in which we currently own hospitals that have certificate of need laws. The failure to obtain any required certificate of need could impair our ability to operate or expand operations in these states.

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

Blackstone acquired our predecessor company during fiscal 2005. We recorded a significant portion of the purchase price as goodwill. At June 30, 2008, we had approximately $689.2 million of goodwill recorded on our financial statements. We expect to recover the carrying value of this goodwill through our future cash flows. On an ongoing basis, we evaluate, based on the fair value of our reporting units, whether the carrying value of our goodwill is impaired. During fiscal 2007, we recorded a $123.8 million ($110.5 million, net of tax benefit) impairment charge to goodwill to reduce the carrying values of our Chicago hospitals to their fair values. If the carrying value of our goodwill is further impaired, we may incur an additional material non-cash charge to earnings.

Additional Risk Factors

See the additional risks related to our business in "Item 7 – Management's Discussion and Analysis of Financial Conditions and Results of Operations – General Trends" which are incorporated by reference in this Item 1A as if fully set forth herein.

Available Information

We currently voluntarily file certain reports with the Securities and Exchange Commission ("SEC"), including annual reports on Form 10-K and quarterly reports on Form 10-Q. The public may read and copy any materials we file with the SEC at the SEC's Public Reference Room at 100 F Street, N.E., Washington, DC 20549. The public may obtain information on the operation of the Public Reference Room by calling the SEC at 1-800-SEC-0330. We are an electronic filer and the SEC maintains an Internet site at http://www.sec.gov that contains the reports and other information we file electronically. Our Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q, Current Reports on Form 8-K and amendments to those reports are also available free of charge on our internet website at www.vanguardhealth.com under "Investor Relations-SEC Filings-SEC Filings on the Edgar Database" as soon as reasonably practicable after such reports are electronically filed with or furnished to the SEC. Please note that our website address is provided as an inactive textual reference only. Also, the information provided on our website is not part of this report, and is therefore not incorporated by reference unless such information is specifically referenced elsewhere in this report.

Item 1B. Unresolved Staff Comments.

Not applicable.

Item 2. Properties.

A listing of our owned acute hospitals is included in Item 1 of this report under the caption "Business-Our Facilities". We also own or lease space for outpatient service facilities complementary to our hospitals and own and operate a limited number of medical office buildings (some of which are joint ventures) associated with our hospitals that are occupied primarily by physicians who practice at our hospitals. The most significant of these complementary outpatient healthcare facilities are two surgery centers in Orange County, California, five diagnostic imaging centers in metropolitan Phoenix, Arizona and a 50% interest in seven diagnostic imaging centers in San Antonio, Texas. Most of these outpatient facilities are in leased facilities, and the diagnostic imaging centers in San Antonio are owned and operated in joint ventures where we have minority partners.

As of June 30, 2008, we leased approximately 53,200 square feet of office space at 20 Burton Hills Boulevard, Nashville, Tennessee, for our corporate headquarters.

Our headquarters, hospitals and other facilities are suitable for their respective uses and are, in general, adequate for our present needs. Our obligations under our senior credit facilities are secured by a pledge of substantially all of our assets, including first priority mortgages on each of our hospitals. Also, our properties are subject to various federal, state and local statutes and ordinances regulating their operation. Management does not believe that compliance with such statutes and ordinances will materially affect our financial position or results from operations.

Item 3. Legal Proceedings.

We operate in a highly regulated and litigious industry. As a result, various lawsuits, claims and legal and regulatory proceedings have been instituted or asserted against us. While we cannot predict the likelihood of future claims or inquiries, we expect that new matters may be initiated against us from time to time. The results of claims, lawsuits and investigations cannot be predicted, and it is possible that the ultimate resolution of these matters, individually or in the aggregate, may have a material adverse effect on our business (both in the near and long term), financial position, results of operations or cash flows. We recognize that, where appropriate, our interests may be best served by resolving certain matters without litigation. If non-litigated resolution is not possible or appropriate with respect to a particular matter, we will continue to defend ourselves vigorously.

Currently pending and recently settled legal proceedings and investigations that are not in the ordinary course of business are set forth below. Where specific amounts are sought in any pending legal proceeding, those amounts are disclosed. For all other matters, where the possible loss or range of loss is reasonably estimable, an estimate is provided. Where no estimate is provided, the possible amount of loss is not reasonably estimable at this time. We record reserves for claims and lawsuits when they are probable and reasonably estimable. For matters where the likelihood or extent of a loss is not probable or cannot be reasonably estimated, we have not recognized in our consolidated financial statements all potential liabilities that may result. We undertake no obligation to update the following disclosures for any new developments.

Sherman Act Antitrust Class Action Litigation – Maderazo, et al v. VHS San Antonio Partners, L.P. d/b/a Baptist Health Systems, et al, Case No. 5:06cv00535 (United States District Court, Western District of Texas, San Antonio Division, filed June 20, 2006 and amended August 29, 2006)

On June 20, 2006, a federal antitrust class action suit was filed in San Antonio, Texas against our Baptist Health System subsidiary in San Antonio, Texas and two other large hospital systems in San Antonio. In the complaint, plaintiffs allege that the three hospital system defendants conspired with each other and with other unidentified San Antonio area hospitals to depress the compensation levels of registered nurses employed at the conspiring hospitals within the San Antonio area by engaging in certain activities that violated the federal antitrust laws. The complaint alleges two separate claims. The first count asserts that the defendant hospitals violated Section 1 of the federal Sherman Act, which prohibits agreements that unreasonably restrain competition, by conspiring to depress nurses' compensation. The second count alleges that the defendant hospital systems also violated Section 1 of the Sherman Act by participating in wage, salary and benefits surveys for the purpose, and having the effect, of depressing registered nurses' compensation or limiting competition for nurses based on their compensation. The class on whose behalf the plaintiffs filed the complaint is alleged to comprise all registered nurses employed by the defendant hospitals since June 20, 2002. The suit seeks unspecified damages, trebling of this damage amount pursuant to federal law, interest, costs and attorneys fees. Currently, the parties are producing documents relating to our efforts to defeat class certification in this suit. We believe that the allegations contained within this putative class action suit are without merit, and we intend to vigorously defend against the litigation.

On the same date that this suit was filed against us in federal district court in San Antonio, the same attorneys filed three other substantially similar putative class action lawsuits in federal district courts in Chicago, Illinois, Albany, New York and Memphis, Tennessee against some of the hospitals in those cities (none of such hospitals being owned by us). The attorneys representing the plaintiffs in all four of these cases said in June 2006 that they may file similar complaints in other jurisdictions and in December 2006 they brought a substantially similar class action lawsuit against various hospitals in the Detroit, Michigan metropolitan area. Since representatives of the Service Employees International Union joined plaintiffs' attorneys in announcing the filing of all four complaints on June 20, 2006, and as has been reported in the media, we believe that SEIU's involvement in

these actions appears to be part of a corporate campaign to attempt to organize nurses in these cities, including San Antonio. The nurses in our hospitals in San Antonio are currently not members of any union.

Medicare Secondary Payor Act Litigation - Brockovich, on behalf of the United States of America v. Vanguard Health Systems, Inc., et al. Case No. SACV06-547 JVS(MLGx) (United States District Court, Central District of California, Southern Division, filed June 9, 2006)

In June 2006, Plaintiff Erin Brockovich, purportedly on behalf of the United States of America, filed a civil complaint in United States District Court in California claiming our violation of the Medicare Secondary Payer Act. In the complaint plaintiff alleged that we have inappropriately received and retained reimbursement from Medicare for treatment given to certain unidentified patients of our facilities whose injuries were caused by us as a result of unidentified and unadjudicated incidents of medical malpractice. Also, in June 2006 this same plaintiff filed identical lawsuits against more than 20 other companies that own hospitals and convalescent homes in California. In the case against us, plaintiff is seeking damages of twice the amount that defendants were allegedly obligated to pay or reimburse Medicare in connection with the treatment in question under the Medicare Secondary Payor Act, plus interest, together with plaintiff's costs and fees, including attorneys' fees. On July 25, 2006, we filed with the court a motion to dismiss this litigation (1) for failure to state a claim in so far as plaintiff has no standing to bring this action since she alleges no injury to herself as a result of our alleged acts and (2) for failure to state a cause of action since no court has ever held that claims may be brought under the Medicare Secondary Payer Act based upon unadjudicated and unidentified tort claims. On October 24, 2006, the United States District Court granted our July 25, 2006 motion to dismiss this litigation on the grounds that plaintiff Erin Brockovich lacked constitutional standing to bring this action. The District Court dismissed the litigation with prejudice because the deficiencies could not be cured by amendment of plaintiff's compliant. On November 17, 2006, plaintiff appealed the District Court's order dismissing this litigation to the United States Court of Appeals for the Ninth Circuit. On June 10, 2008, the Ninth Circuit granted plaintiff's motion for voluntary dismissal of this appeal which has terminated this litigation.

Claims in the ordinary course of business.

We are also subject to claims and lawsuits arising in the ordinary course of business, including potential claims related to care and treatment provided at our hospitals and outpatient services facilities. Although the results of these claims and lawsuits cannot be predicted with certainty, we believe that the ultimate resolution of these ordinary course claims and lawsuits will not have a material adverse effect on our business, financial condition or results of operations.

Item 4. Submission of Matters to a Vote of Security Holders.

No matters were submitted to a vote of stockholders during the fourth quarter ended June 30, 2008, except that the holders of 100% of our outstanding common stock approved Amendments 4 and 5 to our 2004 Stock Incentive Plan pursuant to a written consent dated May 6, 2008. These Amendments increased the total number of our shares which may be issued under the Plan from 98,120 to 101,117 and expanded participants in the Plan from solely our employees to also our non-employed directors and those natural persons who perform services for us like consultants.

PART II

Item 5. Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities.

There is no established public trading market for our common stock. At September 1, 2008, there were five holders of record of our common stock. These holders are VHS Holdings LLC and four investment funds affiliated with Blackstone.

We have not declared or paid any dividends on its common stock in its two most recent fiscal years. We intend to retain all current and foreseeable future earnings to support operations and finance expansion. Our senior secured credit facility and the indentures governing our long-term indebtedness restrict our ability to pay cash dividends on our common stock.

There have been no unregistered sales of our equity securities during the quarter ended June 30, 2008.

Information regarding our equity compensation plans is set forth in this report under "Item 12 – Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters – Equity Compensation Plan Information", which information is incorporated herein by reference.

Item 6. Selected Financial Data.

The following table sets forth our selected historical financial and operating data for, or as of the end of, each of the five years ended June 30, 2008 (including the predecessor and successor periods). The selected historical financial data as of and for the predecessor year ended June 30, 2004, the combined predecessor and successor year ended June 30, 2005 and the years ended June 30, 2006, 2007 and 2008 were derived from our audited consolidated financial statements that have been audited by Ernst & Young LLP, an independent registered public accounting firm. Comparability of the selected historical financial and operating data has been impacted by the timing of acquisitions completed during fiscal 2005. Dispositions completed during fiscal 2006 and 2007 have been excluded from all periods presented. See "Executive Overview" included in "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations." This table should be read in conjunction with the consolidated financial statements and notes thereto.

	Predecessor Year Ended June 30, 2004	Combined Basis Year Ended June 30, 2005	Year Ended June 30, 2006	Year ended June 30, 2007	Year ended June 30, 2008	Predecessor July 1, 2004 through September 22, 2004	Successor September 23, 2004 through June 30, 2005
			(Dollars in millions, except Operating Data)				
Statement of Operations Data:							
Total revenues	$ 1,583.1	$ 2,037.3	$ 2,418.6	$ 2,580.7	$ 2,790.7	$ 397.9	$ 1,639.4
Costs and expenses:							
Salaries and benefits (includes stock compensation of $0.1, $97.4, $1.7, $1.2, $2.5, $96.7 and $0.7, respectively)	633.5	909.2	991.4	1,067.9	1,152.7	248.2	661.0
Supplies	253.2	336.8	394.1	421.8	434.5	63.7	273.1
Medical claims expense	211.8	237.2	270.3	297.0	328.2	55.0	182.2
Provision for doubtful accounts	104.7	133.0	156.8	175.2	205.6	27.8	105.2
Other operating expenses	222.0	288.8	353.0	375.0	405.8	57.3	231.5
Depreciation and amortization	58.8	75.7	100.3	118.6	131.0	16.0	59.7
Interest, net	41.4	82.3	103.8	123.8	122.1	9.0	73.3
Debt extinguishment costs	4.9	62.2	0.1	—	—	62.2	—
Minority interests	(2.5)	(0.3)	2.6	2.6	3.0	(0.5)	0.2
Merger expenses	—	23.3	—	—	—	23.1	0.2
Impairment loss	—	—	—	123.8	—	—	—
Other expenses	(2.3)	3.6	6.5	0.2	6.5	0.4	3.2
Subtotal	1,525.5	2,151.8	2,378.9	2,705.9	2,789.4	562.2	1,589.6
Income (loss) from continuing operations before income taxes	57.6	(114.5)	39.7	(125.2)	1.3	(164.3)	49.8
Income tax expense (benefit)	21.9	(34.7)	17.8	(11.6)	1.7	(52.2)	17.5
Income (loss) from continuing operations	35.7	(79.8)	21.9	(113.6)	(0.4)	(112.1)	32.3
Income (loss) from discontinued operations, net of taxes	4.4	1.7	(9.0)	(19.1)	(0.3)	1.4	0.3
Net income (loss)	40.1	(78.1)	12.9	(132.7)	(0.7)	(110.7)	32.6
Preferred dividends	(4.0)	(1.0)	—	—	—	(1.0)	—
Net income (loss) attributable to common stockholders	$ 36.1	$ (79.1)	$ 12.9	$ (132.7)	$ (0.7)	$ (111.7)	$ 32.6
Balance Sheet Data:							
Assets	$ 1,427.8	$ 2,471.7	$ 2,650.5	$ 2,538.1	$ 2,582.3		$ 2,471.7
Long-term debt, including current portion	623.5	1,357.1	1,519.2	1,528.7	1,537.5		1,357.1
Payable-in-Kind Preferred Stock	61.0	—	—	—	—		—
Working capital	162.7	77.7	193.0	156.4	217.8		77.7
Other Financial Data:							
Capital expenditures	$ 136.1	$ 224.2	$ 275.5	$ 164.3	$ 121.6	$ 27.1	$ 197.1
Cash provided by operating activities	109.0	201.8	149.3	123.3	173.1	78.8	123.0
Cash used in investing activities	(225.1)	(324.3)	(245.4)	(118.5)	(143.8)	(50.0)	(274.3)
Cash provided by (used in) financing activities	139.0	151.6	140.5	(8.3)	(7.8)	(20.0)	171.6
Operating Data-continuing operations: (unaudited)							
Number of hospitals at end of period	12	15	15	15	15		
Number of licensed beds at end of period (a)	3,133	3,907	3,937	4,143	4,181		
Discharges (b)	126,356	147,798	162,446	166,873	169,668		
Adjusted discharges - hospitals (c)	186,464	231,322	261,056	264,698	270,076		
Net revenue per adjusted discharge – hospitals (d)	$ 6,455	$ 6,859	$ 7,319	$ 7,766	$ 8,110		
Patient days (e)	519,589	623,333	701,307	721,832	734,838		
Adjusted patient days – hospitals (f)	766,760	975,593	1,127,024	1,144,989	1,169,710		
Average length of stay (days) (g)	4.1	4.2	4.3	4.3	4.3		
Inpatient surgeries (h)	29,816	33,424	36,606	37,227	37,538		
Outpatient surgeries (i)	54,180	67,944	76,437	76,606	73,339		
Emergency room visits (j)	430,794	504,172	554,250	572,946	588,491		
Occupancy rate (k)	45.5%	48.5%	49.2%	48.2%	48.5%		
Average daily census (l)	1,420	1,708	1,921	1,978	2,008		
Member lives (m)	142,200	146,700	146,200	145,600	149,600		
Medical claims expense percentage (n)	72.1%	71.1%	72.1%	74.0%	72.9%		

(a) Licensed beds are those beds for which a facility has been granted approval to operate from the applicable state licensing agency.

(b) Discharges represent the total number of patients discharged (in the facility for a period in excess of 23 hours) from our hospitals and is used by management and certain investors as a general measure of inpatient volumes.

(c) Adjusted discharges-hospitals is used by management and certain investors as a general measure of combined inpatient and outpatient volumes. Adjusted discharges-hospitals is computed by multiplying discharges by the sum of gross hospital inpatient and outpatient revenues and then dividing the result by gross hospital inpatient revenues. This computation enables management to assess hospital volumes by a combined measure of inpatient and outpatient utilization.

(d) Net revenue per adjusted discharge-hospitals is calculated by dividing hospital net patient revenues by adjusted discharges-hospitals and measures the average net payment expected to be received for a patient's stay in the hospital.

(e) Patient days represent the number of days (calculated as overnight stays) our beds were occupied by patients during the periods.

(f) Adjusted patient days-hospitals is calculated by multiplying patient days by the sum of gross hospital inpatient and outpatient revenues and then dividing the result by gross hospital inpatient revenues. This computation is an indicator of combined inpatient and outpatient volumes.

(g) Average length of stay represents the average number of days an admitted patient stays in our hospitals.

(h) Inpatient surgeries represent the number of surgeries performed in our hospitals where overnight stays are necessary.

(i) Outpatient surgeries represent the number of surgeries performed at hospitals or ambulatory surgery centers on an outpatient basis (patient overnight stay not necessary).

(j) Emergency room visits represent the number of patient visits to a hospital or freestanding emergency room where treatment is received, regardless of whether an overnight stay is subsequently required.

(k) Occupancy rate represents the percentage of hospital licensed beds occupied by patients. Occupancy rate provides a measure of the utilization of inpatient rooms.

(l) Average daily census represents the average number of patients in our hospitals each day during our ownership.

(m) Member lives represent the total number of enrollees in PHP, AAHP and MHP as of the end of the respective period.

(n) Medical claims expense percentage is calculated by dividing medical claims expense by premium revenues.

Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations.

You should read the following discussion together with our historical financial statements and related notes included elsewhere herein and the information set forth under "Item 6. Selected Financial Data." The discussion contains forward-looking statements that involve risks and uncertainties. For additional information regarding some of the risks and uncertainties that affect our business and the industry in which we operate, please read "Item 1A. - Risk Factors" included elsewhere herein. Our actual results may differ materially from those estimated or projected in any of these forward-looking statements.

Executive Overview

As of June 30, 2008, we owned and operated 15 hospitals with a total of 4,181 licensed beds, and related outpatient service facilities complementary to the hospitals in San Antonio, Texas, metropolitan Phoenix, Arizona, metropolitan Chicago, Illinois, and Massachusetts, and two surgery centers in Orange County, California. On October 1, 2006, we sold our three California hospitals with combined 491 licensed beds to subsidiaries of Prime Healthcare, Inc. for a base purchase price of $44.0 million, prior to adjustments for working capital items included in the sale and transaction expenses. The operating results of the California hospitals are classified as discontinued operations in our consolidated statements of operations for all periods presented. In June 2007, we ceased providing acute care services at Phoenix Memorial Hospital ("PMH") and began leasing certain floors of the building to various third party healthcare providers. As a result, the acute care operating results of PMH are also classified as discontinued operations in our consolidated statements of operations for all periods presented.

As of June 30, 2008, we also owned three health plans as set forth in the following table.

Health Plan	Location	June 30, 2008 Membership
Phoenix Health Plan ("PHP") – managed Medicaid	Arizona	103,400
Abrazo Advantage Health Plan ("AAHP") – managed Medicare and Dual Eligible	Arizona	3,200
MacNeal Health Providers ("MHP") – capitated outpatient and physician services	Illinois	43,000
		149,600

Our objective is to provide high-quality, cost-effective healthcare services through an integrated delivery platform serving the needs of the communities in which we operate. We focus our business development efforts and operations on hospitals and other related healthcare facilities where we see an opportunity to improve operating performance and profitability and increase market share.

Operating Environment

We believe that the operating environment for hospital operators is currently undergoing a significant change that presents both challenges and opportunities for us. In order to remain competitive in the markets we serve, we must adapt our operating strategies to not only accommodate changing environmental factors but to make them operating advantages for us relative to our peers. These factors will require continued focus on quality of care initiatives. As consumers become more involved in their healthcare decisions, we believe perceived quality of care will become an even greater factor in determining where physicians choose to practice and where patients choose to receive care. In the following paragraphs we discuss some of the challenges that we currently face and that we expect to become more prominent during the foreseeable future.

Pay for Performance Reimbursement

Many payers, including Medicare and several large managed care organizations, currently require providers to report certain quality measures in order to receive the full amount of payment increases that were awarded automatically in the past. For federal fiscal year 2009, Medicare expanded the number of quality measures to be reported to 42 compared to 30 during federal fiscal year 2008, 21 during federal fiscal year 2007 and 10 during

federal fiscal year 2006. These measures include risk-adjusted outcomes measures such as 30-day mortality measures for patients who suffered a heart attack, heart failure or pneumonia; additional measures related to patients who undergo surgical procedures such as hospital-acquired infections data; and several patient satisfaction indicators. Many large managed care organizations have developed quality measurement criteria that are similar to or even more stringent than these Medicare requirements. We have implemented clinical systems upgrades to enable us to report these measures and will continue to invest in further upgrades as necessary to comply with reporting requirements.

While current payer guidelines are based upon the reporting of quality measures, we believe it is only a matter of time until the quality measures themselves determine reimbursement rates for hospital services. For example, on April 13, 2007, CMS proposed reforms in the hospital inpatient prospective payment system that would implement a provision of the Deficit Reduction Act of 2005 ("DRA") that takes the first steps toward preventing Medicare from giving hospitals higher payment for the additional costs of treating a patient that acquires a medical condition (including an infection) during a hospital stay. The DRA required CMS to select at least two conditions that are (1) high cost, high volume or both; (2) assigned to a higher rate of reimbursement when present as a secondary diagnosis; and (3) are reasonably preventable through application of evidence-based guidelines. These rules were adopted in August 2007. Under the rules, beginning in federal fiscal year 2009 (which commences October 1, 2008) cases with these conditions would not be paid at a higher reimbursement rate unless they were present on admission. The initial rules identified eight conditions, including three serious preventable events (sometimes called "never events"), that meet the statutory criteria. In April 2008, CMS proposed expanding the current list of eight hospital-acquired conditions to seventeen for federal fiscal year 2009. Thus, our ability to demonstrate quality of care in our hospitals could significantly impact our future operating results.

Physician Integration

Our ability to attract skilled physicians to our hospitals is critical to our success. We have adopted several significant physician recruitment goals with primary emphasis on recruiting physicians specializing in family practice, internal medicine, obstetrics and gynecology, cardiology, neurology, orthopedics and inpatient hospital care (hospitalists). To achieve our recruitment goals, we expect to recruit over 140 new physicians to the communities served by our hospitals during our fiscal year June 30, 2009 through employment agreements, relocation agreements or physician practice acquisitions. We have invested heavily in the infrastructure necessary to coordinate our physician recruitment strategies and manage our physician operations. The costs associated with recruiting, integrating and managing such a large number of new physicians will have a negative impact on our operating results and cash flows during our fiscal year ended June 30, 2009. However, we expect to realize improved clinical quality and service expansion capabilities from this initiative that will positively impact our operating results over the long-term. The perceived quality of care at our hospitals will be a key determining factor in whether these physicians agree to partner with us. Similar to hospital reimbursement, payers are developing plans to transform physician reimbursement to a pay for performance basis. In a hospital setting, many of the quality measures that apply to nursing care also apply to physician care. This interdependence aligns the quality of care focus of physicians and hospitals in order that both can receive equitable compensation for services provided.

We also face the risk of heightened physician reimbursement pressures that could cause physicians to seek to increase revenues by competing with hospitals for inpatient business. Additional competition from physician-owned specialty hospitals could adversely impact our future operating results. Again, we expect to mitigate this risk by achieving a competitive advantage with our quality of care initiatives that new specialty hospitals might not be equipped to implement. These pressures may also result in our employing more physicians or pursuing additional opportunities to partner with physicians to provide healthcare services to the communities we serve.

Nursing Salary Pressures

In order to demonstrate high quality services, we must hire and retain nurses who share our ideals and beliefs and who have access to the training necessary to implement our clinical quality initiatives. Given the nationwide nursing shortage and the particular limited nursing availability in the Phoenix area, we expect continued pressures on nursing salaries and benefits. These pressures include higher than normal base wage increases, flexible working hours and other benefits and higher nurse to patient ratios necessary to improve quality of care. Our clinical quality initiatives also require additional nurse training programs that increase salaries and benefits costs. We have

incurred and will continue to incur significant training costs as nurses learn to utilize our new information technology tools that allow us to monitor and report quality performance indicators. Becoming the employer of choice for nurses requires upfront human resource investments that could negatively affect operating results in the short-term. We may also be limited in our ability to adjust staffing levels in periods of lower than expected volumes. However, we expect that reducing turnover and improving the skill sets of our nurses will reduce our reliance on contract labor and result in improved quality of care and increased revenues in the long-term.

We expect to increase our current level of trained nursing professionals by expanding our comprehensive nurse recruiting and retention program. This program includes the following key components, among others:

- Nursing school in San Antonio
- Foreign nurse recruiting initiatives
- Tuition reimbursement and internal training to promote career advancement opportunities, including specialization qualification
- Extern programs and campus events to network with students
- Preceptor and other mentoring programs
- Expansion of orientation programs and employee involvement initiatives
- Performance leadership training for managers and directors
- Flexible work hours for nurses
- Employee safety initiatives
- Competitive pay and benefits and nursing recognition programs

We operate the Baptist Health System School of Health Professions ("SHP") in San Antonio, which offers seven different healthcare educational programs with its greatest enrollment in its professional nursing program. The SHP trains approximately 450 students each year in San Antonio. The majority of these students have historically chosen permanent employment with our hospitals. SHP expects its enrollment to increase by approximately 10% for fall 2008 compared to fall 2007. We have begun the application process to transition SHP's current diploma program to a degree granting program that we expect will be more attractive to potential students. Some of the students are provided with Vanguard-funded scholarships that cover tuition, books and fees in return for a commitment to work at one of our hospitals for a defined period of time. Should we be unsuccessful in our attempts to maintain adequate nursing staff for our present and future needs, our future operating results could be materially adversely impacted.

Competition for Outpatient Services

With advances in medical technologies and pharmaceuticals, many services once provided in an inpatient setting are now available in an outpatient setting. The redirection of services to outpatient settings is also influenced by pressures from payers to reduce costs and by patients who seek convenience. Our hospitals and many other acute hospitals have struggled to retain or increase outpatient business resulting from this inpatient to outpatient shift. Competition for outpatient services has increased significantly with the proliferation of surgery centers, outpatient imaging centers and outpatient laboratories that are often viewed as more convenient to physicians and patients. While we remain at risk for further migration of our hospital-based outpatient services to other facilities we do not own, we expect to mitigate these risks with our quality of care initiatives, physician integration strategies and capital projects to improve the design of and access to outpatient service areas in our hospitals.

Implementation of our Clinical Quality Initiatives

In the previous paragraphs we discuss the industry trends that are integral to our future success and how quality of care is the most important component in achieving success in those areas. While we are in the middle stages of implementing our expanded clinical quality initiatives, we believe that the following programs currently in place represent key building blocks to the implementation of a successful strategy.

- Monthly review of the 30 quality indicators prescribed by CMS for federal fiscal year 2008 with further expansion for new quality indicators set forth by CMS for upcoming federal fiscal year 2009
- Rapid response teams in place at all of our hospitals to provide more timely and efficient care
- Hourly nursing rounds in place at most of our hospitals

- Engagement of an external group to conduct unannounced mock Joint Commission surveys
- Alignment of hospital management incentive compensation with quality performance indicators
- Additional staffing to collect and report quality information and to facilitate action plans to address areas for improvement
- Common information system in place at all hospitals to report quality indicators
- Common information system at departmental level to achieve efficiencies in delivering care and to feed data to the common reporting system (ancillary department and physician portal components implemented, with remaining patient care and advanced physician components to be implemented in stages during the next three years)
- Formation of Physician Advisory Councils at each of our hospitals to align the quality goals of our hospitals with the physicians who practice in our hospitals

Revenue/Volume Trends

Our revenues depend upon inpatient occupancy levels, outpatient procedures performed at our facilities, the ancillary services and therapy programs ordered by physicians and provided to patients and our ability to successfully negotiate appropriate payment rates for these services with third party payers.

Sources of Revenues

The primary sources of our revenues include various managed care payers including managed Medicare and Medicaid programs, the traditional Medicare program, various state Medicaid programs, commercial health plans and the patients themselves. We are typically paid much less than our gross charges regardless of the payer source. Revenues from governmental programs are based upon complex reimbursement methodologies that require us to extensively monitor compliance with regulations including billing, coding and cost reimbursement items. These regulations change frequently and require us to adjust our processes, procedures and information systems in order to ensure that we bill these programs correctly and record related revenues appropriately. Revenues from managed care programs are typically based on contractually-stated rates or discounts we have negotiated with the various managed care plans. The contracts often contain exclusions, carve-outs, performance criteria and other guidelines that also require our constant focus and attention. Private patients who are members of managed care plans are not required to pay us for their healthcare services other than the coinsurance and deductible portions of their plan coverage calculated after managed care discounts have been applied. A more detailed description of these revenue sources is set forth in Part I, Item I, "Business", "Reimbursement for Services Provided" in this document.

The following table sets forth the percentages of net patient revenues by payer for the years ended June 30, 2006, 2007 and 2008.

	Year ended June 30,		
	2006	2007	2008
Medicare	28.2%	26.4%	26.2%
Medicaid	7.1%	8.6%	7.6%
Managed Medicare (1)	n/a	12.8%	14.0%
Managed Medicaid (1)	n/a	7.5%	7.5%
Managed care	51.2%	32.0%	35.0%
Self pay	9.2%	9.7%	8.6%
Other	4.3%	3.0%	1.1%
Total	100%	100.0%	100.0%

(1) Managed Medicare and Managed Medicaid net patient revenues were not separately identifiable and are included in managed care net patient revenues for the year ended June 30, 2006.

Volumes by Payer

During the years ended June 30, 2007 and 2008, we experienced a 2.7% and 1.7% increase in discharges from continuing operations and a 1.4% and 2.0% increase in hospital adjusted discharges from continuing operations, respectively. The following table provides details of discharges from continuing operations by payer for the years ended June 30, 2006, 2007 and 2008.

	Year ended June 30,					
	2006		2007		2008	
Medicare	47,352	29.2%	46,452	27.8%	47,040	27.7%
Medicaid	20,514	12.6%	22,518	13.5%	20,195	11.9%
Managed Medicare (1)	n/a	n/a	23,339	14.0%	26,040	15.3%
Managed Medicaid (1)	n/a	n/a	18,579	11.1%	19,893	11.7%
Managed care	87,910	54.1%	48,481	29.1%	50,040	29.5%
Self pay	5,169	3.2%	6,181	3.7%	5,854	3.5%
Other	1,501	0.9%	1,323	0.8%	606	0.4%
Total	162,446	100.0%	166,873	100.0%	169,668	100.0%

(1) Managed Medicare and Managed Medicaid discharges were not separately identifiable and are included in managed care discharges for the year ended June 30, 2006.

We continue to experience limited volume growth due to stagnant demand for inpatient healthcare services and increased competition for available patients. Additionally, decreases in certain subacute services as a result of regulatory changes and reduced demand for elective procedures as a result of changes in patient insurance coverage continue to weaken our inpatient and outpatient volumes. We expect our volumes to improve more significantly over the long-term as a result of our quality of care and service expansion initiatives and other market-specific strategies.

Traditional Medicare volumes have shifted to managed Medicare volumes during the current year period. These shifts have resulted in increased bad debts and increased exposure to collection risks for patient co-insurance and deductible amounts, which are subject to cost reimbursement under the traditional Medicare program but not under many managed Medicare plans. Our operating results were positively impacted by the lower combined Medicaid and managed Medicaid volumes and higher managed care volumes during the current year compared to the prior year.

Payer Reimbursement Trends

In addition to the volume factors described above, patient mix, acuity factors and pricing trends affect our patient service revenues. Net patient revenue per adjusted hospital discharge from continuing operations was $7,319, $7,766 and $8,110 for the years ended June 30, 2006, 2007 and 2008, respectively. Net patient revenue per adjusted hospital discharge would have been $7,718 for the year ended June 30, 2007 absent the Texas upper payment limit ("UPL") revenues recorded during fiscal 2007 that were not recorded during fiscal 2008. The Texas UPL program is discussed further below. These increases reflect improved reimbursement for services provided under negotiated managed care contracts and improved Medicare reimbursements. However, due to consolidation of managed care plans and federal and state efforts to decrease Medicare and Medicaid spending, our ability to recognize improved reimbursement above or equal to rates recognized in previous periods is becoming more difficult. We cannot assure you that future reimbursement rates, even if improved, will sufficiently cover potential increases in the cost of providing healthcare services to our patients.

During fiscal 2007 we were approved to receive payments under the Bexar County, Texas UPL Medicaid program. UPL programs allow private hospitals to enter into indigent care affiliation agreements with governmental

entities. Within the parameters of these programs, private hospitals expand charity care services to indigent patients and alleviate expenses for the governmental entity. The governmental entity is then able to utilize its tax revenue to fund the Medicaid program for private hospitals. During fiscal 2007 we recorded UPL-related revenues and income from continuing operations before income taxes of $11.6 million and $6.0 million, respectively, that related to services provided during fiscal 2006 and prior. We received a total cash payment of $18.7 million in April 2007, representing amounts earned under the UPL program for all periods through March 31, 2007. Since the beginning of our participation with this Texas UPL program, we have recognized $25.6 million of revenues and $11.6 million of income from continuing operations before income taxes directly related to the program. CMS began reviewing the operations of this private hospital UPL program after the state of Texas made the first payments in April 2007. It is customary for CMS to review Medicaid UPL payment programs. In October 2007, the state of Texas halted all funding of its private hospital UPL programs due to the deferral by CMS of certain federal Medicaid payments to the State of Texas. In August 2008, the state lifted its moratorium on payments under this UPL program, and we received a payment of approximately $12.1 million. While the possible termination of future benefits under this UPL program is not material to our financial statements, should the federal, state or county governments require recoupment of the previous matching funds paid to us, our results of operations and cash flows could be materially adversely impacted.

Premium Revenues

We recognize premium revenues from our three health plans, PHP, AAHP and MHP. AAHP commenced operations on January 1, 2006 primarily to provide healthcare services (including Medicare Part D) to those individuals eligible for both Medicare and Medicaid benefits based on age and income levels. As of June 30, 2008, approximately 3,200 members were enrolled in this program, most of whom were previously enrolled in PHP. PHP's membership increased to approximately 103,400 at June 30, 2008 compared to approximately 98,300 at June 30, 2007 and 96,700 at June 30, 2006. Premium revenues from these three plans increased by $48.8 million or 12.2% during fiscal 2008 compared to fiscal 2007 after an increase of $26.4 million or 7.0% from fiscal 2006 to 2007. These increases resulted primarily from the increased number of enrollees period over period. PHP also experienced period over period increases in per member per month reimbursement as a result of annual rate increases that went into effect on October 1, 2007 and 2006. In September 2007, the Arizona Health Care Cost Containment System ("AHCCCS") exercised its final one-year renewal option under its contract with PHP that commenced on October 1, 2003, which extended the current contract through September 30, 2008. In May 2008, PHP was awarded a new contract with AHCCCS effective for the three-year period beginning October 1, 2008 and ending September 30, 2011. AHCCCS has the option to renew the new contract, in whole or in part, for two additional one-year periods commencing on October 1, 2011 and on October 1, 2012. The new contract will cover the existing three counties under the current contract plus an additional six Arizona counties: Apache, Coconino, Mohave, Navajo, Pima and Yavapai. We expect a significant increase in PHP membership and premium revenues under the new contract but are unable to determine the impact of the new contract on our future operating results and cash flows at this time. The Centers for Medicare and Medicaid Services ("CMS") renewed its contract with AAHP for a one-year period effective January 1, 2008. If AHCCCS terminates PHP's contract due to lack of funding or for other reasons, our future liquidity, operating results and cash flows would be materially reduced.

General Trends

The following paragraphs discuss recent trends that we believe are significant factors in our current and/or future operating results and cash flows. While these trends may involve certain factors that are outside of our control, the extent to which these trends affect us and our ability to manage the impact of these trends play vital roles in our current and future success. In many cases, we are unable to predict what impact these trends, if any, will have on us.

Accounts Receivable Collection Risks Leading to Increased Bad Debts

Similar to other companies in the hospital industry, we face continued pressures in collecting outstanding accounts receivable primarily due to volatility in the uninsured and underinsured populations in the markets we serve. The following table provides a summary of our accounts receivable payer class mix as of each respective period presented.

June 30, 2006	0-90 days	91-180 days	Over 180 days	Total
Medicare	17.0%	1.0%	0.6%	18.6%
Medicaid	7.4%	2.1%	1.3%	10.8%
Managed Medicare	7.5%	1.0%	0.4%	8.9%
Managed Medicaid	5.9%	1.0%	0.6%	7.5%
Managed Care	24.3%	2.4%	1.2%	27.9%
Self Pay[1]	10.7%	9.4%	2.2%	22.3%
Other	2.7%	0.9%	0.4%	4.0%
Total	75.5%	17.8%	6.7%	100.0%

June 30, 2007	0-90 days	91-180 days	Over 180 days	Total
Medicare	15.0%	0.6%	0.6%	16.2%
Medicaid	7.5%	2.0%	1.0%	10.5%
Managed Medicare	7.6%	0.7%	0.6%	8.9%
Managed Medicaid	5.3%	0.6%	0.7%	6.6%
Managed Care	25.1%	2.7%	1.6%	29.4%
Self-Pay[2]	10.2%	8.0%	1.7%	19.9%
Self-Pay after primary[3]	1.8%	2.8%	1.1%	5.7%
Other	1.8%	0.6%	0.4%	2.8%
Total	74.3%	18.0%	7.7%	100.0%

June 30, 2008	0-90 days	91-180 days	Over 180 days	Total
Medicare	15.3%	0.6%	0.4%	16.3%
Medicaid	8.0%	2.2%	1.3%	11.5%
Managed Medicare	8.5%	0.6%	0.5%	9.6%
Managed Medicaid	5.6%	0.4%	0.3%	6.3%
Managed Care	25.8%	2.6%	1.9%	30.3%
Self-Pay[2]	9.3%	7.6%	1.1%	18.0%
Self-Pay after primary[3]	1.9%	2.6%	1.0%	5.5%
Other	1.6%	0.5%	0.4%	2.5%
Total	76.0%	17.1%	6.9%	100.0%

(1) Includes uninsured patients and those patient co-insurance and deductible amounts for which payment has been received from the primary payer. If primary payment has not been received for an account, the patient co-insurance and deductible amounts remain classified in the primary payer category. The breakout between uninsured accounts and patient co-insurance and deductible amounts is not available for this period.
(2) Includes uninsured patient accounts only.
(3) Includes patient co-insurance and deductible amounts after payment has been received from the primary payer.

Our combined allowance for doubtful accounts and allowance for charity care on a consolidated basis covered 91.4% and 96.3% of self-pay accounts receivable as of June 30, 2007 and 2008, respectively. Our combined allowance for doubtful accounts and allowance for charity care from continuing operations covered 87.5% and 95.2% of self-pay accounts receivable from continuing operations as of June 30, 2007 and June 30, 2008, respectively.

While self-pay accounts receivable as a percentage of total accounts receivable at June 30, 2008 decreased relative to the prior year period, self-pay accounts receivable dollars have remained flat compared to the prior year period and have become more difficult to collect. The volume of self-pay accounts receivable remains sensitive to a combination of factors including price increases, acuity of services, higher levels of patient deductibles and co-insurance under managed care plans, economic factors and the increased difficulties of uninsured patients who do not qualify for charity care programs to pay for escalating healthcare costs. We have implemented policies and procedures designed to expedite upfront cash collections and promote repayment plans from our patients. Our upfront cash collections from continuing operations increased 4.8% during fiscal 2008 compared to fiscal 2007. However, we believe bad debts will remain a significant risk for us and the rest of the hospital industry during the foreseeable future.

Charity Care and Self-Pay Discount Programs

We do not pursue collection of amounts due from uninsured patients that qualify for charity care under our guidelines (currently those uninsured patients whose incomes are equal to or less than 200% of the current federal poverty guidelines set forth by the Department of Health and Human Services). We exclude charity care accounts from revenues when we determine that the account meets our charity care guidelines. We deducted $71.1 million, $86.1 million and $86.1 million of charity care from total revenues during the years ended June 30, 2006, 2007 and 2008, respectively. Healthcare services provided to undocumented aliens that qualify for border funding reimbursement, net of payments received, represented $10.5 million, $19.4 million and $29.6 million of the charity care deductions during the years ended June 30, 2006, 2007 and 2008, respectively. Payments received for border funding claims were $0.9 million, $2.0 million and $3.8 million during the years ended June 30, 2006, 2007 and 2008, respectively. We expect that border funding qualification will end after December 31, 2008 and there is no assurance that additional funding will be available for these services.

Medicaid Funding Cuts

Many states, including certain states in which we operate, have periodically reported budget deficits as a result of increased costs and lower than expected tax collections. Health and human service programs, including Medicaid and similar programs, represent a significant component of state spending. To address these budgetary concerns, certain states have decreased funding for these programs and other states may make similar funding cuts. These cuts may include tightened participant eligibility standards, reduction of benefits, enrollment caps or payment reductions. Additionally, pressure exists at the federal level to reduce Medicaid matching funds provided to states. CMS issued a final rule in May 2007 that was expected to reduce Medicaid funding by approximately $12 to $20 billion over five years. Congress has twice enacted bills that placed moratoriums on this rule until April 2009. However, if the second moratorium expires as scheduled in April 2009, this final rule would go into effect and could significantly negatively impact state Medicaid funding. We are unable to assess the financial impact on our business of state and federal funding cuts at this time.

Volatility of Professional Liability Costs

We maintained professional and general liability insurance coverage through a wholly-owned captive insurance subsidiary for individual claims incurred through May 31, 2006 up to $10.0 million. For claims incurred subsequent to May 31, 2006, we self-insure the first $9.0 million per occurrence, and the captive subsidiary insures the next $1.0 million per occurrence. We maintain excess insurance coverage with independent third party carriers on a claims-made basis for individual claims exceeding $10.0 million up to $75.0 million, but limited to total annual payments of $65.0 million in the aggregate. The total cost of our professional and general liability insurance is sensitive to the volume and severity of cases reported. Malpractice premiums have adversely affected the ability of physicians to obtain malpractice insurance at reasonable rates in certain of our markets, particularly in metropolitan Chicago, resulting in physicians relocating to different geographic areas. In the event physicians practicing in our

hospitals are unable to obtain adequate malpractice insurance coverage, our hospitals are likely to incur a greater percentage of the amounts paid to claimants. Our professional liability exposures also increase when we employ physicians. As a result of our current plans to employ more than 90 new physicians during our fiscal year ended June 30, 2009, our exposure to professional and general liability risks could increase significantly in future years. On the other hand, some states in which we operate, including Texas and Illinois, have passed in recent years tort reform legislation to place limits on non-economic damages. However, in November 2007 a judge in the Illinois Cook County Circuit Court declared that these Illinois malpractice limits were unconstitutional under state law. While such ruling is being considered in an appeal to the Illinois Supreme Court, we understand that the trial courts are not enforcing the non-economic damages limits under that Illinois tort reform statute. Additionally, in Texas an action has been brought to declare its tort reform legislation unconstitutional under federal law. Thus, while we have taken multiple steps at our facilities to reduce our professional liability exposures, without significant legislation (not later declared unconstitutional) to curb the size of malpractice judgments in the states in which we operate, our insurance costs may increase in the future.

Increased Cost of Compliance in a Heavily Regulated Industry

We conduct business in a heavily regulated industry. Accordingly, we maintain a comprehensive, company-wide compliance program to address healthcare regulatory and other compliance requirements. This compliance program includes, among other things, initial and periodic ethics and compliance training, a toll-free reporting hotline for employees, annual fraud and abuse audits and annual coding audits. The organizational structure of our compliance program includes oversight by our board of directors and a high-level corporate management compliance committee. Our Senior Vice President of Compliance and Ethics reports jointly to our Chairman and Chief Executive Officer and to our board of directors, serves as our Chief Compliance Officer and is charged with direct responsibility for the day-to-day management of our compliance program. We also have regional compliance officers in our markets that are 100% dedicated to compliance duties. The financial resources necessary for program oversight, internal enforcement and periodic improvements to our program continue to grow, especially when we add new features to our program or engage external resources to assist with these highly complex matters.

Critical Accounting Policies

Our consolidated financial statements have been prepared in accordance with accounting principles generally accepted in the United States. In preparing these financial statements, we make estimates and assumptions that affect the reported amounts of assets, liabilities, revenues and expenses included in the financial statements. Management bases its estimates on historical experience and other available information, the results of which form the basis of the estimates and assumptions. We consider the following accounting policies to be critical because they involve highly subjective and complex assumptions and assessments, are subject to a great degree of fluctuation period over period and are the most critical to our operating performance.

Revenues and Revenue Deductions

We recognize patient service revenues during the period the healthcare services are provided based upon estimated amounts due from payers. We record contractual adjustments to our gross charges to reflect expected reimbursement negotiated with or prescribed by third party payers. We estimate contractual adjustments and allowances based upon payment terms set forth in managed care health plan contracts and by federal and state regulations. For the majority of our patient service revenues, we apply contractual adjustments to patient accounts at the time of billing using specific payer contract terms entered into the accounts receivable systems, but in some cases we record an estimated allowance until payment is received. We derive most of our patient service revenues from healthcare services provided to patients with Medicare (including managed Medicare plans) or managed care insurance coverage.

Services provided to Medicare patients are generally reimbursed at prospectively determined rates per diagnosis ("PPS"), while services provided to managed care patients are generally reimbursed based upon predetermined rates per diagnosis, per diem rates or discounted fee-for-service rates. Medicaid reimbursements vary by state. Other than Medicare and related Medicare managed plans, no individual payer represents more than 10% of our patient service revenues.

Medicare regulations and many of our managed care contracts are often complex and may include multiple reimbursement mechanisms for different types of services provided in our healthcare facilities. To obtain reimbursement for certain services under the Medicare program, we must submit annual cost reports and record estimates of amounts owed to or receivable from Medicare. These cost reports include complex calculations and estimates related to indirect medical education, reimbursable Medicare bad debts, disproportionate share and other items that are often subject to interpretation that could result in payments that differ from recorded estimates. We estimate amounts owed to or receivable from the Medicare program using the best information available and our interpretation of the applicable Medicare regulations. We include differences between original estimates and subsequent revisions to those estimates (including final cost report settlements) in our consolidated statements of operations in the period in which the revisions are made. Net adjustments for final third party settlements increased patient service revenues and income from continuing operations before income taxes by $8.6 million, $6.3 million and $7.9 million during the years ended June 30, 2006, 2007 and 2008, respectively. Additionally, updated regulations and contract negotiations with payers occur frequently, which necessitates continual review of revenue estimation processes by management. Management believes that future adjustments to its current third party settlement estimates will not materially impact our results of operations, cash flows or financial position.

We do not pursue collection of amounts due from uninsured patients that qualify for charity care under our guidelines (currently those uninsured patients whose incomes are equal to or less than 200% of the current federal poverty guidelines set forth by the Department of Health and Human Services). We deduct charity care accounts from revenues when we determine that the account meets our charity care guidelines. We also provide discounts from billed charges and alternative payment structures for uninsured patients who do not qualify for charity care but meet certain other minimum income guidelines, primarily those uninsured patients with incomes between 200% and 500% of the federal poverty guidelines. During the years ended June 30, 2006, 2007 and 2008, we deducted $71.1 million, $86.1 million and $86.1 million of charity care from revenues, respectively.

During our fiscal year ended June 30, 2007, we were approved to receive payments under the Bexar County, Texas upper payment limit ("UPL") Medicaid payment program. UPL programs allow private hospitals to enter into indigent care affiliation agreements with governmental entities. Within the parameters of these programs, private hospitals expand charity care services to indigent patients and alleviate expenses for the governmental entity. The governmental entity is then able to utilize its tax revenue to fund the Medicaid program for private hospitals. We recognize revenues from the UPL program when we become entitled to the reimbursements, including a federal match portion, and such reimbursements are assured.

We earned premium revenues of $375.0 million, $401.4 million and $450.2 million during the years ended June 30, 2006, 2007 and 2008, respectively, from our health plans. Our health plans, PHP, AAHP and MHP, have agreements with AHCCCS, CMS and various health maintenance organizations ("HMOs"), respectively, to contract to provide medical services to subscribing participants. Under these agreements, our health plans receive monthly payments based on the number of HMO participants in MHP or the number and coverage type of enrollees in PHP and AAHP. Our health plans recognize the payments as revenues in the month in which members are entitled to healthcare services with the exception of AAHP Medicare Part D reinsurance premiums and low income subsidy cost sharing premiums that are recorded as a liability to fund future healthcare costs or else repaid to the government.

Allowance for Doubtful Accounts and Provision for Doubtful Accounts

Our ability to collect the self-pay portions of our receivables is critical to our operating performance and cash flows. Our allowance for doubtful accounts was approximately 28.3% and 28.1% of accounts receivable, net of contractual discounts, as of June 30, 2007 and 2008, respectively. The primary collection risk relates to uninsured patient accounts and patient accounts for which primary insurance has paid but patient deductibles or co-insurance portions remain outstanding.

Effective July 1, 2007, we began estimating the allowance for doubtful accounts using a standard policy that reserves 100% of all accounts aged greater than 365 days subsequent to discharge date plus 85% of uninsured accounts less than 365 days old plus 40% of self pay after insurance/Medicare less than 365 days old. Our previous policy reserved all accounts greater than 180 days plus a market-specific percentage of uninsured and self pay after insurance/Medicare balances. Effective June 30, 2008, we adjusted our policy to reserve for all accounts aged

greater than 365 days subsequent to discharge date plus 92% of uninsured accounts less than 365 days old plus 45% of self-pay after insurance/Medicare less than 365 days old. These changes in our policy negatively impacted our provision for doubtful accounts during the year ended June 30, 2008. However, management believes the revised policy will adjust more quickly to payer mix shifts over time. We test our allowance for doubtful accounts policy quarterly using a hindsight calculation that utilizes write-off data for all payer classes during the previous twelve-month period to estimate the allowance for doubtful accounts at a point in time. We also supplement our analysis by comparing cash collections to net patient revenues and monitoring self-pay utilization. If our uninsured accounts receivable as of June 30, 2008 were 1% higher, our provision for doubtful accounts would have increased by $1.0 million. Significant changes in payer mix, business office operations, general economic conditions and healthcare coverage provided by federal or state governments or private insurers may have a significant impact on our estimates and significantly affect our liquidity, results of operations and cash flows.

We classify accounts pending Medicaid approval as Medicaid accounts in our accounts receivable aging report and record a manual contractual allowance for these accounts equal to the average Medicaid reimbursement rate for that specific state until qualification is confirmed at which time the account is netted. We have historically been successful in qualifying approximately 40%-45% of submitted accounts for Medicaid coverage. As of June 30, 2008, we had approximately $13.0 million of Medicaid pending accounts receivable from continuing operations ($4.1 million of which was stated at gross charges with a manual contractual allowance and $8.9 million of which was stated net of contractual discounts). In the event an account is not successfully qualified for Medicaid coverage and does not meet our charity guidelines, the previously recorded Medicaid contractual adjustment remains a revenue deduction (similar to a self-pay discount), and the remaining net account balance is reclassified to uninsured status and subjected to our allowance for doubtful accounts policy. During the years ended June 30, 2007 and 2008, approximately $13.2 million and $25.1 million, respectively, of net accounts receivable from continuing operations was reclassified from Medicaid pending status to uninsured status. If accounts do not qualify for Medicaid coverage but do qualify as charity care, the contractual adjustments are reversed and the gross account balances are recorded as charity deductions. During the years ended June 30, 2007 and 2008, we recorded $6.4 million and $7.1 million, respectively, of charity deductions from continuing operations for the net balances of accounts previously classified as Medicaid pending that did not meet Medicaid eligibility requirements.

Because we require patient verification of coverage at the time of admission, reclassifications of Medicare or managed care accounts to self-pay, other than patient coinsurance or deductible amounts, occur infrequently and are not material to our financial statements. Additionally, the impact of these classification changes is further limited by our ability to identify any necessary classification changes prior to patient discharge or soon thereafter. Due to information system limitations, we are unable to quantify patient deductible and co-insurance receivables that are included in the primary payer classification in the accounts receivable aging report at any given point in time. When classification changes occur, the account balance remains aged from the patient discharge date.

Insurance Reserves

Due to the nature of our operating environment, we are subject to professional and general liability and workers compensation claims and related lawsuits in the ordinary course of business. For professional and general liability claims incurred from June 1, 2002 to May 31, 2006, our wholly owned captive subsidiary insured our professional and general liability risks at a $10.0 million retention level. For professional and general liability claims incurred subsequent to May 31, 2006, we self-insure the first $9.0 million per claim, and the captive subsidiary insures the next $1.0 million per claim. We maintain excess coverage from independent third party insurers on a claims-made basis for individual claims exceeding $10.0 million up to $75.0 million, but limited to total annual payments of $65.0 million in the aggregate.

We insured our excess coverage under a retrospectively rated policy, and premiums under this policy are recorded based on our historical claims experience. We self-insure our workers compensation claims up to $1.0 million per claim and purchase excess insurance coverage for claims exceeding $1.0 million.

The following tables summarize our professional and general liability and workers compensation reserve balances as of June 30, 2007 and 2008 and our total provision for professional and general liability and workers compensation losses and related claims payments during the years ended June 30, 2006, 2007 and 2008.

	Professional and General Liability	Workers Compensation
	(In millions)	
Reserve balance:		
June 30, 2007	$ 64.6	$ 18.5
June 30, 2008	$ 74.3	$ 18.8
Provision for claims losses:		
Fiscal Year 2006	$ 21.0	$ 8.9
Fiscal Year 2007	$ 20.2	$ 9.4
Fiscal Year 2008	$ 21.8	$ 5.3
Claims paid:		
Fiscal Year 2006	$ 12.7	$ 6.4
Fiscal Year 2007	$ 14.4	$ 6.2
Fiscal Year 2008	$ 12.1	$ 5.0

In developing our estimates of our reserves for professional and general liability and workers compensation claims, we utilize actuarial information. Each reserve is comprised of estimated indemnity and expense payments related to: 1) reported events ("case reserves") and 2) incurred but not reported ("IBNR") events as of the end of the period. Management uses information from its risk managers and its best judgment to estimate case reserves. Actuarial IBNR estimates are dependent on multiple variables including our risk exposures, our self-insurance limits, geographic locations in which we operate, the severity of our historical losses compared to industry averages and the reporting pattern of our historical losses compared to industry averages, among others. Most of these variables require judgment, and changes in these variables could result in significant period over period fluctuations in our estimates. We discount our workers compensation reserve using actuarial estimates of projected cash payments in future periods. We adjust these reserves from time to time as we receive updated information. During our fiscal years ended June 30, 2006, 2007 and 2008, due to changes in historical loss trends, we decreased our professional and general liability reserve related to prior fiscal years by $6.9 million, $4.5 million and $0.6 million, respectively. Similarly, we decreased our workers compensation reserve related to prior fiscal years by $2.3 million during our fiscal year ended June 30, 2008. Adjustments to the workers compensation reserve related to prior years during fiscal years ended June 30, 2006 and 2007 were not significant. Additional adjustments to prior year estimates may be necessary in future periods as our reporting history and loss portfolio matures.

Our best estimate of IBNR utilizes statistical confidence levels that are below 75%. Using a higher statistical confidence level, while not permitted under United States generally accepted accounting principles, would increase the estimated reserve. The following table illustrates the sensitivity of the reserve estimates at 75% and 90% confidence levels.

	Professional and General Liability	Workers Compensation
	(In millions)	
June 30, 2007 reserve:		
As reported	$ 64.6	$ 18.5
With 75% Confidence Level	$ 76.9	$ 20.8
With 90% Confidence Level	$ 88.9	$ 22.6
June 30, 2008 reserve:		
As reported	$ 74.3	$ 18.8
With 75% Confidence Level	$ 85.7	$ 21.5
With 90% Confidence Level	$ 97.2	$ 23.8

Medical Claims Reserves

During the years ended June 30, 2006, 2007 and 2008, medical claims expense was $270.3 million, $297.0 million and $328.2 million, respectively, primarily representing medical claims of PHP. Vanguard estimates PHP's reserve for medical claims using historical claims experience (including cost per member and payment lag time) and other actuarial data including number of enrollees and certain enrollee demographic information. The reserve for medical claims and related payer settlements, including incurred but not reported claims, for all of our health plans combined was approximately $61.4 million and $51.1 million as of June 30, 2007 and 2008, respectively. The year over year decrease was primarily due to the payment of settlement amounts due to AHCCCS and CMS. While management believes that its estimation methodology effectively captures trends in medical claims costs, actual payments could differ significantly from its estimates given changes in the healthcare cost structure or adverse experience. During the years ended June 30, 2006, 2007 and 2008, approximately $40.0 million, $34.2 million and $31.2 million, respectively, of accrued and paid claims for services provided to our health plan enrollees by our hospitals and our other healthcare facilities were eliminated in consolidation. Our operating results and cash flows could be materially affected by increased or decreased utilization of our healthcare facilities by enrollees in our health plans.

Income Taxes

We believe that our income tax provisions are accurate and supportable, but certain tax matters require interpretations of tax law that may be subject to future challenge and may not be upheld under tax audit. To reflect the possibility that all of our tax positions may not be sustained, we maintain tax reserves that are subject to adjustment as updated information becomes available or as circumstances change. We record the impact of tax reserve changes to our income tax provision in the period in which the additional information, including the progress of tax audits, is obtained.

We assess the realization of our deferred tax assets to determine whether an income tax valuation allowance is required. Based on all available evidence, both positive and negative, and the weight of that evidence to the extent such evidence can be objectively verified, we determine whether it is more likely than not that all or a portion of the deferred tax assets will be realized. The factors used in this determination include the following:

- Cumulative losses in recent years
- Income/losses expected in future years
- Unsettled circumstances that, if favorably resolved, would adversely affect future operations
- Availability, or lack thereof, of taxable income in prior carryback periods that would limit realization of tax benefits
- Carryforward period associated with the deferred tax assets and liabilities
- Prudent and feasible tax planning strategies

In addition, financial forecasts used in determining the need for or amount of federal and state valuation allowances are subject to changes in underlying assumptions and fluctuations in market conditions that could significantly alter our recoverability analysis and thus have a material adverse effect on our consolidated financial condition, results of operations or cash flows.

Effective July 1, 2007, we adopted the provisions of FASB Interpretation No. 48, *Accounting for Uncertainty in Income Taxes – An Interpretation of FASB Statement No. 109* ("FIN 48"). In connection with the adoption of FIN 48, we recorded a $0.4 million net liability for unrecognized tax benefits, accrued interest and penalties, which was comprised of the following (in millions).

Reclassification from income taxes payable	$	0.3
Increase to non-current deferred tax assets		2.7
Cumulative impact of change recorded to retained earnings		(2.6)
	$	0.4

The provisions of FIN 48 allow for the classification election of interest on an underpayment of income taxes, when the tax law requires interest to be paid, and penalties, when a tax position does not meet the minimum statutory threshold to avoid payment of penalties, in income taxes, interest expense or another appropriate expense classification based on the accounting policy election of the entity. We elected to continue our historical practice of classifying interest and penalties as a component of income tax expense. Approximately $0.3 million of the $0.4 million of unrecognized tax benefits, if recognized, would impact the effective tax rate, while the remaining $0.1 million of unrecognized tax benefits, if recognized, would increase goodwill.

Long-Lived Assets and Goodwill

Long-lived assets, including property, plant and equipment and amortizable intangible assets, comprise a significant portion of our total assets. We evaluate the carrying value of long-lived assets when impairment indicators are present or when circumstances indicate that impairment may exist under the provisions of SFAS 144, *Accounting for the Impairment or Disposal of Long-Lived Assets*. When management believes impairment indicators may exist, projections of the undiscounted future cash flows associated with the use of and eventual disposition of long-lived assets held for use are prepared. If the projections indicate that the carrying values of the long-lived assets are not expected to be recoverable, we reduce the carrying values to fair value. For long-lived assets held for sale, we compare the carrying values to an estimate of fair value less selling costs to determine potential impairment. We test for impairment of long-lived assets at the lowest level for which cash flows are measurable. These impairment tests are heavily influenced by assumptions and estimates that are subject to change as additional information becomes available. Given the relatively few number of hospitals we own and the significant amounts of long-lived assets attributable to those hospitals, an impairment of the long-lived assets for even a single hospital could materially adversely impact our operating results or financial position.

Goodwill also represents a significant portion of our total assets. We review goodwill for impairment annually during our fourth fiscal quarter or more frequently if certain impairment indicators arise under the provisions of SFAS 142, *Goodwill and Other Intangible Assets*. We review goodwill at the reporting level unit, which is one level below an operating segment. We review the carrying value of the net assets of each reporting unit to the net present value of estimated discounted future cash flows of the reporting unit. If the carrying value exceeds the net present value of estimated discounted future cash flows, an impairment indicator exists and an estimate of the impairment loss is calculated. The fair value calculation includes multiple assumptions and estimates, including the projected cash flows and discount rates applied. Changes in these assumptions and estimates could result in goodwill impairment that could materially adversely impact our financial position or results of operations. In December 2006, we recorded a goodwill impairment charge in the amount of $123.8 million ($110.5 million, net of tax benefit) related to our Chicago hospitals.

We completed our annual goodwill impairment test during the fourth quarter of fiscal 2008 noting no impairment. However, we will continue to closely monitor the operations of our Chicago hospitals, with goodwill of approximately $40.6 million, due to the sensitivity of the projected operating results of this reporting unit to the goodwill impairment analysis. If projected future cash flows become less favorable than those projected by management, an additional impairment charge relating to our Chicago hospitals may become necessary that could have a material adverse impact on our financial position and results of operations.

Selected Operating Statistics

The following table sets forth certain operating statistics for the periods indicated below.

	Year Ended June 30,		
	2006	2007	2008
Number of hospitals at end of period	15	15	15
Number of licensed beds at end of period	3,937	4,143	4,181
Discharges (a)	162,446	166,873	169,668
Adjusted discharges - hospitals (b)	261,056	264,698	270,076
Net revenue per adjusted discharge-hospitals (c)	$ 7,319	$ 7,766	$ 8,110
Patient days (d)	701,307	721,832	734,838
Adjusted patient days-hospitals (e)	1,127,024	1,144,989	1,169,710
Average length of stay (days) (f)	4.3	4.3	4.3
Inpatient surgeries (g)	36,606	37,227	37,538
Outpatient surgeries (h)	76,437	76,606	73,339
Emergency room visits (i)	554,250	572,946	588,491
Occupancy rate (j)	49.2%	48.2%	48.5%
Average daily census (k)	1,921	1,978	2,008
Member lives (l)	146,200	145,600	149,600
Medical claims expense percentage (m)	72.1%	74.0%	72.9%

(a) Discharges represent the total number of patients discharged (in the facility for a period in excess of 23 hours) from our hospitals and is used by management and certain investors as a general measure of inpatient volumes.

(b) Adjusted discharges-hospitals is used by management and certain investors as a general measure of combined hospital inpatient and outpatient volumes. Adjusted discharges-hospitals is computed by multiplying discharges by the sum of gross hospital inpatient and outpatient revenues and then dividing the result by gross hospital inpatient revenues.

(c) Net revenue per adjusted discharge-hospitals is calculated by dividing net hospital patient revenues by adjusted discharge-hospitals and measures the average net payment expected to be received for a patient's stay in the hospital.

(d) Patient days represent the number of days (calculated as overnight stays) our beds were occupied by patients during the periods.

(e) Adjusted patient days-hospitals is calculated by multiplying patient days by the sum of gross hospital inpatient and outpatient revenues and then dividing the result by gross hospital inpatient revenues. This computation is an indicator of combined inpatient and outpatient volumes.

(f) Average length of stay represents the average number of days an admitted patient stays in our hospitals.

(g) Inpatient surgeries represent the number of surgeries performed in our hospitals where overnight stays are necessary.

(h) Outpatient surgeries represent the number of surgeries performed at hospitals or ambulatory surgery centers on an outpatient basis (patient overnight stay not necessary).

(i) Emergency room visits represent the number of patient visits to a hospital emergency room where treatment is received, regardless of whether an overnight stay is subsequently required.

(j) Occupancy rate represents the percentage of hospital licensed beds occupied by patients. Occupancy rate provides a measure of the utilization of inpatient beds.

(k) Average daily census represents the average number of patients in our hospitals each day during our ownership.

(l) Member lives represent the total number of enrollees in PHP, AAHP and MHP as of the end of the respective period.

(m) Medical claims expense percentage is calculated by dividing medical claims expense by premium revenues.

Results of Operations

The following tables present a summary of our operating results for the respective periods shown.

	Year Ended June 30,					
	2006		2007		2008	
	Amount	%	Amount	%	Amount	%
	(Dollars in millions)					
Patient service revenues	$ 2,043.6	84.5%	$ 2,179.3	84.4%	$ 2,340.5	83.9%
Premium revenues	375.0	15.5	401.4	15.6	450.2	16.1
Total revenues	2,418.6	100.0	2,580.7	100.0	2,790.7	100.0
Salaries and benefits (includes stock compensation of $1.7, $1.2 and $2.5 respectively)	991.4	41.0	1,067.9	41.4	1,152.7	41.3
Supplies	394.1	16.3	421.8	16.3	434.5	15.5
Medical claims expense	270.3	11.2	297.0	11.5	328.2	11.8
Provision for doubtful accounts	156.8	6.5	175.2	6.8	205.6	7.4
Other operating expenses	353.0	14.6	375.0	14.5	405.8	14.5
Depreciation and amortization	100.3	4.1	118.6	4.6	131.0	4.7
Interest, net	103.8	4.3	123.8	4.8	122.1	4.4
Debt extinguishment costs	0.1	0.0	–	0.0	–	0.0
Impairment loss	–	0.0	123.8	4.8	–	0.0
Other expenses	9.1	0.4	2.8	0.1	9.5	0.3
Income (loss) from continuing operations before income taxes	39.7	1.6	(125.2)	(4.8)	1.3	0.1
Provision for income taxes	17.8	0.7	(11.6)	(0.4)	1.7	(0.1)
Income (loss) from continuing operations	21.9	0.9	(113.6)	(4.4)	(0.4)	(0.0)
Loss from discounted operations, net of taxes	(9.0)	(0.4)	(19.1)	(0.7)	(0.3)	(0.0)
Net income (loss)	$ 12.9	0.5%	$ (132.7)	(5.1)%	$ (0.7)	(0.0)%

Year Ended June 30, 2008 Compared to the Year Ended June 30, 2007

Revenues. Patient service revenues increased 7.4% year over year primarily as a result of a 4.4% increase in patient revenues per adjusted hospital discharge and a 2.0% increase in adjusted hospital discharges. Total outpatient volumes increased year over year, including a 2.7% increase in emergency room visits, although outpatient surgeries decreased year over year. We experienced positive year over year payer mix shifts highlighted by an increase in combined Medicare and managed Medicare volumes compared to a decrease in combined Medicaid and managed Medicaid volumes. The acuity level of our patients also increased year over year. However, we continued to generate most of our inpatient stays from emergency room visits and struggled to improve our elective admissions. Patients often elect to defer elective procedures when general economic conditions are weak. We also face continued intense competition from other hospitals to recruit and retain the best physicians to practice in our facilities. In order to improve our operating results, we must increase our elective inpatient and outpatient business to maintain a favorable payer mix. We believe our quality initiatives will be the catalyst for long-term revenue growth especially given the forecasted population growth for most of the markets in which we operate. However, environmental factors outside our control, including patient demand, deterioration of general economic conditions, payer pressures and increased competition could limit our future revenue growth.

Premium revenues increased 12.2% during fiscal 2008 primarily as a result of a 5.7% in year over year annual membership at PHP and a capitation rate increase that went into effect for PHP as of October 1, 2007. PHP's membership increased as a result of a greater number of AHCCCS-eligible residents as a result of weakened general economic conditions and a greater allocation of the AHCCCS enrollees to PHP. PHP was awarded a new AHCCCS contract that commences on October 1, 2008 that adds six additional counties to the three counties already served by PHP. We expect PHP to experience a significant increase in membership during fiscal 2009, which would increase our premium revenues, but we are unable to estimate the impact to our future financial position, results of operations or cash flows at this time.

Costs and Expenses. Total costs and expenses, exclusive of income taxes and discontinued operations, were $2,789.4 million or 99.9% of total revenues during fiscal 2008 compared to 104.9% during fiscal 2007. Fiscal 2007 costs and expenses were negatively impacted by the $123.8 million impairment loss related to our Chicago hospitals. Salaries and benefits, supplies, medical claims and provision for doubtful accounts represent our most significant individual costs and expenses or those subject to the greatest level of fluctuation period over period.

- **Salaries and benefits.** Salaries and benefits as a percentage of total revenues were relatively flat period over period. Excluding the growth in our health plan operations, salaries and benefits would have increased to 42.0% during fiscal 2008 compared to the 41.4% during the prior year. The national nursing shortage, which is particularly prevalent in Phoenix, continues to hinder our ability to fully manage salaries and benefits costs. Even with the nursing shortage in Phoenix, we made progress in stabilizing our nurse workforce in Phoenix to reduce contract labor utilization. We incurred a significant increase in period over period salaries and benefits costs in our Massachusetts hospitals primarily resulting from requirements set forth in our most recent collective bargaining agreement ratified with the nurses union at St. Vincent Hospital. We expect to face continued competition from other healthcare providers to obtain qualified nurses, which will increase our salaries and benefits costs, but we expect to mitigate a portion of this increase through implementation of expanded recruiting and retention initiatives, care management efficiency initiatives and our clinical quality programs.

- **Supplies.** Supplies as a percentage of total revenues decreased from 16.3% during fiscal 2007 to 15.5% during fiscal 2008. Supplies as a percentage of patient service revenues decreased to 18.6% during fiscal 2008 compared to 19.4% during fiscal 2007. Fiscal 2008 was the first full year that certain of our supply chain corporate initiatives were fully implemented. These initiatives included formulary refinements, standardization of commodities and supplies reprocessing and improved compliance with our group purchasing contract. Effective May 2008, we renewed our group purchasing contract with HealthTrust Purchasing Group for an additional five years. We expect to recognize only slight improvement in this ratio during fiscal 2009 as additional supply chain initiatives are implemented. However, because most of our growth strategies include expansion of high acuity services, we will continue to be exposed to increased pricing pressures for pharmaceuticals and expensive medical devices including those used in cardiac and orthopedic surgeries that could negate our cost containment initiatives.

- **Medical claims expense.** Medical claims expense as a percentage of premium revenues decreased from 74.0% during fiscal 2007 to 72.9% during fiscal 2008. Capitation revenues for our health plans increased at a greater rate year over year than did the utilization of medical services by our health plans' enrollees. Medical claims expense represents the amounts paid by health plans for healthcare services provided to their members, including an estimate of incurred but not reported claims that is determined based upon lag data and other actuarial assumptions. Revenues and expenses between the health plans and our hospitals and related outpatient service providers of approximately $31.2 million, or 8.7% of gross health plan medical claims expense, were eliminated in consolidation during fiscal 2008 compared to $34.2 million or 10.3% of gross health plan medical claims expense during fiscal 2007.

- **Provision for doubtful accounts.** During fiscal 2008, the provision for doubtful accounts as a percentage of patient service revenues increased to 8.8% from 8.0% during fiscal 2007. During fiscal 2008, our self-pay discharges as a percentage of total discharges decreased to 3.5% from 3.7% during fiscal 2007. However, price increases at our hospitals and increased levels of patient co-insurance and deductibles under managed care plans increased our exposure to uncollectible revenues. The previously discussed change in our allowance for doubtful accounts policy during fiscal 2008 resulted in a higher provision for doubtful accounts as a percentage of patient service revenues during fiscal 2008 compared to fiscal 2007. Our provision for doubtful accounts as a percentage of patient service revenues is reduced by our policy of deducting charity accounts from revenues at the time in which those accounts meet our charity care guidelines. On a combined basis, the provision for doubtful accounts and charity care deductions as a percentage of patient service revenues increased to 12.5% during fiscal 2008 compared to 12.0% during fiscal 2007. We do not expect these ratios to improve significantly in the near future given current trends in patient insurance coverage. However, we believe our upfront collection efforts and revenues growth initiatives will help mitigate future increases to these ratios.

Other operating expenses. Other operating expenses include, among others, purchased services, insurance, property taxes, rents and leases, repairs and maintenance and utilities. Other operating expenses as a percentage of total revenues were flat year over year. We continue to incur increasing physician recruiting costs, higher repairs and maintenance costs related to the implementation of our clinical information systems in our hospitals and higher utilities costs.

Other. Depreciation and amortization as a percentage of total revenues increased to 4.7% during fiscal 2008 compared to 4.6% during fiscal 2007 as a result of our capital improvement and expansion initiatives. Portions of our clinical quality systems were placed into service during fiscal 2008, and fiscal 2008 was the first full year in which all of our previous significant expansion projects in Phoenix and San Antonio had been fully in service. The decrease in net interest as a percentage of total revenues to 4.4% during fiscal 2008 compared to 4.8% during fiscal 2007 resulted primarily from the increase in total revenues during fiscal 2008 compared to fiscal 2007 without additional debt borrowings.

Income taxes. Income taxes were not significant during fiscal 2008. The effective tax rate for fiscal 2007 was 9.3% due to the majority of the impairment loss being nondeductible for tax purposes.

Discontinued operations. Our loss from discontinued operations was not significant during the fiscal year ended June 30, 2008 due to the winding down of operations at PMH compared to fiscal 2007 when PMH operated as an acute care hospital for the majority of the fiscal year.

Net loss. The $132.0 million year over year decrease in net loss resulted primarily from the improved operating results during fiscal 2008 and the after tax impact of the impairment loss recorded during fiscal 2007.

Year Ended June 30, 2007 Compared to the Year Ended June 30, 2006

Revenues. Patient service revenues increased by 6.6% year over year primarily as a result of a 6.1% increase in patient revenues per adjusted hospital discharge and a 1.4% increase in adjusted hospital discharges. Outpatient volumes increased year over year with outpatient surgeries increasing 0.2% and emergency room visits increasing 3.4%. However, much of the year over year revenues improvement related to low acuity services provided to uninsured and Medicaid patients. Self-pay and Medicaid discharges increased 19.6% and 9.8%, respectively, year over year, while combined Medicare, managed care and commercial discharges were relatively flat year over year. We also continued to generate a lot of our inpatient stays from emergency room activity. We attribute this payer mix shift to the continued rising cost of healthcare insurance that has forced many people to go uninsured or else participate in a plan with higher deductibles and coinsurance.

Premium revenues increased by 7.0% during fiscal 2007 primarily as a result of having AAHP operations for the full fiscal year. Per member per month reimbursement rates are significantly higher under AAHP than under the traditional AHCCCS Medicaid program. Per member per month reimbursement for PHP also increased effective October 1, 2006, and PHP supplemental revenues increased year over year. Total average membership in PHP and AAHP decreased slightly from approximately 100,300 during fiscal 2006 to approximately 99,500 during fiscal 2007.

Costs and Expenses. Total costs and expenses, exclusive of income taxes and discontinued operations, were $2,705.9 million or 104.8% of total revenues during fiscal 2007 compared to 98.4% during fiscal 2006. Fiscal 2007 costs and expenses were negatively impacted by the impairment loss related to our Chicago hospitals and significant increases in net interest and depreciation and amortization. Salaries and benefits, supplies, medical claims and provision for doubtful accounts represent our most significant individual costs and expenses or those subject to the greatest level of fluctuation period over period.

- **Salaries and benefits.** Salaries and benefits as a percentage of total revenues increased to 41.4% during fiscal 2007 from 41.0% during fiscal 2006 primarily as a result of salaries and benefits pressures in our Phoenix market. The national nursing shortage has been particularly challenging in Phoenix during the past few years. Our salaries and benefits at our Phoenix hospitals increased by 2.5% of patient service revenues year over year primarily due to a 6.5% year over year increase in total hospital employed and contract labor full-time equivalents and the limited revenue growth previously discussed. We were

successful in building our employed nurse workforce in Phoenix and decreasing our dependence on contract labor in light of the nursing shortage. We also successfully negotiated a new three-year union contract with a significant portion of our nurse workforce in Massachusetts during fiscal 2007.

- **Supplies**. Supplies as a percentage of total revenues remained flat at 16.3% year over year. Supplies as a percentage of patient service revenues increased slightly to 19.4% during fiscal 2007 compared to 19.3% during fiscal 2006. Advances in medical technologies and new medications continue to pressure our supplies costs. We added additional corporate resources and increased our focus on supply chain management and group purchasing organization compliance during fiscal 2007 to manage supplies utilization.

- **Medical claims expense**. Medical claims expense as a percentage of premium revenues increased from 72.1% during fiscal 2006 to 74.0% during fiscal 2007 primarily as a result of increased healthcare utilization by PHP enrollees during fiscal 2007. Inpatient days for PHP enrollees increased by 3.5% year over year. Medical claims expense represents the amounts paid by the health plans for healthcare services provided to their members, including an estimate of incurred but not reported claims that is determined based upon lag data and other actuarial assumptions. Revenues and expenses between the health plans and our hospitals and related outpatient service providers of approximately $34.2 million, or 10.3% of gross health plan medical claims expense, were eliminated in consolidation during fiscal 2007.

- **Provision for doubtful accounts**. During fiscal 2007, the provision for doubtful accounts as a percentage of patient service revenues increased to 8.0% from 7.7% during fiscal 2006. During fiscal 2007, self-pay revenues as a percentage of net patient revenues increased from 9.2% to 9.7%. Self-pay discharges as a percentage of total discharges increased from 3.2% during fiscal 2006 to 3.7% during fiscal 2007. Our provision for doubtful accounts as a percentage of patient service revenues is reduced by our policy of deducting charity accounts from revenues at the time in which those accounts meet our charity care guidelines. On a combined basis, the provision for doubtful accounts and charity care deductions as a percentage of patient service revenues increased to 12.0% during fiscal 2007 compared to 11.2% during fiscal 2006.

Other operating expenses. Other operating expenses include, among others, purchased services, insurance, property taxes, rents and leases, repairs and maintenance and utilities. Other operating expenses as a percentage of total revenues were relatively flat year over year. We continue to incur increasing physician costs for coverage in our emergency rooms and other specialty programs. Our repairs and maintenance costs also increased year over year as we began to roll out portions of our quality information systems in our hospitals.

Other. Depreciation and amortization as a percentage of total revenues increased to 4.6% during fiscal 2007 compared to 4.1% during fiscal 2006 as a result of our capital improvement and expansion initiatives. Four of our six significant expansion projects were placed into service during fiscal 2007 and portions of the other two were completed during fiscal 2007. The increase in net interest as a percentage of total revenues to 4.8% during fiscal 2007 compared to 4.3% during fiscal 2006 resulted primarily from our incurring interest on the September 2005 $175.0 million delayed draw term loan borrowing for all 12 months of fiscal 2007 and increased LIBOR rates on our term loan borrowings. As previously discussed, we incurred a $123.8 million ($110.5 million, net of tax benefit) impairment loss during fiscal 2007 related to our Chicago hospitals.

Income taxes. The effective tax rate decreased from 44.8% in fiscal 2006 to 9.3% in fiscal 2007. The significant decrease is due to the majority of the Chicago impairment loss during fiscal 2007 being nondeductible for tax purposes.

Discontinued operations. The significant year over year increase in loss from discontinued operations, net of taxes, primarily relates to the deterioration in the operating results of PMH during fiscal 2007 that led to our decision to eliminate acute care services at PMH.

Net income. The $145.6 million year over year decrease in net income resulted primarily from the after tax impact of the impairment loss recorded during fiscal 2007 and the significant increases in depreciation and amortization and net interest discussed above.

Liquidity and Capital Resources

Operating Activities

At June 30, 2008, we had working capital of $217.8 million, including cash and cash equivalents of $141.6 million. Working capital at June 30, 2007 was $156.4 million. Cash provided by operating activities increased from $123.3 million during fiscal 2007 to $173.1 million during fiscal 2008. The significant increase was primarily due to improved operating results, improved collections of outstanding receivables and more efficient cash management processes.

Investing Activities

Cash used in investing activities increased from $118.5 million during fiscal 2007 to $143.8 million during fiscal 2008. We received $37.0 million of cash proceeds from the sale of the California hospitals during fiscal 2007. During fiscal 2008, capital expenditures were $121.6 million and decreased by $42.7 million from fiscal 2007 primarily due to the completion of our spending related to the significant expansion projects in Phoenix and San Antonio during fiscal 2007. During fiscal 2008, cash used in investing activities was negatively impacted by our inability to liquidate $26.3 million of investments in student loan-backed auction rate securities due to the global credit crisis that resulted in failed auctions of these securities.

We anticipate spending a total of $170.0 million to $190.0 million in capital expenditures during fiscal 2009. This estimate includes the remaining expenditures for our clinical information systems upgrades necessary to support our quality initiatives and all other renovation projects and technology upgrades at our facilities. These capital expenditures will be funded by cash flows from operations and availability under our revolving credit facility. We believe our capital expenditure program is sufficient to service, expand and improve our existing facilities to meet our quality objectives and growth strategies.

Financing Activities

Cash used in financing activities decreased from $8.3 million during fiscal 2007 to $7.8 million during fiscal 2008.

As of June 30, 2008, we had outstanding $1,537.5 million in aggregate indebtedness and $222.0 million of available borrowing capacity under our revolving credit facility ($250.0 million net of outstanding letters of credit of $28.0 million). Our liquidity requirements are significant, primarily due to debt service requirements. Our estimated remaining principal and interest due on our outstanding debt borrowings exceeds $2.0 billion through our fiscal year ending June 30, 2016. The 9.0% Notes require semi-annual interest payments. However, prior to October 1, 2009, the interest expense on the 11.25% Notes consists solely of non-cash accretions of principal.

On September 26, 2005, we refinanced and repriced all $795.7 million of the then outstanding term loans under the initial term loan facility by borrowing $795.7 million of replacement term loans (the "2005 term loan facility").

The 2005 term loan facility borrowings bear interest at a rate equal to, at our option, a base rate plus 1.25% per annum or LIBOR plus 2.25% per annum. These rates reflect a savings of 1.0% per annum over the interest rate options for our previous initial term loan facility. The borrowings under the revolving credit facility currently bear interest at a rate equal to, at our option, a base rate plus 1.25% per annum or LIBOR plus 2.25% per annum. These rates are subject to increase by up to 0.25% per annum should our leverage ratio exceed certain designated levels.

In April 2008, we entered into an interest rate swap agreement with Bank of America, N.A. that went into effect on June 30, 2008. We will continue to make our usual quarterly term debt interest payments at a rate equal to the 90-day LIBOR rate plus 2.25%. In addition, we will begin making quarterly fixed interest payments on

September 30, 2008 at a rate equal to 2.785% on a notional $450.0 million of our term debt in exchange for payments to us from Bank of America, N.A. based upon the applicable variable 90-day LIBOR rate on the same notional amount. We account for this swap as a highly effective cash flow hedge with critical terms that substantially match the underlying term debt and will measure any ineffectiveness using the hypothetical derivative method. We will make quarterly adjustments to other comprehensive income equal to the change in the fair value of the swap from quarter to quarter until the maturity of the swap on March 31, 2010. As of June 30, 2008, the estimated fair value of the interest rate swap was an asset for Vanguard of approximately $2.8 million (net of taxes).

We are required to pay a commitment fee to the lenders under the revolving credit facility in respect of the unutilized commitments thereunder at a rate equal to 0.50% per annum. We also pay customary letter of credit fees.

The 2005 term loan facility and the revolving credit facility contain a number of covenants that, among other things, restrict, subject to certain exceptions, our ability, and the ability of our subsidiaries, to sell assets, incur additional indebtedness or issue preferred stock, repay other indebtedness (including the 9.0% Notes and 11.25% Notes), pay dividends and distributions or repurchase our capital stock, create liens on assets, make investments, loans or advances, make certain acquisitions, engage in mergers or consolidations, enter into sale and leaseback transactions, engage in certain transactions with affiliates, amend certain material agreements governing our indebtedness, including the 9.0% Notes and 11.25% Notes, change the business conducted by our subsidiaries and enter into certain hedging agreements. In addition, the senior credit facilities require us to maintain the following financial covenants: a maximum total leverage ratio, a maximum senior leverage ratio, a minimum interest coverage ratio and a maximum capital expenditures limitation.

As of June 30, 2008, our capital expenditures, as defined in the senior credit agreement, were in compliance with our capital expenditures covenant, and we were also in compliance with the other debt covenant ratios as defined in our senior secured credit agreement, as follows.

	Debt Covenant Ratio	Actual Ratio
Interest coverage ratio requirement	2.00x	2.85x
Total leverage ratio limit	5.75x	4.26x
Senior leverage ratio limit	3.50x	2.15x

The table below summarizes our credit ratings as of the date of the filing of this report.

	Standard & Poor's	Moody's
Corporate credit rating	B	B2
9% Senior Subordinated Notes	CCC+	Caa1
11¼% Senior Discount Notes	CCC+	Caa1
Senior credit facilities	B+	Ba3

We expect that cash generated from our operations and cash available under our revolving credit facility will be sufficient to meet our working capital needs, debt service requirements and planned capital expenditure programs that we consider necessary to continue our growth during the next twelve months and into the foreseeable future. However, we cannot assure you that our operations will generate sufficient cash or that future borrowings under our refinanced senior credit facilities will be available to enable us to meet these requirements and needs.

We continually assess our capital structure to ensure the optimal mix of debt and equity. As market conditions warrant, we and our primary equity sponsors, including The Blackstone Group L.P. and its affiliates, may from time to time, at our or their sole discretion, purchase, repay, redeem or retire any of our outstanding 9.0% Notes, 11.25% Notes, term or revolving loan borrowings or equity securities (including any publicly issued securities) in privately negotiated or open market transactions, by tender offer or otherwise.

We also intend to continue to pursue acquisitions or partnering arrangements, either in existing markets or new markets, which fit our growth strategies. To finance such transactions, we may draw upon amounts available under our revolving credit facility or seek additional funding sources. However, if our operating results and borrowing capacities do not sufficiently support these capital projects or acquisition opportunities, our growth strategies may not be fully realized. Our future operating performance, ability to service or refinance our debt and ability to utilize other sources of capital will be subject to future economic conditions and other business factors, many of which are beyond our control.

Guarantees and Off Balance Sheet Arrangements

We are a party to certain rent shortfall agreements with certain unconsolidated entities, physician income guarantees and service agreement guarantees and other guarantee arrangements, including parent-subsidiary guarantees, in the ordinary course of business. We have not engaged in any transaction or arrangement with an unconsolidated entity that is reasonably likely to materially affect liquidity.

Obligations and Commitments

The following table reflects a summary of obligations and commitments outstanding, including both the principal and interest portions of long-term debt and capital leases, with payment dates as of June 30, 2008.

	Payments due by period				
	Within 1 year	During Years 2-3	During Years 4-5	After 5 years	Total
Contractual Cash Obligations:			*(In millions)*		
Long-term debt (1)	$ 98.5	$ 220.2	$ 911.8	$ 941.5	$ 2,172.0
Operating leases (2)	33.6	53.6	37.0	55.8	180.0
Purchase obligations (2)	18.9	–	–	–	18.9
Health claims payable (3)	51.1	–	–	–	51.1
Estimated self-insurance liabilities (4)	20.5	44.4	22.2	7.4	94.5
Subtotal	$ 222.6	$ 318.2	$ 971.0	$ 1,004.7	$ 2,516.5

	Within 1 year	During Years 2-3	During Years 4-5	After 5 years	Total
Other Commitments:			*(In millions)*		
Construction and capital improvements (5)	$ 24.1	$ 5.4	$ –	$ –	$ 29.5
Guarantees of surety bonds (6)	22.0	–	–	–	22.0
Letters of credit (7)	–	28.0	–	–	28.0
Physician commitments (8)	5.3	–	–	–	5.3
FIN 48 net liability (9)	0.6	–	–	–	0.6
Subtotal	$ 52.0	$ 33.4	$ –	$ –	$ 85.4
Total obligations and commitments	$ 274.6	$ 351.6	$ 971.0	$ 1,004.7	$ 2,601.9

(1) Includes both principal and interest portions of outstanding debt. The interest portion of our debt assumes an approximate 5.0% rate over the remaining term of the debt.

(2) These obligations are not reflected in our consolidated balance sheets.

(3) Represents estimated payments to be made in future periods for healthcare costs incurred by enrollees in PHP, AAHP and MHP and is separately stated on our consolidated balance sheets.

(4) Includes the current and long-term portions of our professional and general liability, workers' compensation and employee health reserves.

(5) Represents our estimate of amounts we are committed to fund in future periods through executed agreements to complete projects included as construction in progress on our consolidated balance sheets.

(6) Represents performance bonds we have purchased related to medical claims liabilities of PHP.

(7) Amounts relate primarily to instances in which we have letters of credit outstanding with the third party administrator of our self-insured workers' compensation program.

(8) Includes physician guarantee liabilities recognized in our consolidated balance sheets under the provisions of FSP 45-3, *Application of FASB Interpretation No. 45 to Minimum Revenue Guarantees Granted to a Business or Its Owners*, and liabilities for other fixed expenses under physician relocation agreements not yet paid.

(9) Represents expected future tax liabilities determined under the provisions of FIN 48.

Healthcare Reform

In recent years, an increasing number of legislative proposals have been introduced or proposed to Congress and in some state legislatures that would significantly affect the services provided by and reimbursement to healthcare providers in our markets. The cost of certain proposals would be funded in significant part by reduction in payments by government programs, including Medicare and Medicaid, to healthcare providers or by taxes levied on hospitals or other providers. While we are unable to predict which, if any, proposals for healthcare reform will be adopted, we cannot assure you that proposals adverse to our business will not be adopted.

Federal and State Regulation and Investigations

The healthcare industry is subject to extensive federal, state and local laws and regulations relating to licensing, conduct of operations, ownership of facilities, addition of facilities and services, confidentiality and security issues associated with medical records, financial arrangements with physicians and other referral sources, and billing for services and prices for services. These laws and regulations are extremely complex and the penalties for violations are severe. In many instances, the industry does not have the benefit of significant regulatory or judicial interpretation of these laws and regulations. As a result of these laws and regulations, some of our activities could become the subject of governmental investigations or inquiries. Both federal and state government agencies have heightened and coordinated civil and criminal enforcement efforts as part of numerous ongoing investigations of hospital companies. Several hospital companies have settled allegations raised during such investigations for substantial sums out of concern for the possible exclusion from the Medicare and Medicaid programs. In the event of a determination that we are in violation of any of these laws, rules or regulations, or if further changes in the regulatory framework occur, our results of operations could be adversely affected.

Effects of Inflation and Changing Prices

Various federal, state and local laws have been enacted that, in certain cases, limit our ability to increase prices. Revenues for acute hospital services rendered to Medicare patients are established under the federal government's prospective payment system. We believe that hospital industry operating margins have been, and may continue to be, under significant pressure because of changes in payer mix and growth in operating expenses in excess of the increase in prospective payments under the Medicare program. In addition, as a result of increasing regulatory and competitive pressures, our ability to maintain operating margins through price increases to non-Medicare patients is limited.

Item 7A. Quantitative and Qualitative Disclosures About Market Risk.

We are subject to market risk from exposure to changes in interest rates based on our financing, investing, and cash management activities. As of June 30, 2008, we had in place $1,024.1 million of senior credit facilities bearing interest at variable rates at specified margins above either the agent bank's alternate base rate or its LIBOR rate. The senior credit facilities consist of $774.1 million in term loans maturing in September 2011 and a $250.0 million revolving credit facility maturing in September 2010 (of which $28.0 million of capacity was utilized by outstanding letters of credit as of June 30, 2008). Although changes in the alternate base rate or the LIBOR rate would affect the cost of funds borrowed in the future, we believe the effect, if any, of reasonably possible near-term changes in interest rates would not be material to our results of operations or cash flows. The variable interest rate risk is partially mitigated by the interest rate swap that became effective on June 30, 2008, as discussed below.

Our $250.0 million revolving credit facility bears interest at the alternate base rate plus a margin ranging from 1.00%-1.50% per annum or the LIBOR rate plus a margin ranging from 2.00%-2.50% per annum, in each case dependent upon our leverage ratio. Our revolving credit facility matures in September 2010. Our $774.1 million in outstanding term loans bear interest at the alternate base rate plus a margin of 1.25% per annum or the LIBOR rate plus a margin of 2.25% per annum and mature in September 2011. The interest rate related to the unhedged term loans was approximately 5.1% as of June 30, 2008.

In April 2008, we entered into an interest rate swap agreement with Bank of America, N.A. that became effective on June 30, 2008. We continue to make our usual quarterly term debt interest payments at a rate equal to the 90-day LIBOR rate plus 2.25%. In addition, we will begin making quarterly fixed interest payments on

September 30, 2008 at a rate equal to 2.785% on a notional $450.0 million of our term debt in exchange for payments to us from Bank of America, N.A. based upon the applicable variable 90-day LIBOR rate on the same notional amount. We account for this swap as a highly effective cash flow hedge with critical terms that substantially match the underlying term debt and will measure any ineffectiveness using the hypothetical derivative method. We will make quarterly adjustments to other comprehensive income equal to the change in the fair value of the swap from quarter to quarter until the maturity of the swap on March 31, 2010. As of June 30, 2008, the estimated fair value of the interest rate swap was an asset for Vanguard of approximately $2.8 million (net of taxes).

We use derivatives such as interest rate swaps from time to time to manage our market risk associated with variable rate debt or similar derivatives for fixed rate debt. We do not hold or issue derivative instruments for trading purposes and are not a party to any instruments with leverage features.

At June 30, 2008, we held $26.3 million par value investments in auction rate securities ("ARS") backed by student loans. Our ARS have maturity dates ranging from 2039 to 2043. Despite the underlying long-term maturity of ARS, these securities have been priced and traded as short-term investments as a result of a Dutch auction process that resets the ARS interest rates at predetermined periods ranging from 7 to 35 days. Historically, the Dutch auction process has enabled us to liquidate our ARS prior to each fiscal quarter-end. However, due to liquidity issues affecting the global credit and capital markets, the auctions for our remaining ARS since February 2008 have "failed", and we were unable to liquidate these ARS as of June 30, 2008. A failed auction does not result in default of the debt instrument. The ARS continue to accrue interest until a successful auction occurs, the issuer calls the securities or the securities mature. We accepted a par value tender of approximately $3.7 million of our previously outstanding ARS during May 2008. The ARS continue to accrue interest until a successful auction occurs, the issuer calls the securities or the securities mature.

Our ARS were rated "AAA" by one or more major credit rating agencies at June 30, 2008 based on their most recent ratings update. The ratings take into account insurance policies guaranteeing both the principal and accrued interest of the investments. The U.S. government guarantees approximately 96%-98% of the principal and accrued interest on each investment in student loans under the Federal Family Education Loan Program or similar programs.

Based upon the tender completed in May 2008 for a portion of our ARS and additional available market information, we believe that the remaining $26.3 million par value of our ARS will become liquid during the next 12 months. Thus, we classified the ARS as current marketable securities on our consolidated balance sheet as of June 30, 2008. We determined that the fair value of the ARS approximated par value due to their expected short-term liquidation with no expectation of liquidation discounts. We will continue to monitor market conditions for this type of ARS to ensure that our classification and fair value estimate remain appropriate. Should market conditions in future periods warrant a reclassification or other than temporary impairment of our ARS, we do not believe our financial position, results of operations, cash flows or compliance with debt covenants would be materially impacted. We believe that we currently have adequate working capital to fund operations during the near future based on access to cash and cash equivalents, expected operating cash flows and availability under our revolving credit facility. We do not expect that our holding of the ARS until market conditions improve will significantly adversely impact our operating cash flows.

Item 8. Financial Statements and Supplementary Data.

INDEX TO AUDITED CONSOLIDATED FINANCIAL STATEMENTS

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

Board of Directors
Vanguard Health Systems, Inc.

We have audited the accompanying consolidated balance sheets of Vanguard Health Systems, Inc. as of June 30, 2008 and 2007 and the related consolidated statements of operations, stockholders' equity and cash flows for each of the three years in the period ended June 30, 2008. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. We were not engaged to perform an audit of the Company's internal control over financial reporting. Our audits included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Vanguard Health Systems, Inc. at June 30, 2008 and 2007 and the consolidated results of its operations and its cash flows for each of the three years in the period ended June 30, 2008, in conformity with U.S. generally accepted accounting principles.

As discussed in Note 9 to the consolidated financial statements, the Company adopted FASB Interpretation No. 48, *Accounting for Uncertainty in Income Taxes – An Interpretation of FASB Statement No. 109*, effective July 1, 2007.

/s/ Ernst & Young LLP

Nashville, Tennessee
September 15, 2008

VANGUARD HEALTH SYSTEMS, INC.
CONSOLIDATED BALANCE SHEETS

	June 30, 2007	June 30, 2008
	(In millions except share and per share amounts)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 120.1	$ 141.6
Restricted cash	6.2	2.1
Marketable securities	–	26.3
Accounts receivable, net of allowance for doubtful accounts of approximately $113.2 and $117.7 at June 30, 2007 and 2008, respectively	287.3	300.4
Inventories	46.8	49.2
Prepaid expenses and other current assets	64.4	80.3
Total current assets	524.8	599.9
Property, plant and equipment, net of accumulated depreciation	1,186.6	1,174.0
Goodwill	689.2	689.2
Intangible assets, net of accumulated amortization	68.0	61.4
Investments in and advances to affiliates	7.3	6.0
Other assets	62.2	51.8
Total assets	$ 2,538.1	$ 2,582.3
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Accounts payable	$ 144.1	$ 162.8
Accrued salaries and benefits	75.0	97.4
Accrued health claims	61.4	51.1
Accrued interest	13.4	13.2
Other accrued expenses and current liabilities	66.5	49.6
Current maturities of long-term debt	8.0	8.0
Total current liabilities	368.4	382.1
Minority interests in equity of consolidated entities	9.3	9.1
Other liabilities	82.3	97.0
Long-term debt, less current maturities	1,520.7	1,529.5
Commitments and contingencies		
Stockholders' equity:		
Common Stock; $.01 par value, 1,000,000 shares authorized, 749,550 shares issued and outstanding at June 30, 2007 and 2008, respectively	–	–
Additional paid-in capital	644.6	647.1
Accumulated other comprehensive income	–	2.8
Retained deficit	(87.2)	(85.3)
Total stockholders' equity	557.4	564.6
Total liabilities and stockholders' equity	$ 2,538.1	$ 2,582.3

See accompanying notes.

VANGUARD HEALTH SYSTEMS, INC.
CONSOLIDATED STATEMENTS OF OPERATIONS

	For the Year Ended June 30,		
	2006	2007	2008
		(In millions)	
Patient service revenues	$ 2,043.6	$ 2,179.3	$ 2,340.5
Premium revenues	375.0	401.4	450.2
Total revenues	2,418.6	2,580.7	2,790.7
Costs and expenses:			
Salaries and benefits (includes stock compensation of $1.7, $1.2 and $2.5, respectively)	991.4	1,067.9	1,152.7
Supplies	394.1	421.8	434.5
Medical claims expense	270.3	297.0	328.2
Purchased services	128.1	141.2	149.5
Provision for doubtful accounts	156.8	175.2	205.6
Other operating expenses	191.0	196.4	214.5
Rents and leases	33.9	37.4	41.8
Depreciation and amortization	100.3	118.6	131.0
Interest, net	103.8	123.8	122.1
Debt extinguishment costs	0.1	–	–
Impairment loss	–	123.8	–
Other expenses	9.1	2.8	9.5
Income (loss) from continuing operations before income taxes	39.7	(125.2)	1.3
Income tax expense (benefit)	17.8	(11.6)	1.7
Income (loss) from continuing operations	21.9	(113.6)	(0.4)
Loss from discontinued operations, net of taxes	(9.0)	(19.1)	(0.3)
Net income (loss)	$ 12.9	$ (132.7)	$ (0.7)

See accompanying notes.

VANGUARD HEALTH SYSTEMS, INC.
CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

	Common Stock		Additional Paid-In Capital	Accumulated Other Comprehensive Income	Retained Earnings (Deficit)	Total Stockholders' Equity
	Shares	Amount				
			(In millions, except share amounts)			
Balance at June 30, 2005	749,550	$ –	$ 643.2	$ –	$ 32.6	$ 675.8
Stock compensation (non-cash)	–	–	1.7	–	–	1.7
Repurchase of equity incentive units	–	–	(1.5)	–	–	(1.5)
Issuance of common stock	141	–	0.1	–	–	0.1
Repurchase of common stock	(141)	–	(0.1)	–	–	(0.1)
Adjustment to income tax effect of options payouts in connection with merger	–	–	0.3	–	–	0.3
Net income	–	–	–	–	12.9	12.9
Balance at June 30, 2006	749,550	–	643.7	–	45.5	689.2
Stock compensation (non-cash)	–	–	1.2	–	–	1.2
Repurchase of equity incentive units	–	–	(0.2)	–	–	(0.2)
Issuance of common stock	195	–	0.2	–	–	0.2
Repurchase of common stock	(195)	–	(0.3)	–	–	(0.3)
Net loss	–	–	–	–	(132.7)	(132.7)
Balance at June 30, 2007	749,550	–	644.6	–	(87.2)	557.4
Stock compensation (non-cash)	–	–	2.5	–	–	2.5
Issuance of common stock	168	–	0.2	–	–	0.2
Repurchase of common stock	(168)	–	(0.2)	–	–	(0.2)
Cumulative effect of adoption of FIN 48	–	–	–	–	2.6	2.6
Comprehensive income:						
Fair value of interest rate swap (net of tax effect)	–	–	–	2.8	–	2.8
Net loss	–	–	–	–	(0.7)	(0.7)
Total comprehensive income	–	–	–	2.8	(0.7)	2.1
Balance at June 30, 2008	749,550	$ –	$ 647.1	$ 2.8	$ (85.3)	$ 564.6

See accompanying notes.

VANGUARD HEALTH SYSTEMS, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS

	For the Year Ended June 30,		
	2006	2007	2008
		(In millions)	
Operating activities:			
Net income (loss)	$ 12.9	$ (132.7)	$ (0.7)
Adjustments to reconcile net income (loss) to net cash provided by operating activities			
Loss from discontinued operations	9.0	19.1	0.3
Depreciation and amortization	100.3	118.6	131.0
Provision for doubtful accounts	156.8	175.2	205.6
Amortization of loan costs	4.0	4.5	4.9
Accretion of principal on senior discount notes	15.7	17.5	19.5
Debt extinguishment costs	0.1	–	–
Loss (gain) on disposal of assets	1.5	(4.1)	0.9
Stock compensation	1.7	1.2	2.5
Deferred income taxes	10.1	(12.7)	(2.2)
Impairment loss	–	123.8	–
Changes in operating assets and liabilities, net of effects of acquisitions and dispositions			
Accounts receivable	(162.4)	(204.0)	(223.6)
Inventories	(5.2)	(1.9)	(4.1)
Prepaid expenses and other current assets	3.6	(30.0)	(19.7)
Accounts payable	2.4	7.4	19.9
Accrued expenses and other liabilities	(11.9)	37.8	37.3
Net cash provided by operating activities – continuing operations	138.6	119.7	171.6
Net cash provided by operating activities – discontinued operations	10.7	3.6	1.5
Net cash provided by operating activities	149.3	123.3	173.1
Investing activities:			
Acquisitions	(1.2)	(0.2)	(0.2)
Capital expenditures	(275.5)	(164.3)	(121.6)
Proceeds from asset dispositions	11.1	9.5	0.4
Purchases of marketable securities	(128.4)	(120.0)	(90.0)
Sales of marketable securities	128.4	120.0	63.7
Other	0.6	2.0	1.1
Net cash used in investing activities – continuing operations	(265.0)	(153.0)	(146.6)
Net cash provided by investing activities – discontinued operations	19.6	34.5	2.8
Net cash used in investing activities	(245.4)	(118.5)	(143.8)
Financing activities:			
Proceeds from long-term debt	175.0	–	–
Payments of long-term debt and capital leases	(31.4)	(8.0)	(7.8)
Payments of loan costs and debt termination fees	(0.7)	–	–
Payments to retire stock, equity incentive units and stock options	(2.5)	(0.5)	(0.2)
Proceeds from the exercise of stock options	0.1	0.2	0.2
Net cash provided by (used in) financing activities	140.5	(8.3)	(7.8)
Increase (decrease) in cash and cash equivalents	44.4	(3.5)	21.5
Cash and cash equivalents at beginning of year	79.2	123.6	120.1
Cash and cash equivalents at end of year	$ 123.6	$ 120.1	$ 141.6

VANGUARD HEALTH SYSTEMS, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS
(continued)

	For the Year Ended June 30,		
	2006	2007	2008
		(In millions)	
Supplemental cash flow information:			
Net interest paid	$ 101.3	$ 107.8	$ 99.1
Net income taxes paid	$ 2.1	$ 0.9	$ 1.3
Supplemental noncash activities:			
Capitalized interest	$ 8.3	$ 3.0	$ 1.4
Fair value of interest rate swap, net of taxes	$ 2.8	$ –	$ –
Acquisitions:			
Cash paid, net of cash received	$ 1.2	$ 0.2	$ 0.2
Fair value of assets acquired	(3.3)	–	0.2
Liabilities assumed	0.7	–	–
Additional paid-in capital	(0.3)	–	–
Net assets acquired	(4.3)	–	0.2
Goodwill and intangible assets acquired	$ 5.5	$ 0.2	$ –
Dispositions:			
Cash received	$ 28.7	$ 37.0	$ 3.0
Carrying value of assets sold	(14.8)	(42.1)	–
Gain on sale	11.1	–	–
Escrow receivable	–	3.0	(3.0)
Liabilities assumed by buyer	–	5.5	–
Goodwill and intangible assets disposed	$ 2.8	$ 3.4	$ –

See accompanying notes.

1. Business and Basis of Presentation

Business

Vanguard Health Systems, Inc. ("Vanguard") is an investor-owned healthcare company whose affiliates own and operate hospitals and related healthcare businesses in urban and suburban areas. As of June 30, 2008, Vanguard's affiliates owned and managed 15 acute care hospitals with 4,181 licensed beds and related outpatient service locations complementary to the hospitals providing healthcare services in San Antonio, Texas; metropolitan Phoenix, Arizona; metropolitan Chicago, Illinois; and Massachusetts. Vanguard also owns managed health plans in Chicago and Phoenix and two surgery centers in Orange County, California.

Basis of Presentation

The accompanying consolidated financial statements include the accounts of subsidiaries and affiliates controlled by Vanguard. Vanguard generally defines control as the ownership of the majority of an entity's voting interests. Vanguard also consolidates any entities for which it receives the majority of the entity's expected returns or is at risk for the majority of the entity's expected losses based upon its investment or financial interest in the entity. All material intercompany accounts and transactions have been eliminated. Since none of Vanguard's common shares are publicly held, no earnings per share information is presented in the accompanying consolidated financial statements. Certain prior year amounts from the accompanying consolidated balance sheet have been reclassified to conform to current year presentation. The majority of Vanguard's expenses are "cost of revenue" items. Costs that could be classified as general and administrative include certain Vanguard corporate office costs, which approximated $30.6 million, $30.2 million and $44.3 million for the years ended June 30, 2006, 2007 and 2008, respectively.

Use of Estimates

In preparing Vanguard's consolidated financial statements in conformity with accounting principles generally accepted in the United States, management makes estimates and assumptions that affect the amounts recorded or classification of items in the consolidated financial statements and accompanying notes. Actual results could differ from those estimates.

2. Summary of Significant Accounting Policies

Revenues and Revenue Deductions

Vanguard recognizes patient service revenues during the period the healthcare services are provided based upon estimated amounts due from payers. Vanguard estimates contractual adjustments and allowances based upon payment terms set forth in managed care health plan contracts and by federal and state regulations. For the majority of its patient service revenues, Vanguard applies contractual adjustments to patient accounts at the time of billing using specific payer contract terms entered into the accounts receivable systems, but in some cases Vanguard records an estimated allowance until payment is received. Vanguard derives most of its patient service revenues from healthcare services provided to patients with Medicare and related managed Medicare plans or managed care insurance coverage. Medicare was the only individual payer for which Vanguard derived more than 10% of net patient revenues during its fiscal years ended June 30, 2006, 2007 and 2008.

Services provided to Medicare and related managed Medicare patients are generally reimbursed at prospectively determined rates per diagnosis ("PPS"), while services provided to managed care patients are generally reimbursed based upon predetermined rates per diagnosis, per diem rates or discounted fee-for-service rates. Medicaid reimbursements vary by state.

Medicare regulations and Vanguard's principal managed care contracts are often complex and may include multiple reimbursement mechanisms for different types of services provided in its healthcare facilities. To obtain reimbursement for certain services under the Medicare program, Vanguard must submit annual cost reports and record estimates of amounts owed to or receivable from Medicare. These cost reports include complex calculations and estimates related to indirect medical education, reimbursable Medicare bad debts and other items that are often subject to interpretation that could result in payments that differ from recorded estimates. Vanguard estimates amounts owed to or receivable from the Medicare program using the best information available and its interpretation of the applicable Medicare regulations. Vanguard includes differences between original estimates and subsequent revisions to those estimates (including final cost report settlements) in the consolidated statements of operations in the period in which the revisions are made. Net adjustments for final third party settlements increased patient service revenues and income from continuing operations before income taxes by $8.6 million, $6.3 million and $7.9 million during the years ended June 30, 2006, 2007 and 2008, respectively. Additionally, updated regulations and contract negotiations occur frequently, which necessitates continual review of estimation processes by management. Management believes that future adjustments to its current third party settlement estimates will not significantly impact Vanguard's results of operations or financial position.

Vanguard does not pursue collection of amounts due from uninsured patients that qualify for charity care under its guidelines (currently those uninsured patients whose incomes are equal to or less than 200% of the current federal poverty guidelines set forth by the Department of Health and Human Services). Vanguard deducts charity care accounts from revenues when it determines that the account meets its charity care guidelines. Vanguard also provides discounts from billed charges and alternative payment structures for uninsured patients who do not qualify for charity care but meet certain other minimum income guidelines, primarily those uninsured patients with incomes between 200% and 500% of the federal poverty guidelines. During the years ended June 30, 2006, 2007 and 2008, Vanguard deducted $71.1 million, $86.1 million and $86.1 million of charity care from revenues, respectively.

During the third quarter of its fiscal year ended June 30, 2007, Vanguard was approved to receive payments under the Bexar County, Texas upper payment limit ("UPL") Medicaid payment program. UPL programs allow private hospitals to enter into indigent care affiliation agreements with governmental entities. Within the parameters of these programs, private hospitals expand charity care services to indigent patients and alleviate expenses for the governmental entity. The governmental entity is then able to utilize its tax revenue to fund the Medicaid program for private hospitals. Vanguard recognizes revenues from the UPL program when Vanguard becomes entitled to the expected reimbursements, including a federal match portion, and such reimbursements are assured.

Vanguard had premium revenues from its health plans of $375.0 million, $401.4 million and $450.2 million during the years ended June 30, 2006, 2007 and 2008, respectively. Vanguard's health plans, Phoenix Health Plan ("PHP"), Abrazo Advantage Health Plan ("AAHP") and MacNeal Health Providers ("MHP"), have agreements with the Arizona Health Care Cost Containment System ("AHCCCS"), Centers for Medicare and Medicaid Services ("CMS") and various health maintenance organizations ("HMOs"), respectively, to contract to provide medical services to subscribing participants. Under these agreements, Vanguard's health plans receive monthly payments based on the number of HMO participants in MHP or the number and coverage type of enrollees in PHP and AAHP. Vanguard's health plans recognize the payments as revenues in the month in which members are entitled to healthcare services with the exception of AAHP Medicare Part D reinsurance premiums and low income subsidy cost sharing premiums that are recorded as a liability to fund future healthcare costs or else repaid to the government.

Cash and Cash Equivalents

Vanguard considers all highly liquid investments with maturity of 90 days or less when purchased to be cash equivalents. Vanguard manages its credit exposure by placing its investments in high quality securities and by periodically evaluating the relative credit standing of the financial institutions holding its cash and investments.

Restricted Cash

As of June 30, 2008 and 2007, Vanguard had restricted cash balances of $2.1 million and $6.2 million, respectively. These balances primarily represent restricted cash accounts related to liquidity requirements of AAHP and certain other arrangements.

Marketable Securities

At June 30, 2008, Vanguard held $26.3 million par value investments in auction rate securities ("ARS") backed by student loans. The ARS have maturity dates ranging from 2039 to 2043. Despite the underlying long-term maturity of the ARS, these securities have been priced and traded as short-term investments as a result of a Dutch auction process that resets the ARS interest rates at predetermined periods ranging from 7 to 35 days. Historically, the Dutch auction process has enabled Vanguard to liquidate its ARS prior to each fiscal quarter-end. However, due to liquidity issues affecting the global credit and capital markets, the auctions for these ARS since February 2008 have "failed", and Vanguard was unable to liquidate these ARS as of June 30, 2008. A failed auction does not result in default of the debt instrument. The ARS continue to accrue interest until a successful auction occurs, the issuer calls the securities or the securities mature. During May 2008, Vanguard liquidated approximately $3.7 million of the $30.0 million ARS it held as of March 31, 2008 at par value plus accrued interest through a tender from the holder leaving $26.3 million of ARS outstanding as of June 30, 2008.

Vanguard's ARS were rated "AAA" by one or more major credit rating agencies at June 30, 2008. The ratings take into account insurance policies guaranteeing both the principal and accrued interest of the investments. The U.S. government guarantees approximately 96%-98% of the principal and accrued interest on each investment in student loans under the Federal Family Education Loan Program or other similar programs.

Based upon the ARS successfully liquidated in May 2008 and additional available market information, Vanguard believes that the remaining $26.3 million par value of its ARS will become liquid during fiscal 2009. Thus, Vanguard has classified the ARS as current available-for-sale marketable securities under SFAS 115, *Accounting for Certain Investments in Debt and Equity* Securities ("SFAS 115"), on its consolidated balance sheet as of June 30, 2008. Vanguard determined that the fair value of the ARS, as required by SFAS 115, approximated par value due to the expected short-term liquidation of these marketable securities with no expectation of significant liquidation discounts supported by the governmental guarantee of the ARS. Vanguard intends and has the ability to hold the ARS until liquidation. Vanguard will continue to monitor market conditions for this type of ARS to ensure that its classification and fair value estimate for the ARS remain appropriate in future periods.

If Vanguard sells any of the ARS, prior to maturity, at an amount below carrying value, or if it becomes probable that Vanguard will not receive full par value and accrued interest as to any of the ARS, Vanguard will be required to recognize an other-than-temporary impairment.

Accounts Receivable

Vanguard's primary concentration of credit risk is patient accounts receivable, which consists of amounts owed by various governmental agencies, insurance companies and private patients. Vanguard manages the receivables by regularly reviewing its accounts and contracts and by providing appropriate allowances for contractual discounts and uncollectible amounts. Vanguard typically writes off uncollected accounts receivable 180 days subsequent to discharge date. Medicare program net receivables, including managed Medicare receivables, comprised approximately 29% and 31% of net patient receivables as of June 30, 2007 and 2008, respectively. Medicare revenues are included in the acute care services operating segment. Receivables from various state Medicaid programs and managed Medicaid programs comprised approximately 24% and 23% of net patient receivables as of June 30, 2007 and 2008, respectively. Remaining receivables relate primarily to various HMO and Preferred Provider Organization ("PPO") payers, commercial insurers and private patients. Concentration of credit risk for these payers is limited by the number of patients and payers.

Effective July 1, 2007, Vanguard began estimating the allowance for doubtful accounts using a standard policy that reserves 100% of all accounts aged greater than 365 days subsequent to discharge date plus 85% of uninsured accounts less than 365 days old plus 40% of self-pay after insurance/Medicare less than 365 days old.

Vanguard's previous policy reserved all accounts greater than 180 days plus a market-specific percentage of uninsured and self-pay after insurance/Medicare balances. Effective June 30, 2008, Vanguard adjusted its policy to reserve for all accounts aged greater than 365 days subsequent to discharge date plus 92% of uninsured accounts less than 365 days old plus 45% of self-pay after insurance/Medicare less than 365 days old. These changes in policy negatively impacted Vanguard's provision for doubtful accounts during the year ended June 30, 2008. However, management believes the revised policy will adjust more quickly to payer mix shifts over time. Vanguard tests its allowance for doubtful accounts policy quarterly using a hindsight calculation that utilizes write-off data for all payer classes during the previous twelve-month period to estimate the allowance for doubtful accounts at a point in time. Vanguard also supplements its analysis by comparing cash collections to net patient revenues and monitoring self-pay utilization. Significant changes in payer mix, business office operations, general economic conditions and healthcare coverage provided by federal or state governments or private insurers may have a significant impact on Vanguard's estimates and significantly affect its results of operations and cash flows.

Vanguard classifies accounts pending Medicaid approval as Medicaid accounts in its accounts receivable aging report and records a manual contractual allowance for these accounts equal to the average Medicaid reimbursement rate for that specific state. Vanguard has historically been successful in qualifying approximately 40%-45% of submitted accounts for Medicaid coverage. As of June 30, 2008, Vanguard had approximately $13.0 million of Medicaid pending accounts receivable from continuing operations ($4.1 million of which was stated at gross charges with a manual contractual allowance and $8.9 million of which was stated net of contractual discounts). In the event an account is not successfully qualified for Medicaid coverage and does not meet Vanguard's charity guidelines, the previously recorded Medicaid contractual adjustment remains a revenue deduction (similar to a self-pay discount), and the remaining net account balance is reclassified to uninsured status and subjected to Vanguard's allowance for doubtful accounts policy. During the years ended June 30, 2007 and 2008, approximately $13.2 million and $25.1 million, respectively, of net accounts receivable from continuing operations was reclassified from Medicaid pending status to uninsured status. If accounts do not qualify for Medicaid coverage but do qualify as charity care, the contractual adjustments are reversed and the gross account balances are recorded as charity deductions. During the years ended June 30, 2007 and 2008, Vanguard recorded $6.4 million and $7.1 million, respectively, of charity deductions from continuing operations for the net balances of accounts previously classified as Medicaid pending that did not meet Medicaid eligibility requirements.

Because Vanguard requires patient verification of coverage at the time of admission, reclassifications of Medicare or managed care accounts to self-pay, other than patient coinsurance or deductible amounts, occur infrequently and are not material to its financial statements. Additionally, the impact of these classification changes is further limited by Vanguard's ability to identify any necessary classification changes prior to patient discharge or soon thereafter. Due to information system limitations, Vanguard is unable to quantify patient deductible and coinsurance receivables that are included in the primary payer classification in the accounts receivable aging report at any given point in time. When classification changes occur, the account balance remains aged from the patient discharge date.

A summary of Vanguard's allowance for doubtful accounts activity, including those for discontinued operations, during the three most recent fiscal years follows (in millions).

	Balance at Beginning of Period	Additions Charged to Costs and Expenses	Accounts Written Off, Net of Recoveries	Balance at End of Period
Allowance for doubtful accounts:				
Year ended June 30, 2006	$ 90.1	$ 178.1	$ 164.7	$ 103.5
Year ended June 30, 2007	$ 103.5	$ 191.3	$ 181.6	$ 113.2
Year ended June 30, 2008	$ 113.2	$ 201.0	$ 196.5	$ 117.7

Inventories

Inventories, consisting of medical supplies and pharmaceuticals, are stated at the lower of cost (first-in, first-out) or market.

Property, Plant and Equipment

Purchases of property, plant and equipment are stated at cost. Routine maintenance and repairs are charged to expense as incurred. Expenditures that increase values, change capacities or extend useful lives are capitalized. Depreciation is computed using the straight-line method over the estimated useful lives of the assets, which approximate 18 months to 44 years. Depreciation expense was approximately $97.1 million, $115.4 million and $127.8 million for the years ended June 30, 2006, 2007 and 2008, respectively. Vanguard tests its property, plant and equipment and other long-lived assets for impairment as management becomes aware of impairment indicators.

During fiscal 2006, 2007 and 2008, Vanguard capitalized $8.3 million, $3.0 million and $1.4 million of interest, respectively, associated with certain of its hospital construction and expansion projects. Vanguard estimates that it is contractually obligated to expend approximately $29.5 million related to projects classified as construction in progress as of June 30, 2008. Vanguard also capitalizes costs associated with developing computer software for internal use under the provisions of AICPA Statement of Position 98-1 ("SOP 98-1"). Under SOP 98-1, Vanguard capitalizes both internal and external direct costs, excluding training, during the application development stage primarily for the purpose of customizing vendor software to integrate with our hospitals' information systems. The following table provides the gross asset balances for each major class of asset and total accumulated depreciation as of June 30, 2007 and 2008 (in millions).

	June 30, 2007	June 30, 2008
Class of asset:		
Land and improvements	$ 131.8	$ 143.5
Buildings and improvements	794.2	826.2
Equipment	485.0	558.9
Construction in progress	46.3	40.4
	1,457.3	1,569.0
Less: accumulated depreciation	(270.7)	(395.0)
Net property, plant and equipment	$ 1,186.6	$ 1,174.0

Long-Lived Assets and Goodwill

Long-lived assets, including property, plant and equipment and amortizable intangible assets, comprise a significant portion of Vanguard's total assets. Vanguard evaluates the carrying value of long-lived assets when impairment indicators are present or when circumstances indicate that impairment may exist under the provisions of SFAS 144, *Accounting for the Impairment or Disposal of Long-Lived Assets*. When management believes impairment indicators may exist, projections of the undiscounted future cash flows associated with the use of and eventual disposition of long-lived assets held for use are prepared. If the projections indicate that the carrying values of the long-lived assets are not expected to be recoverable, Vanguard reduces the carrying values to fair value. For long-lived assets held for sale, Vanguard compares the carrying values to an estimate of fair value less selling costs to determine potential impairment. Vanguard tests for impairment of long-lived assets at the lowest level for which cash flows are measurable. These impairment tests are heavily influenced by assumptions and estimates that are subject to change as additional information becomes available. Given the relatively few number of hospitals Vanguard owns and the significant amounts of long-lived assets attributable to those hospitals, an impairment of the long-lived assets for even a single hospital could materially adversely impact its operating results or financial position.

Goodwill also represents a significant portion of Vanguard's total assets. Vanguard reviews goodwill for impairment annually during its fourth fiscal quarter or more frequently if certain impairment indicators arise under the provisions of SFAS 142, *Goodwill and Other Intangible Assets*. Vanguard reviews goodwill at the reporting unit level, which is one level below an operating segment. Vanguard compares the carrying value of the net assets of each reporting unit to the net present value of estimated discounted future cash flows of the reporting unit. If the carrying value exceeds the net present value of estimated discounted future cash flows, an impairment indicator exists and an estimate of the impairment loss is calculated. The fair value calculation includes multiple assumptions

and estimates, including the projected cash flows and discount rates applied. Changes in these assumptions and estimates could result in goodwill impairment that could materially adversely impact Vanguard's results of operations or statement of position.

Amortization of Intangible Assets

Amounts allocated to contract-based intangible assets are amortized over their useful lives, which equal 10 years. No amortization is recorded for indefinite-lived intangible assets. Deferred loan costs and syndication costs are amortized over the life of the applicable credit facility or notes using the effective interest method. Physician income and service agreement guarantee intangible assets are recorded based upon the estimated future payments under the contracts and are amortized over the applicable contract service periods.

Income Taxes

Vanguard accounts for income taxes using the asset and liability method in accordance with SFAS No. 109, *Accounting for Income Taxes* ("SFAS 109") and FASB Interpretation No. 48, *Accounting for Uncertainty in Income Taxes – An Interpretation of FASB Statement No. 109* ("FIN 48"). These guidelines require the recognition of deferred tax assets and liabilities for the expected future tax consequences of temporary differences between the carrying amounts and the tax bases of assets and liabilities.

Vanguard believes that its tax return provisions are accurate and supportable, but certain tax matters require interpretations of tax law that may be subject to future challenge and may not be upheld under tax audit. To reflect the possibility that all of its tax positions may not be sustained, Vanguard maintains tax reserves that are subject to adjustment as updated information becomes available or as circumstances change. Vanguard records the impact of tax reserve changes to its income tax provision in the period in which the additional information, including the progress of tax audits, is obtained.

Vanguard assesses the realization of its deferred tax assets to determine whether an income tax valuation allowance is required. Based on all available evidence, both positive and negative, and the weight of that evidence to the extent such evidence can be objectively verified, Vanguard determines whether it is more likely than not that all or a portion of the deferred tax assets will be realized. The factors used in this determination include the following:

- Cumulative losses in recent years
- Income/losses expected in future years
- Unsettled circumstances that, if favorably resolved, would adversely affect future operations
- Availability, or lack thereof, of taxable income in prior carryback periods that would limit realization of tax benefits
- Carryforward period associated with the deferred tax assets and liabilities
- Prudent and feasible tax planning strategies

In addition, financial forecasts used in determining the need for or amount of federal and state valuation allowances are subject to changes in underlying assumptions and fluctuations in market conditions that could significantly alter Vanguard's recoverability analysis and thus have a material adverse impact on Vanguard's consolidated financial condition, results of operations or cash flows.

Medical Claims Reserves

During the years ended June 30, 2006, 2007 and 2008, medical claims expense was $270.3 million, $297.0 million and $328.2 million, respectively, primarily representing medical claims of PHP. Vanguard estimates PHP's reserve for medical claims using historical claims experience (including cost per member and payment lag time) and other actuarial data including number of enrollees and certain enrollee demographic information. The reserve for medical claims, including incurred but not reported claims, for all Vanguard health plans combined was approximately $61.4 million and $51.1 million as of June 30, 2007 and 2008, respectively. While management believes that its estimation methodology effectively captures trends in medical claims costs, actual payments could differ significantly from its estimates given changes in the healthcare cost structure or adverse experience. During the years ended June 30, 2006, 2007 and 2008, approximately $40.0 million, $34.2 million and $31.2 million,

respectively, of accrued and paid claims for services provided to Vanguard's health plan enrollees by its hospitals and its other healthcare facilities were eliminated in consolidation. Vanguard's operating results and cash flows could be materially affected by increased or decreased utilization of its healthcare facilities by enrollees in its health plans.

Employee Health Insurance

As of June 30, 2008, Vanguard maintained self-insured medical and dental plans for a limited number of its employees. Claims are accrued under the self-insured plans as the incidents that give rise to them occur. Unpaid claims accruals are based on the estimated ultimate cost of settlement, including claim settlement expenses, in accordance with an average lag time and historical experience. The reserve for self-insured medical and dental plans was approximately $1.2 million and $1.5 million as of June 30, 2007 and 2008, respectively, and is included in accrued salaries and benefits in the accompanying consolidated balance sheets. Effective July 1, 2008, Vanguard began covering all of its employees under its self-insured medical and dental plans, which will subject it to higher risks and reserve levels. Vanguard mitigated this risk by purchasing stop-loss coverage for catastrophic claims at a $500,000 per enrollee annual limit.

Insurance Reserves

Given the nature of its operating environment, Vanguard is subject to professional and general liability and workers compensation claims and related lawsuits in the ordinary course of business. For professional and general liability claims incurred from June 1, 2002 to May 31, 2006, Vanguard's wholly owned captive subsidiary insured its professional and general liability risks at a $10.0 million retention level. For professional and general liability claims incurred subsequent to May 31, 2006, Vanguard self-insures the first $9.0 million per claim, and the captive subsidiary insures the next $1.0 million per claim. Vanguard maintains excess coverage from independent third party insurers on a claims-made basis for individual claims exceeding $10.0 million up to $75.0 million, but limited to total annual payments of $65.0 million in the aggregate.

Vanguard insures its excess coverage under a retrospectively rated policy, and premiums under this policy are recorded based on Vanguard's historical claims experience. Vanguard self-insures its workers compensation claims up to $1.0 million per claim and purchases excess insurance coverage for claims exceeding $1.0 million.

The following tables summarize Vanguard's professional and general liability and workers compensation reserve balances as of June 30, 2007 and 2008 and its total provision for professional and general liability and workers compensation losses and related claims payments during the years ended June 30, 2006, 2007 and 2008.

	Professional and General Liability	Workers Compensation
	(In millions)	
Reserve balance:		
June 30, 2007	$ 64.6	$ 18.5
June 30, 2008	$ 74.3	$ 18.8
Provision for claims losses:		
Fiscal Year 2006	$ 21.0	$ 8.9
Fiscal Year 2007	$ 20.2	$ 9.4
Fiscal Year 2008	$ 21.8	$ 5.3
Claims paid:		
Fiscal Year 2006	$ 12.7	$ 6.4
Fiscal Year 2007	$ 14.4	$ 6.2
Fiscal Year 2008	$ 12.1	$ 5.0

Vanguard utilizes actuarial information to estimate its reserves for professional and general liability and workers compensation claims. Each reserve is comprised of estimated indemnity and expense payments related to: (1) reported events ("case reserves") and (2) incurred but not reported ("IBNR") events as of the end of the period. Management uses information from its risk managers and its best judgment to estimate case reserves. Actuarial IBNR estimates are dependent on multiple variables including Vanguard's risk exposures, its self-insurance limits, geographic locations in which it operates, the severity of its historical losses compared to industry averages and the reporting pattern of its historical losses compared to industry averages, among others. Most of these variables require judgment, and changes in these variables could result in significant period over period fluctuations in Vanguard's estimates. Vanguard discounts its workers compensation reserve using actuarial estimates of projected cash payments in future periods. Vanguard adjusts these reserves from time to time as it receives updated information. During its fiscal years ended June 30, 2006, 2007 and 2008, due to changes in historical loss trends, Vanguard decreased its professional and general liability reserve related to prior fiscal years by $6.9 million, $4.5 million and $0.6 million, respectively. Similarly, Vanguard decreased its workers compensation reserve related to prior fiscal years by $2.3 million during its fiscal year ended June 30, 2008. Adjustments to the workers compensation reserve related to prior years during fiscal years ended June 30, 2006 and 2007 were not significant. Additional adjustments to prior year estimates may be necessary in future periods as Vanguard's reporting history and loss portfolio matures.

Market and Labor Risks

Vanguard operates primarily in four geographic markets. If economic or other factors limit its ability to provide healthcare services in one or more of these markets, Vanguard's cash flows and results of operations could be materially adversely impacted. Approximately 1,600 full-time employees in Vanguard's Massachusetts hospitals are subject to collective organizing agreements. This group represents approximately 9% of Vanguard's workforce. During fiscal 2007, Vanguard entered into a new three-year contract with the union representing the majority of this group that ends on December 31, 2009. If Vanguard experiences significant future labor disruptions related to these unionized employees, its cash flows and results of operations could be materially adversely impacted.

Stock-Based Compensation

Vanguard accounts for stock-based employee compensation granted prior to July 1, 2006 under the provisions of Statement of Financial Accounting Standards No. 123, *Accounting for Stock-Based Compensation* ("SFAS 123"). Effective July 1, 2003, Vanguard adopted SFAS 123 on a prospective basis, an acceptable transition method set forth in SFAS No. 148, *Accounting for Stock-Based Compensation Transition and Disclosure* ("SFAS 148"). For grants dated July 1, 2006 and subsequent, Vanguard accounts for stock-based employee compensation under the provisions of Statement of Financial Accounting Standards No. 123(R), *Share-Based Payment* ("SFAS 123(R)"). Vanguard also adopted SFAS 123(R) on a prospective basis and such adoption did not significantly impact Vanguard's results of operations or cash flows.

The following table sets forth the weighted average assumptions utilized in the minimum value pricing model for stock option grants under the 2004 Option Plan prior to July 1, 2006 and those utilized in the Black-Scholes-Merton valuation model for grants under the 2004 Option Plan subsequent to July 1, 2006.

	Minimum Value	Black-Scholes-Merton
Risk-free interest rate	4.5%	4.0%
Dividend yield	0.0%	0.0%
Volatility (annual)	N/A	30.2%
Expected option life	10 years	6.5 years

For stock options included in the Black-Scholes-Merton valuation model, Vanguard used historical stock price information of certain peer group companies for a period of time equal to the expected option life period to determine estimated volatility. Vanguard determined the expected life of the stock options by averaging the contractual life of the options and the vesting period of the options. The estimated fair value of options is amortized to expense on a straight-line basis over the options' vesting period.

Fair Value of Financial Instruments

Cash and Cash Equivalents and Restricted Cash

The carrying amounts reported for cash and cash equivalents and restricted cash approximate fair value because of the short-term maturity of these instruments.

Marketable Securities

The carrying amounts reported for marketable securities approximate fair value because of the expected liquidation of these securities during the fiscal year ending June 30, 2009 at par value.

Accounts Receivable and Accounts Payable

The carrying amounts reported for accounts receivable and accounts payable approximate fair value because of the short-term maturity of these instruments.

Long-Term Debt

The fair values of Vanguard's 9.0% Notes, and 11.25% Notes and term debt as of June 30, 2008 were approximately $577.9 million, $190.1 million and $750.8, respectively, based upon stated market prices. The fair values are subject to change as market conditions change.

Interest Rate Swap

The fair value of Vanguard's interest rate swap as of June 30, 2008 was an asset of $2.8 million, net of taxes, based upon information obtained from the counterparty.

Recently Issued Accounting Pronouncements

In May 2008, the Financial Accounting Standards Board ("FASB") issued Statement of Financial Accounting Standards No. 163, *Accounting for Financial Guarantee Insurance Contracts* ("SFAS 163"). SFAS 163 requires that an insurance entity recognize a claim liability prior to the occurrence of an insured event when evidence of credit deterioration within an insured financial obligation exists. SFAS 163 also sets forth guidance related to the recognition and measurement to be used to account for premium revenues and claim liabilities and provides expanded disclosure requirements. SFAS 163 is effective for Vanguard's fiscal year ending June 30, 2009 and all interim periods within that fiscal year with early application not permitted. Vanguard does not expect the adoption of SFAS 163 to significantly impact its financial position, results of operations or cash flows.

In March 2008, the FASB issued Statement of Financial Accounting Standards No. 161, *Disclosure About Derivative Instruments and Hedging Activities – an amendment of FASB Statement No. 133* ("SFAS 161"). SFAS 161 requires enhanced disclosures about an entity's derivative and hedging activities to improve the financial reporting for these derivative instruments. These disclosures include how and why an entity uses derivative instruments, the accounting treatment of the instruments under SFAS 133 and related interpretations and how the instruments affect the entity's financial position, results of operations and cash flows. SFAS 161 also requires tabular presentation of the fair values of derivatives and their related gains and losses. SFAS 161 is effective for Vanguard's fiscal quarter beginning January 1, 2009 with early adoption permitted. Other than additional required disclosures, Vanguard does not expect adoption of SFAS 161 to impact its consolidated financial statements.

In December 2007, the FASB issued Statement of Financial Accounting Standards No. 141(R), *Business Combinations* ("SFAS 141(R)"). SFAS 141(R) applies to all transactions or other events in which an entity obtains control of one or more businesses even if the acquirer does not acquire 100% of all interests of the target. Under SFAS 141(R) the acquirer recognizes 100% of the fair values of acquired assets, including goodwill, and assumed liabilities with only limited exceptions. This methodology replaces the previous cost-allocation process set forth in SFAS No. 141 that often resulted in the measurement of assets and liabilities at values other than fair value at the acquisition date. SFAS 141(R) also requires contingent consideration to be measured at fair value at acquisition date

with subsequent adjustments measured in future periods. Transactions costs are not considered part of the acquired assets and thus are expensed as incurred under SFAS 141(R). The acquisition date is deemed to be the date on which the acquisition is completed, not when the acquisition agreement is executed. Vanguard will adopt SFAS 141(R) prospectively for acquisitions completed on or after July 1, 2009. However, SFAS 141(R) requires changes to estimates of deferred taxes arising from business combinations to be adjusted through earnings even if the business combination occurred prior to the effective date of SFAS 141(R). SFAS 141(R) will affect Vanguard's future financial position, results of operations or cash flows to the extent Vanguard completes a business combination on or subsequent to July 1, 2009 and could significantly impact Vanguard's future results of operations should deferred tax estimates attributable to the Blackstone merger differ significantly from their ultimate resolution.

In December 2007, the FASB issued Statement of Financial Accounting Standards No. 160, *Noncontrolling Interests in Consolidated Financial Statements* ("SFAS 160"). SFAS 160 amended Accounting Research Bulletin No. 51, *Consolidated Financial Statements*, to establish a single method of accounting for non-controlling interests in subsidiaries, or previously referred to as minority interests. SFAS 160 requires that the noncontrolling interest in a subsidiary be reported as a component of stockholder's equity in the consolidated balance sheet. SFAS 160 also requires that consolidated net income include both the parent and noncontrolling interest's portion of the operating results of the subsidiary with separate disclosure on the statement of operations of the amounts attributable to the parent versus the noncontrolling interest. Changes in the parent's ownership interest that do not result in deconsolidation are treated as equity transactions under SFAS 160. Vanguard will adopt SFAS 160 prospectively on July 1, 2009 with retrospective presentation for comparative periods shown. Vanguard does not expect SFAS 160 to have a material impact on its future financial position, results of operations or cash flows.

In February 2007, the FASB issued Statement of Financial Accounting Standards No. 159, *The Fair Value Option for Financial Assets and Financial Liabilities* ("SFAS 159"). SFAS 159 gives entities the option to voluntarily choose, at certain election dates, to measure many financial assets and liabilities at fair value. Elections are made on an instrument by instrument basis and are irrevocable once made. Subsequent changes to the fair value of any instrument for which an election is made are reflected through earnings. SFAS 159 is effective for Vanguard as of July 1, 2008 with early adoption permitted. Vanguard does not expect SFAS 159 to significantly impact its future financial position, results of operations or cash flows.

On September 15, 2006, the FASB issued Statement of Financial Accounting Standards No. 157, *Fair Value Measurement* ("SFAS 157"). SFAS 157 sets forth comprehensive guidance for measuring fair value of assets and liabilities. Under the provisions of SFAS 157, fair value should be based on the assumptions market participants would use to complete the sale of an asset or transfer of a liability. SFAS 157 provides a hierarchy of information to be used to determine the applicable market assumptions, and fair value measurements would be separately disclosed under each applicable layer of the hierarchy. SFAS 157 does not expand or restrict the use of fair value for measuring assets and liabilities but provides a single methodology to be used when fair value accounting is applied. For those financial assets and financial liabilities defined in SFAS 159, SFAS 157 is effective for Vanguard's fiscal year beginning July 1, 2008 with early adoption permitted. For non-recurring nonfinancial assets and nonfinancial liabilities, SFAS 157 is effective for Vanguard's fiscal year beginning July 1, 2009. Vanguard does not expect the adoption of SFAS 157 to significantly impact its future financial position, results of operations or cash flows.

3. Discontinued Operations

On March 8, 2006, certain subsidiaries of Vanguard sold medical office buildings in California to an independent third party for net sales proceeds of approximately $28.7 million. The net book value of the property, plant and equipment sold was approximately $14.8 million, and Vanguard allocated approximately $2.8 million of existing goodwill to the disposed assets. Vanguard recognized a gain on the sale of approximately $11.1 million ($8.3 million net of taxes) related to this transaction during fiscal 2006.

On October 1, 2006, certain of Vanguard's subsidiaries completed the sale of their three hospitals in Orange County, California (West Anaheim Medical Center, Huntington Beach Hospital and La Palma Intercommunity Hospital) to subsidiaries of Prime Healthcare, Inc. for net proceeds of $40.0 million, comprised of cash proceeds of $37.0 million and $3.0 million of proceeds placed in escrow which was distributed to a subsidiary of Vanguard on July 2, 2007. Approximately $12.8 million of retained working capital, including $25.3 million of patient accounts receivable, was excluded from the sale.

The operations of the California hospitals and medical office buildings are included in discontinued operations, net of taxes, in the accompanying statements of operations for all periods presented in accordance with SFAS 144, *Accounting for the Impairment or Disposal of Long-Lived Assets* ("SFAS 144") and EITF 03-13, *Applying the Conditions of Paragraph 42 of FASB Statement No. 144 in Determining Whether to Report Discontinued Operations* ("EITF 03-13"). The post-transaction direct cash flows that previously precluded the California medical office buildings operations from being included in discontinued operations under EITF 03-13 were eliminated upon the sale of the California hospitals.

During fiscal 2006, prior to the sale of the California hospitals, Vanguard recorded an impairment charge of $15.0 million ($9.4 million net of taxes) to write down its basis in the net property, plant and equipment of these hospitals to estimated fair value using a discounted cash flows model. This impairment charge is included in discontinued operations, net of taxes in the accompanying consolidated statement of operations for the year ended June 30, 2006.

In June 2007, Vanguard ceased providing acute care services at Phoenix Memorial Hospital ("PMH") and began leasing certain floors of the building to various third party healthcare providers. The leases are 5-year and 7-year leases with renewal options. When comparing the projected lease income to the historical total revenues of PMH, Vanguard determined that the expected cash inflows under the leases were insignificant and deemed indirect cash flows. Thus, the acute care operations of PMH are included in discontinued operations, net of taxes in the accompanying statements of operations for all periods presented in accordance with SFAS 144 and EITF 03-13.

The following table sets forth the components of discontinued operations, net of taxes for the years ended June 30, 2006, 2007 and 2008, respectively (in millions).

	Year ended June 30,		
	2006	2007	2008
Total revenues	$ 234.1	$ 91.7	$ (1.5)
Operating expenses	239.3	115.9	(1.6)
Allocated interest	7.2	2.7	–
Impairment loss	15.0	–	–
Loss (gain) on sale of assets	(11.1)	1.7	0.6
Income tax benefit	(7.3)	(9.5)	(0.2)
Loss from discontinued operations, net of taxes	$ 9.0	$ 19.1	$ 0.3

The interest allocations to discontinued operations for the years ended June 30, 2006 and 2007 were based upon the ratio of net assets to be divested to the sum of total net assets and Vanguard's outstanding debt. Income taxes were calculated using an effective tax rate of approximately 44.8%, 33.2% and 40.0% for the years ended June 30, 2006, 2007 and 2008, respectively.

4. Prepaid Expenses and Other Current Assets

Prepaid expenses and other current assets in the accompanying consolidated balance sheets consist of the following at June 30, 2007 and 2008 (in millions).

	2007	2008
Prepaid insurance	$ 6.0	$ 5.2
Other prepaid expenses	10.1	10.5
Deferred tax assets	8.9	24.5
Interest rate swap receivable	–	2.8
Third party settlements	6.7	4.4
Other receivables	32.7	32.9
	$ 64.4	$ 80.3

5. Impairment of Long-Lived Assets

During the second quarter of fiscal 2007, as a result of certain trends in the business climate at its Chicago hospitals including payer mix shifts, Vanguard performed an impairment test of the long-lived assets of these two hospitals under SFAS 144 and SFAS 142, *Goodwill and Other Intangible Assets*. Based upon independent estimates of the fair value of the hospitals, Vanguard recorded a $123.8 million ($110.5 million, net of tax benefit) impairment charge during the quarter and six months ended December 31, 2006. The independent fair value estimates were developed using a discounted net cash flows approach and two market-based approaches. As a result of the impairment charge, Vanguard reduced goodwill for its acute care services segment by $123.8 million. Goodwill related to the Chicago hospitals was approximately $40.6 million as of June 30, 2008.

Vanguard will continue to monitor the operations of its Chicago hospitals due to the sensitivity of the projected cash flows of this reporting unit to the goodwill impairment analysis. If projected future cash flows become less favorable than those projected by management, an additional impairment charge may become necessary that could have a material adverse impact on Vanguard's financial position and results of operations.

6. Goodwill and Intangible Assets

The following table provides information regarding the intangible assets, including deferred loan costs, included in the accompanying consolidated balance sheets as of June 30, 2007 and 2008 (in millions).

	Gross Carrying Amount		Accumulated Amortization	
Class of Intangible Asset	2007	2008	2007	2008
Amortized intangible assets:				
Deferred loan costs	$ 43.8	$ 43.8	$ 11.2	$ 16.1
Contracts	31.4	31.4	8.6	11.8
Physician income and other guarantees	13.8	22.2	5.4	12.1
Other	1.3	1.3	0.3	0.5
Subtotal	90.3	98.7	25.5	40.5
Indefinite-lived intangible assets:				
License and accreditation	3.2	3.2	–	–
Total	$ 93.5	$ 101.9	$ 25.5	$ 40.5

Amortization expense for the contract-based intangibles, which represent PHP's contract with AHCCCS and PHP's various contracts with network providers, during each of the years ended June 30, 2006, 2007 and 2008 was approximately $3.2 million. Vanguard expects amortization expense for the contract intangible assets to approximate $3.2 million during each of the fiscal years ending June 30, 2009 through June 30, 2012. Amortization of deferred loan costs of $4.0 million, $4.4 million and $4.9 million during the years ended June 30, 2006, 2007 and 2008, respectively, is included in net interest. Amortization of physician income and other guarantees of $0.2 million, $5.1 million and $6.7 million during the years ended June 30, 2006, 2007 and 2008, respectively, is included in purchased services or other operating expenses. The useful lives over which intangible assets are amortized range from two years to eleven years. The following table presents the changes in the carrying amount of goodwill from June 30, 2006 through June 30, 2008 (in millions).

	Acute Care Services	Health Plans	Total
Balance as of June 30, 2006	$ 733.4	$ 79.4	$ 812.8
Chicago hospitals goodwill impairment	(123.8)	–	(123.8)
Acquisition of physician practice	0.2	–	0.2
Balance as of June 30, 2007 and 2008	$ 609.8	$ 79.4	$ 689.2

Vanguard completed its annual impairment test of goodwill and indefinite-lived intangible assets during the fourth quarter of fiscal 2008 noting no impairment. Approximately $148.6 million of Vanguard's goodwill is deductible for tax purposes.

7. Other Accrued Expenses and Current Liabilities

The following table presents summaries of items comprising other accrued expenses and current liabilities in the accompanying consolidated balance sheets as of June 30, 2007 and 2008 (in millions).

	2007	2008
Property taxes	$ 15.3	$ 14.6
Current portion of insurance risks	21.5	19.0
Construction retention payable	1.7	–
Accrued income guarantees	4.3	4.4
Income taxes payable	–	2.4
Other	23.7	9.2
	$ 66.5	$ 49.6

8. Long-Term Debt

A summary of Vanguard's long-term debt at June 30, 2007 and 2008 follows (in millions).

	2007	2008
9.0% Senior Subordinated Notes	$ 575.0	$ 575.0
11.25% Senior Discount Notes	168.9	188.4
Term loans payable under credit facility	781.9	774.1
Other	2.9	–
	1,528.7	1,537.5
Less: current maturities	(8.0)	(8.0)
	$ 1,520.7	$ 1,529.5

9.0% Notes

In connection with the Blackstone acquisition of Vanguard by merger on September 23, 2004 (the "Blackstone merger"), two of Vanguard's wholly owned subsidiaries, Vanguard Health Holding Company II, LLC and Vanguard Holding Company II, Inc. (collectively, the "Issuers"), completed a private placement of $575.0 million 9% Senior Subordinated Notes due 2014 ("9.0% Notes"). Interest on the 9.0% Notes is payable semi-annually on October 1 and April 1 of each year. The 9.0% Notes are general unsecured senior subordinated obligations and rank junior in right of payment to all existing and future senior indebtedness of the Issuers. All payments on the 9.0% Notes are guaranteed jointly and severally on a senior subordinated basis by Vanguard and its domestic subsidiaries, other than those subsidiaries that do not guarantee the obligations of the borrowers under the senior credit facilities.

Prior to October 1, 2009, the Issuers may redeem the 9.0% Notes, in whole or in part, at a price equal to 100% of the principal amount thereof plus a make-whole premium. On or after October 1, 2009, the Issuers may redeem all or part of the 9.0% Notes at various redemption prices given the date of redemption as set forth in the indenture governing the 9.0% Notes. The initial redemption price for the 9.0% Notes on October 1, 2009 is equal to 104.50% of their principal amount, plus accrued and unpaid interest. The redemption price declines each year after 2009. The redemption price will be 100% of the principal amount, plus accrued and unpaid interest, beginning on October 1, 2012.

On January 26, 2005, Vanguard exchanged all of its outstanding 9.0% senior subordinated notes due 2014 for new 9.0% senior subordinated notes due 2014 with identical terms and conditions, except that they were registered under the Securities Act of 1933. Terms and conditions of the exchange offer were set forth in Vanguard's registration statement on Form S-4 filed with the Securities and Exchange Commission that became effective on December 23, 2004.

11.25% Notes

In connection with the Blackstone merger on September 23, 2004, two of Vanguard's wholly owned subsidiaries, Vanguard Health Holding Company I, LLC and Vanguard Holding Company I, Inc. (collectively, the "Discount Issuers"), completed a private placement of $216.0 million aggregate principal amount at maturity ($124.7 million in gross proceeds) of 11.25% Senior Discount Notes due 2015 ("11.25% Notes"). The 11.25% Notes accrete at the stated rate compounded semi-annually on April 1 and October 1 of each year to, but not including, October 1, 2009. Subsequent to October 1, 2009, cash interest on the 11.25% Notes will accrue at 11.25% per annum, and will be payable on April 1 and October 1 of each year, commencing on April 1, 2010 until maturity. The 11.25% Notes are general senior unsecured obligations and rank junior in right of payment to all existing and future senior indebtedness of the Discount Issuers but senior to any of the Discount Issuers' future senior subordinated indebtedness. All payments on the 11.25% Notes are guaranteed by Vanguard as a holding company guarantee.

Prior to October 1, 2009, the Discount Issuers may redeem the 11.25% Notes, in whole or in part, at a price equal to 100% of the accreted value thereof, plus accrued and unpaid interest, plus a make-whole premium. On or after October 1, 2009, the Discount Issuers may redeem all or a part of the 11.25% Notes at various redemption prices given the date of redemption as set forth in the indenture governing the 11.25% Notes. The initial redemption price for the 11.25% Notes on October 1, 2009 is equal to 105.625% of their principal amount, plus accrued and unpaid interest. The redemption price declines each year after 2009. The redemption price will be 100% of the principal amount, plus accrued and unpaid interest, beginning on October 1, 2012.

On January 26, 2005, Vanguard exchanged all of its outstanding 11.25% senior discount notes due 2015 for new 11.25% senior discount notes due 2015 with identical terms and conditions, except that they were registered under the Securities Act of 1933. Terms and conditions of the exchange offer were set forth in Vanguard's registration statement on Form S-4 filed with the Securities and Exchange Commission that became effective on December 23, 2004.

Credit Facility Debt

In connection with the Blackstone merger on September 23, 2004, two of Vanguard's wholly owned subsidiaries, Vanguard Health Holding Company II, LLC and Vanguard Holding Company II, Inc. (collectively, the "Co-borrowers"), entered into new senior secured credit facilities (the "merger credit facilities") with various lenders and Bank of America, N.A. as administrative agent and Citicorp North America, Inc. as syndication agent, and repaid all amounts outstanding under its previous credit facility. The merger credit facilities include a seven-year term loan facility in the aggregate principal amount of $800.0 million (of which $475.0 million was funded at closing) and a six-year $250.0 million revolving credit facility. Of the $325.0 million unfunded term loans, $150.0 million was made available to finance the acquisition of hospitals and related businesses provided that the acquisition occurred on or prior to February 20, 2005, and to fund capital expenditures and other corporate needs. Also, $175.0 million was made available for working capital, capital expenditures and other general corporate purposes until September 23, 2005. Vanguard borrowed all $325.0 million delayed draw term loans at various times during its fiscal years 2005 and 2006.

On September 26, 2005, the Co-borrowers refinanced and repriced all $795.7 million of the then outstanding term loans under the merger credit facilities by borrowing $795.7 million of replacement term loans that also mature on September 23, 2011 (the "2005 term loan facility"). In addition, upon the occurrence of certain events, the Co-borrowers may request an incremental term loan facility to be added to the 2005 term loan facility in an amount not to exceed $300.0 million in the aggregate, subject to receipt of commitments by existing lenders or other financing institutions and to the satisfaction of certain other conditions. The revolving loan facility under the merger credit facilities did not change in connection with the term loan refinancing. As of June 30, 2008, $774.1 million of indebtedness was outstanding under the 2005 term loan facility. Vanguard's remaining borrowing capacity under the revolving credit facility, net of letters of credit outstanding, was $222.0 million as of June 30, 2008.

The 2005 term loan facility borrowings bear interest at a rate equal to, at Vanguard's option, LIBOR plus 2.25% per annum or a base rate plus 1.25% per annum. These interest rates reflect a savings of 1.00% per annum over the interest rate options for term loan borrowings under the merger credit facilities. Borrowings under the revolving credit facility currently bear interest at a rate equal to, at Vanguard's option, LIBOR plus 2.25% per annum or a base rate plus 1.25% per annum, subject to an increase of up to 0.25% per annum should Vanguard's leverage ratio increase over certain designated levels. Vanguard also pays a commitment fee to the lenders under the revolving credit facility in respect of unutilized commitments thereunder at a rate equal to 0.50% per annum. Vanguard also pays customary letter of credit fees under this facility. Vanguard makes quarterly principal payments equal to one-fourth of one percent of the outstanding principal balance of the 2005 term loan facility, and will continue to make such payments until maturity of the term debt.

Vanguard is subject to certain restrictive and financial covenants under the credit agreement governing the 2005 term loan facility and the revolving credit facility including a total leverage ratio, senior leverage ratio, interest coverage ratio and capital expenditure restrictions. Vanguard was in compliance with each of these financial covenants as of June 30, 2008. Obligations under the credit agreement are unconditionally guaranteed by Vanguard and Vanguard Health Holding Company I, LLC ("VHS Holdco I") and, subject to certain exceptions, each of VHS Holdco I's wholly-owned domestic subsidiaries (the "U.S. Guarantors"). Obligations under the credit agreement are also secured by substantially all of the assets of Vanguard Health Holding Company II, LLC ("VHS Holdco II") and the U.S. Guarantors including a pledge of 100% of the membership interests of VHS Holdco II, 100% of the capital stock of substantially all U.S. Guarantors (other than VHS Holdco I) and 65% of the capital stock of each of VHS Holdco II's non-U.S. subsidiaries that are directly owned by VHS Holdco II or one of the U.S. Guarantors and a security interest in substantially all tangible and intangible assets of VHS Holdco II and each U.S. Guarantor.

Interest Rate Swap Agreement

During April 2008, Vanguard entered into an interest rate swap agreement with Bank of America, N.A. (the "counterparty") that went into effect on June 30, 2008. Given the turbulence in the credit markets and the attractive swap rates then available, Vanguard executed the swap agreement to hedge its cash flows related to a portion of the 2005 term loan facility against potential market fluctuations to the variable 90-day LIBOR interest rate. Vanguard will continue to make its normal quarterly interest payments under the 2005 term loan facility as described above.

However, Vanguard will also begin making quarterly fixed interest payments on September 30, 2008 at a rate equal to 2.785% on a notional $450.0 million of the 2005 term loan facility in exchange for payments to Vanguard from the counterparty based upon the applicable variable 90-day LIBOR rate on the same notional amount. Vanguard will account for this swap as a highly effective cash flow hedge with critical terms that substantially match the underlying term debt and will measure any ineffectiveness using the hypothetical derivative method. Vanguard deems the counterparty to be creditworthy. As of June 30, 2008, the estimated fair value of the interest rate swap was an asset for Vanguard of approximately $2.8 million (net of taxes of $1.8 million), which is included in prepaid expenses and other current assets and accumulated other comprehensive income on the accompanying balance sheet. Vanguard will make quarterly adjustments to other comprehensive income equal to the change in the fair value of the swap from quarter to quarter until the maturity of the swap on March 31, 2010 with any ineffectiveness included in earnings.

Deferred Loan Costs

In connection with the Blackstone merger, Vanguard incurred $43.8 million of deferred offering and loan costs related to the 9.0% Notes, the 11.25% Notes and term and revolving loan borrowings under the merger credit facilities and the 2005 term loan facility. Vanguard incurred $4.0 million, $4.5 million and $4.9 million of interest expense, respectively, during the years ended June 30, 2006, 2007 and 2008 related to the amortization of these offering and loan costs.

Future Maturities

Future maturities of Vanguard's debt as of June 30, 2008 follow (in millions).

Fiscal Year	Amount
2009	$ 8.0
2010	7.9
2011	8.0
2012	750.2
2013	–
Thereafter	791.0
	$ 1,565.1

Other Information

Vanguard conducts substantially all of its business through its subsidiaries. Most of Vanguard's subsidiaries jointly and severally guarantee the 9.0% Notes on an unsecured senior subordinated basis. Certain of Vanguard's other consolidated wholly-owned and non wholly-owned entities do not guarantee the 9.0% Notes in conformity with the provisions of the indenture governing the 9.0% Notes and do not guarantee Vanguard's 2005 term loan facility in conformity with the provisions thereof. The condensed consolidating financial information for the parent company, the issuers of the 9.0% Notes, the issuers of the 11.25% Notes, the guarantor subsidiaries, the combined non-guarantor subsidiaries, certain eliminations and consolidated Vanguard as of June 30, 2007 and 2008, and for the years ended June 30, 2006, 2007 and 2008, follows.

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING BALANCE SHEETS
June 30, 2007

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
ASSETS							
Current assets:							
Cash and cash equivalents	$ –	$ –	$ –	$ 11.7	$ 108.4	$ –	$ 120.1
Restricted cash	–	–	–	4.4	1.8	–	6.2
Accounts receivable, net	–	–	–	260.0	27.3	–	287.3
Inventories	–	–	–	41.8	5.0	–	46.8
Prepaid expenses and other current assets	0.1	–	–	44.5	22.4	(2.6)	64.4
Total current assets	0.1	–	–	362.4	164.9	(2.6)	524.8
Property, plant and equipment, net	–	–	–	1,112.1	74.5	–	1,186.6
Goodwill	–	–	–	605.6	83.6	–	689.2
Intangible assets, net	–	29.2	3.4	11.1	24.3	–	68.0
Investments in consolidated subsidiaries	608.8	–	–	–	26.6	(635.4)	–
Other assets	–	–	–	69.4	0.1	–	69.5
Total assets	$ 608.9	$ 29.2	$ 3.4	$ 2,160.6	$ 374.0	$ (638.0)	$ 2,538.1
LIABILITIES AND STOCKHOLDERS' EQUITY							
Current liabilities:							
Accounts payable	$ –	$ –	$ –	$ 132.8	$ 11.3	$ –	$ 144.1
Accrued expenses and other current liabilities	–	13.4	–	130.5	87.9	(15.5)	216.3
Current maturities of long-term debt	–	8.0	–	(0.2)	0.2	–	8.0
Total current liabilities	–	21.4	–	263.1	99.4	(15.5)	368.4
Other liabilities	–	–	–	50.6	45.3	(4.3)	91.6
Long-term debt, less current maturities	–	1,348.9	168.9	2.9	–	–	1,520.7
Intercompany	51.5	(1,013.2)	(120.9)	1,368.3	51.8	(337.5)	–
Stockholders' equity	557.4	(327.9)	(44.6)	475.7	177.5	(280.7)	557.4
Total liabilities and stockholders' equity	$ 608.9	$ 29.2	$ 3.4	$ 2,160.6	$ 374.0	$ (638.0)	$ 2,538.1

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING BALANCE SHEETS
June 30, 2008

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
ASSETS							
Current assets:							
Cash and cash equivalents	$ –	$ –	$ –	$ 82.0	$ 59.6	$ –	$ 141.6
Restricted cash	–	–	–	0.3	1.8	–	2.1
Marketable securities	–	–	–	–	26.3	–	26.3
Accounts receivable, net	–	–	–	275.7	24.7	–	300.4
Inventories	–	–	–	44.3	4.9	–	49.2
Prepaid expenses and other current assets	0.1	–	–	62.5	20.0	(2.3)	80.3
Total current assets	0.1	–	–	464.8	137.3	(2.3)	599.9
Property, plant and equipment, net	–	–	–	1,106.4	67.6	–	1,174.0
Goodwill	–	–	–	605.6	83.6	–	689.2
Intangible assets, net	–	24.5	3.2	12.9	20.8	–	61.4
Investments in consolidated subsidiaries	608.8	–	–	–	16.7	(625.5)	–
Other assets	–	–	–	57.6	0.2	–	57.8
Total assets	$ 608.9	$ 24.5	$ 3.2	$ 2,247.3	$ 326.2	$ (627.8)	$ 2,582.3
LIABILITIES AND STOCKHOLDERS' EQUITY							
Current liabilities:							
Accounts payable	$ –	$ –	$ –	$ 144.9	$ 17.9	$ –	$ 162.8
Accrued expenses and other current liabilities	–	13.2	–	125.2	72.9	–	211.3
Current maturities of long-term debt	–	8.0	–	(0.2)	0.2	–	8.0
Total current liabilities	–	21.2	–	269.9	91.0	–	382.1
Other liabilities	–	–	–	70.6	38.7	(3.2)	106.1
Long-term debt, less current maturities	–	1,341.1	188.4	–	–	–	1,529.5
Intercompany	44.3	(900.0)	(120.8)	1,373.9	(51.9)	(345.5)	–
Stockholders' equity	564.6	(437.8)	(64.4)	532.9	248.4	(279.1)	564.6
Total liabilities and stockholders' equity	$ 608.9	$ 24.5	$ 3.2	$ 2,247.3	$ 326.2	$ (627.8)	$ 2,582.3

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF OPERATIONS
For the year ended June 30, 2006

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Patient service revenues	$ –	$ –	$ –	$ 1,929.0	$ 144.5	$ (29.9)	$ 2,043.6
Premium revenues	–	–	–	47.9	358.9	(31.8)	375.0
Total revenues	–	–	–	1,976.9	503.4	(61.7)	2,418.6
Salaries and benefits	1.7	–	–	914.8	74.9	–	991.4
Supplies	–	–	–	369.3	24.8	–	394.1
Medical claims expense	–	–	–	29.1	271.1	(29.9)	270.3
Purchased services	–	–	–	110.1	18.0	–	128.1
Provision for doubtful accounts	–	–	–	149.7	7.1	–	156.8
Other operating expenses	0.2	–	–	179.5	43.1	(31.8)	191.0
Rents and leases	–	–	–	27.2	6.7	–	33.9
Depreciation and amortization	–	–	–	86.0	14.3	–	100.3
Interest, net	–	109.5	15.9	(22.3)	0.7	–	103.8
Management fees	–	–	–	(6.7)	6.7	–	–
Debt extinguishment costs	0.1	–	–	–	–	–	0.1
Other	–	–	–	8.4	0.7	–	9.1
Total costs and expenses	2.0	109.5	15.9	1,845.1	468.1	(61.7)	2,378.9
Income (loss) from continuing operations before income taxes	(2.0)	(109.5)	(15.9)	131.8	35.3	–	39.7
Income tax expense (benefit)	17.8	–	–	6.7	7.6	(14.3)	17.8
Equity in earnings of subsidiaries	32.7	–	–	–	–	(32.7)	–
Income (loss) from continuing operations	12.9	(109.5)	(15.9)	125.1	27.7	(18.4)	21.9
Loss from discontinued operations, net of taxes	–	–	–	(7.8)	(1.2)	–	(9.0)
Net income (loss)	$ 12.9	$ (109.5)	$ (15.9)	$ 117.3	$ 26.5	$ (18.4)	$ 12.9

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF OPERATIONS
For the year ended June 30, 2007

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Patient service revenues	$ –	$ –	$ –	$ 2,053.9	$ 150.9	$ (25.5)	$ 2,179.3
Premium revenues	–	–	–	56.5	345.3	(0.4)	401.4
Total revenues	–	–	–	2,110.4	496.2	(25.9)	2,580.7
Salaries and benefits	1.2	–	–	986.6	80.1	–	1,067.9
Supplies	–	–	–	394.1	27.7	–	421.8
Medical claims expense	–	–	–	35.6	286.9	(25.5)	297.0
Purchased services	–	–	–	126.6	14.6	–	141.2
Provision for doubtful accounts	–	–	–	169.2	6.0	–	175.2
Other operating expenses	0.2	–	–	171.2	25.4	(0.4)	196.4
Rents and leases	–	–	–	30.8	6.6	–	37.4
Depreciation and amortization	–	–	–	104.1	14.5	–	118.6
Interest, net	–	119.5	17.7	(8.2)	(5.2)	–	123.8
Management fees	–	–	–	(8.2)	8.2	–	–
Impairment loss	–	–	–	120.1	3.7	–	123.8
Other	–	–	–	2.8	–	–	2.8
Total costs and expenses	1.4	119.5	17.7	2,124.7	468.5	(25.9)	2,705.9
Income (loss) from continuing operations before income taxes	(1.4)	(119.5)	(17.7)	(14.3)	27.7	–	(125.2)
Income tax expense (benefit)	(11.6)	–	–	–	2.1	(2.1)	(11.6)
Equity in earnings of subsidiaries	(142.9)	–	–	–	–	142.9	–
Income (loss) from continuing operations	(132.7)	(119.5)	(17.7)	(14.3)	25.6	145.0	(113.6)
Loss from discontinued operations, net of taxes	–	–	–	(6.0)	(13.1)	–	(19.1)
Net income (loss)	$ (132.7)	$ (119.5)	$ (17.7)	$ (20.3)	$ 12.5	$ 145.0	$ (132.7)

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF OPERATIONS
For the year ended June 30, 2008

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Patient service revenues	$ –	$ –	$ –	$ 2,212.2	$ 150.8	$ (22.5)	$ 2,340.5
Premium revenues	–	–	–	57.7	392.7	(0.2)	450.2
Total revenues	–	–	–	2,269.9	543.5	(22.7)	2,790.7
Salaries and benefits	2.5	–	–	1,068.7	81.5	–	1,152.7
Supplies	–	–	–	405.8	28.7	–	434.5
Medical claims expense	–	–	–	35.8	314.9	(22.5)	328.2
Purchased services	–	–	–	136.5	13.0	–	149.5
Provision for doubtful accounts	–	–	–	196.9	8.7	–	205.6
Other operating expenses	0.2	–	–	182.4	32.1	(0.2)	214.5
Rents and leases	–	–	–	34.8	7.0	–	41.8
Depreciation and amortization	–	–	–	116.8	14.2	–	131.0
Interest, net	–	109.9	19.8	(9.3)	1.7	–	122.1
Management fees	–	–	–	(8.2)	8.2	–	–
Other	–	–	–	63.5	(54.0)	–	9.5
Total costs and expenses	2.7	109.9	19.8	2,223.7	456.0	(22.7)	2,789.4
Income (loss) from continuing operations before income taxes	(2.7)	(109.9)	(19.8)	46.2	87.5	–	1.3
Income tax expense (benefit)	1.7	–	–	–	13.4	(13.4)	1.7
Equity in earnings of subsidiaries	3.7	–	–	–	–	(3.7)	–
Income (loss) from continuing operations	(0.7)	(109.9)	(19.8)	46.2	74.1	9.7	(0.4)
Income (loss) from discontinued operations, net of taxes	–	–	–	2.9	(3.2)	–	(0.3)
Net income (loss)	$ (0.7)	$ (109.9)	$ (19.8)	$ 49.1	$ 70.9	$ 9.7	$ (0.7)

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS
For the year ended June 30, 2006

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Operating activities:							
Net income (loss)	$ 12.9	$ (109.5)	$ (15.9)	$ 117.3	$ 26.5	$ (18.4)	$ 12.9
Adjustments to reconcile net income (loss) to net cash provided by (used in) operating activities							
Loss from discontinued operations	–	–	–	7.8	1.2	–	9.0
Depreciation and amortization	–	–	–	86.0	14.3	–	100.3
Provision for doubtful accounts	–	–	–	149.7	7.1	–	156.8
Deferred income taxes	10.1	–	–	–	–	–	10.1
Amortization of loan costs	–	3.8	0.2	–	–	–	4.0
Accretion of principal on senior discount notes	–	–	15.7	–	–	–	15.7
Loss (gain) on disposal of assets	–	–	–	6.1	(4.6)	–	1.5
Stock compensation	1.7	–	–	–	–	–	1.7
Debt extinguishment costs	0.1	–	–	–	–	–	0.1
Changes in operating assets and liabilities, net of effects of acquisitions:							
Equity in earnings of subsidiaries	(31.1)	–	–	–	–	31.1	–
Accounts receivable	–	–	–	(158.5)	(3.9)	–	(162.4)
Inventories	–	–	–	(5.5)	0.3	–	(5.2)
Prepaid expenses and other current assets	11.7	–	–	(40.0)	31.9	–	3.6
Accounts payable	–	–	–	4.4	(2.0)	–	2.4
Accrued expenses and other liabilities	(5.4)	(1.1)	–	39.2	(31.9)	(12.7)	(11.9)
Net cash provided by (used in) operating activities – continuing operations	–	(106.8)	–	206.5	38.9	–	138.6
Net cash provided by operating activities - discontinued operations	–	–	–	4.4	6.3	–	10.7
Net cash provided by (used in) operating activities	–	(106.8)	–	210.9	45.2	–	149.3
Investing activities:							
Acquisitions	–	–	–	(1.2)	–	–	(1.2)
Capital expenditures	–	–	–	(264.7)	(10.8)	–	(275.5)
Proceeds from asset dispositions	–	–	–	11.1	–	–	11.1
Purchases of short-term investments	–	–	–	–	(128.4)	–	(128.4)
Sales of short-term investments	–	–	–	–	128.4	–	128.4
Other	–	–	–	(17.8)	(4.2)	22.6	0.6
Net cash used in investing activities-continuing operations	–	–	–	(272.6)	(15.0)	22.6	(265.0)
Net cash provided by (used in) operating activities – discontinued operations	–	–	–	24.3	(4.7)	–	19.6
Net cash used in investing activities	–	–	–	(248.3)	(19.7)	22.6	(245.4)

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS
For the year ended June 30, 2006
(continued)

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Financing activities:							
Payments of long-term debt	–	175.0	–	–	–	–	175.0
Payments of long-term debt and capital leases	–	(30.0)	–	(0.8)	(0.6)	–	(31.4)
Payments of loan costs and debt termination fees	–	–	–	(0.7)	–	–	(0.7)
Payments to retire stock and stock options	(2.5)	–	–	–	–	–	(2.5)
Cash provided by (used in) intercompany activity	1.6	(38.2)	–	83.3	(24.1)	(22.6)	–
Exercise of stock options	0.1	–	–	–	–	–	0.1
Net cash provided by (used in) financing activities	(0.8)	106.8	–	81.8	(24.7)	(22.6)	140.5
Net increase (decrease) in cash and cash equivalents	(0.8)	–	–	44.4	0.8	–	44.4
Cash and cash equivalents, beginning of period	0.8	–	–	(5.9)	84.3	–	79.2
Cash and cash equivalents, end of period	$ –	$ –	$ –	$ 38.5	$ 85.1	$ –	$ 123.6

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS
For the year ended June 30, 2007

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Operating activities:							
Net income (loss)	$ (132.7)	$ (119.5)	$ (17.7)	$ (20.3)	$ 12.5	$ 145.0	$ (132.7)
Adjustments to reconcile net income (loss) to net cash provided by (used in) operating activities							
Loss from discontinued operations	–	–	–	6.0	13.1	–	19.1
Depreciation and amortization	–	–	–	104.1	14.5	–	118.6
Provision for doubtful accounts	–	–	–	169.2	6.0	–	175.2
Deferred income taxes	(12.7)	–	–	–	–	–	(12.7)
Amortization of loan costs	–	4.3	0.2	–	–	–	4.5
Accretion of principal on senior discount notes	–	–	17.5	–	–	–	17.5
Gain on disposal of assets	–	–	–	(4.1)	–	–	(4.1)
Stock compensation	1.2	–	–	–	–	–	1.2
Impairment loss	–	–	–	120.1	3.7	–	123.8
Changes in operating assets and liabilities, net of effects of acquisitions:							
Equity in earnings of subsidiaries	142.9	–	–	–	–	(142.9)	–
Accounts receivable	–	–	–	(206.9)	2.9	–	(204.0)
Inventories	–	–	–	(2.9)	1.0	–	(1.9)
Prepaid expenses and other current assets	–	–	–	(28.5)	(1.5)	–	(30.0)
Accounts payable	–	–	–	11.2	(3.8)	–	7.4
Accrued expenses and other liabilities	1.3	0.1	–	61.3	(22.8)	(2.1)	37.8
Net cash provided by (used in) operating activities – continuing operations	–	(115.1)	–	209.2	25.6	–	119.7
Net cash provided by operating activities - discontinued operations	–	–	–	0.5	3.1	–	3.6
Net cash provided by (used in) operating activities	–	(115.1)	–	209.7	28.7	–	123.3
Investing activities:							
Acquisitions	–	–	–	(0.2)	–	–	(0.2)
Capital expenditures	–	–	–	(153.3)	(11.0)	–	(164.3)
Proceeds from asset dispositions	–	–	–	9.5	–	–	9.5
Purchases of short-term investments	–	–	–	–	(120.0)	–	(120.0)
Sales of short-term investments	–	–	–	–	120.0	–	120.0
Other	–	–	–	1.8	0.2	–	2.0
Net cash used in investing activities-continuing operations	–	–	–	(142.2)	(10.8)	–	(153.0)
Net cash provided by (used in) operating activities – discontinued operations	–	–	–	36.3	(1.8)	–	34.5
Net cash used in investing activities	–	–	–	(105.9)	(12.6)	–	(118.5)

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS
For the year ended June 30, 2007
(continued)

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Financing activities:							
Payments of long-term debt and capital leases	–	(7.9)	–	–	(0.1)	–	(8.0)
Payments to retire stock, equity incentive units and stock options	–	–	–	(0.5)	–	–	(0.5)
Cash provided by (used in) intercompany activity	–	123.0	–	(130.3)	7.3	–	–
Exercise of stock options	–	–	–	0.2	–	–	0.2
Net cash provided by (used in) financing activities	–	115.1	–	(130.6)	7.2	–	(8.3)
Net increase (decrease) in cash and cash equivalents	–	–	–	(26.8)	23.3	–	(3.5)
Cash and cash equivalents, beginning of period	–	–	–	38.5	85.1	–	123.6
Cash and cash equivalents, end of period	$ –	$ –	$ –	$ 11.7	$ 108.4	$ –	$ 120.1

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS
For the year ended June 30, 2008

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Operating activities:							
Net income (loss)	$ (0.7)	$ (109.9)	$ (19.8)	$ 49.1	$ 70.9	$ 9.7	$ (0.7)
Adjustments to reconcile net income (loss) to net cash provided by (used in) operating activities							
Loss (income) from discontinued operations	–	–	–	(2.9)	3.2	–	0.3
Depreciation and amortization	–	–	–	116.8	14.2	–	131.0
Provision for doubtful accounts	–	–	–	196.9	8.7	–	205.6
Deferred income taxes	(2.2)	–	–	–	–	–	(2.2)
Amortization of loan costs	–	4.6	0.3	–	–	–	4.9
Accretion of principal on senior discount notes	–	–	19.5	–	–	–	19.5
Loss on disposal of assets	–	–	–	0.9	–	–	0.9
Stock compensation	2.5	–	–	–	–	–	2.5
Changes in operating assets and liabilities, net of effects of acquisitions:							
Equity in earnings of subsidiaries	(3.7)	–	–	–	–	3.7	–
Accounts receivable	–	–	–	(217.5)	(6.1)	–	(223.6)
Inventories	–	–	–	(4.3)	0.2	–	(4.1)
Prepaid expenses and other current assets	(4.5)	–	–	(17.6)	2.4	–	(19.7)
Accounts payable	–	–	–	13.3	6.6	–	19.9
Accrued expenses and other liabilities	4.9	(0.2)	–	67.6	(21.6)	(13.4)	37.3
Net cash provided by (used in) operating activities – continuing operations	(3.7)	(105.5)	–	202.3	78.5	–	171.6
Net cash provided by operating activities – discontinued operations	–	–	–	0.2	1.3	–	1.5
Net cash provided by (used in) operating activities	(3.7)	(105.5)	–	202.5	79.8	–	173.1
Investing activities:							
Acquisitions	–	–	–	(0.2)	–	–	(0.2)
Capital expenditures	–	–	–	(118.1)	(3.5)	–	(121.6)
Purchases of marketable securities	–	–	–	–	(90.0)	–	(90.0)
Sales of marketable securities	–	–	–	–	63.7	–	63.7
Other	–	–	–	–	1.5	–	1.5
Net cash used in investing activities – continuing operations	–	–	–	(118.3)	(28.3)	–	(146.6)
Net cash provided by (used in) operating activities – discontinued operations	–	–	–	3.1	(0.3)	–	2.8
Net cash used in investing activities	–	–	–	(115.2)	(28.6)	–	(143.8)

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS
For the year ended June 30, 2008
(continued)

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Financing activities:							
Payments of long-term debt	–	(7.8)	–	–	–	–	(7.8)
Payments to retire stock, equity incentive units and stock options	–	–	–	(0.2)	–	–	(0.2)
Cash provided by (used in) intercompany activity	3.7	113.3	–	(17.0)	(100.0)	–	–
Exercise of stock options	–	–	–	0.2	–	–	0.2
Net cash provided by (used in) financing activities	3.7	105.5	–	(17.0)	(100.0)	–	(7.8)
Net increase (decrease) in cash and cash equivalents	–	–	–	70.3	(48.8)	–	21.5
Cash and cash equivalents, beginning of period	–	–	–	11.7	108.4	–	120.1
Cash and cash equivalents, end of period	$ –	$ –	$ –	$ 82.0	$ 59.6	$ –	$ 141.6

9. Income Taxes

Significant components of income tax expense/benefit attributable to continuing operations are as follows (in millions):

	2006	2007	2008
Current:			
Federal	$ 2.2	$ 0.9	$ 1.5
State	(0.3)	0.1	2.4
	1.9	1.0	3.9
Deferred:			
Federal	15.2	(13.7)	(1.2)
State	(3.9)	(4.8)	(8.6)
	11.3	(18.5)	(9.8)
Increase in valuation allowance	4.6	5.9	7.6
Total	$ 17.8	$ (11.6)	$ 1.7

The following table presents the income taxes associated with continuing operations and discontinued operations as reflected in the accompanying consolidated statements of operations (in millions).

	2006	2007	2008
Continuing operations	$ 17.8	$ (11.6)	$ 1.7
Discontinued operations	(7.3)	(9.5)	(0.2)
Total	$ 10.5	$ (21.1)	$ 1.5

The increases in the valuation allowance during all three years presented result from state net operating loss carryforwards that may not ultimately be utilized because of the uncertainty regarding Vanguard's ability to generate taxable income in certain states. The effective income tax rate differed from the federal statutory rate for the years ended June 30, 2006, 2007 and 2008 as follows:

	2006	2007	2008
Income tax expense at federal statutory rate	35.0%	35.0%	35.0%
Income tax expense at state statutory rate	(3.8)	3.6	(564.6)
Nondeductible expenses and other	1.9	(0.6)	44.0
Increase in valuation allowance	11.7	(4.7)	616.4
Nondeductible impairment loss	–	(24.0)	–
Effective income tax rate	44.8%	9.3%	130.8%

Deferred income taxes reflect the net tax effects of temporary differences between the carrying amounts of assets and liabilities for financial reporting purposes and the amounts used for income tax purposes. Significant components of Vanguard's deferred tax assets and liabilities as of June 30, 2007 and 2008, were approximately as follows (in millions):

	2007	2008
Deferred tax assets:		
Net operating loss carryover	$ 77.4	$ 69.7
Excess tax basis over book basis of accounts receivable	5.9	8.2
Accrued expenses and other	12.8	24.7
Deferred loan costs	2.5	2.3
Professional liabilities reserves	10.7	16.4
Self-insurance reserves	10.1	9.4
Alternative minimum tax credit and other credits	2.3	3.4
Total deferred tax assets	121.7	134.1
Valuation allowance	(22.5)	(29.9)
Total deferred tax assets, net of valuation allowance	99.2	104.2
Deferred tax liabilities:		
Depreciation, amortization and fixed assets basis differences	29.7	29.3
Excess book basis over tax basis of prepaid assets and other	7.9	8.0
Total deferred tax liabilities	37.6	37.3
Net deferred tax assets and liabilities	$ 61.6	$ 66.9

Net non-current deferred tax assets of $52.7 million and $42.4 million as of June 30, 2007 and 2008, respectively, are included in the accompanying consolidated balance sheets in other assets. Net current deferred tax assets were $8.9 million and $24.5 million as of June 30, 2007 and 2008, respectively.

As of June 30, 2008, Vanguard had generated net operating loss ("NOL") carryforwards for federal income tax purposes and state income tax purposes of approximately $107.0 million and $596.0 million, respectively. The federal and state NOL carryforwards expire from 2020 to 2027 and 2008 to 2027, respectively. Approximately $2.8 million of these NOLs are subject to annual limitations for federal purposes. These limitations are not expected to significantly affect Vanguard's ability to ultimately recognize the benefit of these NOLs in future years.

Effective July 1, 2007, Vanguard adopted the provisions of FIN 48. In connection with the adoption of FIN 48, Vanguard recorded a $0.4 million net liability for unrecognized tax benefits, accrued interest and penalties, which was comprised of the following (in millions).

Reclassification from income taxes payable	$ 0.3
Increase to non-current deferred tax assets	2.7
Cumulative impact of change recorded to retained earnings	(2.6)
	$ 0.4

The provisions of FIN 48 allow for the classification election of interest on an underpayment of income taxes, when the tax law requires interest to be paid, and penalties, when a tax position does not meet the minimum statutory threshold to avoid payment of penalties, in income taxes, interest expense or another appropriate expense classification based on the accounting policy election of the entity. Vanguard has elected to continue its historical practice of classifying interest and penalties as a component of income tax expense.

Approximately $0.3 million of the $0.4 million of unrecognized tax benefits existing upon adoption of FIN 48, if recognized, would impact the effective tax rate, while the remaining $0.1 million of unrecognized tax benefits, if recognized, would increase goodwill. The unrecognized tax benefits increased by $0.2 million during the year ended June 30, 2008 to $0.6 million. Due to the insignificant changes in Vanguard's unrecognized tax benefits during the year ended June 30, 2008, a tabular reconciliation is not warranted.

Vanguard's U.S. federal income tax returns for tax years 2005 and beyond remain subject to examination by the Internal Revenue Service.

On May 18, 2006, Texas repealed its current income tax and replaced it with a gross margins tax to be accounted for as an income tax. Vanguard became subject to the Texas margins tax on July 1, 2006. On July 3, 2008, Massachusetts enacted corporate tax reform legislation that will become effective for Vanguard for its fiscal year ending June 30, 2010. State deferred tax assets increased by $1.0 million during the fiscal year ended June 30, 2008 to reflect the impact of the Massachusetts corporate tax reform legislation.

10. Stockholders' Equity

Vanguard has the authority to issue 1,000,000 shares of common stock, par value $.01 per share.

Common Stock of Vanguard and Class A Membership Units of Holdings

In connection with the Blackstone merger, Blackstone, MSCP, management and other investors purchased $624.0 million of Class A Membership Units of Holdings. Holdings then invested the $624.0 million in the common stock of Vanguard, and in addition Blackstone invested $125.0 million directly in the common stock of Vanguard. In February 2005, other investors purchased approximately $0.6 million of Class A membership units of Holdings. Holdings then invested the $0.6 million in the common stock of Vanguard.

Equity Incentive Membership Units of Holdings

In connection with the Blackstone merger, certain members of senior management purchased Class B, Class C and Class D membership units in Holdings (collectively the "equity incentive units") for approximately $5.7 million pursuant to the Amended and Restated Limited Liability Company Operating Agreement of Holdings dated September 23, 2004 ("LLC Agreement"). Vanguard determined the value of the equity incentive units by utilizing appraisal information. The Class B and D units vest 20% on each of the first five anniversaries of the purchase date, while the Class C units vest on the eighth anniversary of the purchase date subject to accelerated vesting upon the occurrence of a sale by Blackstone of at least 25% of its Class A units at a price per unit exceeding 2.5 times the per unit price paid on September 23, 2004. Upon a change of control (as defined in the LLC Agreement), all Class B and D units fully vest, and Class C units fully vest if the change in control constitutes a liquidity event (as defined in the LLC Agreement). In exchange for a cash payment of $5.7 million, Vanguard issued to Holdings 83,890 warrants with an exercise price of $1,000 per share and 35,952 warrants with an exercise price of $3,000 per share to purchase Vanguard's common stock. The warrants may be exercised at any time. Vanguard reserved 119,842 shares of its common stock to be issued upon exercise of the warrants.

During fiscal 2006 and fiscal 2007, Vanguard and Holdings repurchased a total of 33,708 outstanding equity incentive units from former executive officers for approximately $1.7 million. The purchase price for unvested units was based upon the lower of cost or fair market value (determined by an independent appraisal) or the lower of cost or fair market value less a 25% discount, as set forth in the LLC Agreement. The purchase price for vested units was fair market value or fair market value less a 25% discount.

Put and Call Features of Acquisition Subsidiary Stock

For a period of 30 days commencing June 1, 2007 and each June 1 thereafter, University of Chicago Hospitals ("UCH") has the right to require Vanguard to purchase its shares in the subsidiary that acquired Louis A. Weiss Memorial Hospital for a purchase price equal to four times the acquisition subsidiary's Adjusted EBITDA (as defined in the shareholders agreement between the parties) for the most recent 12 months of operations less all indebtedness of the acquisition subsidiary (including capital leases) at such time, multiplied by UCH's percentage

interest in the acquisition subsidiary on the date of purchase. Similarly, during the same 30-day periods, Vanguard has the right to require UCH to sell to it UCH's shares in the acquisition subsidiary for a purchase price equal to the greater of (i) six times the acquisition subsidiary's Adjusted EBITDA (as defined in the shareholders agreement among the parties) for the most recent 12 months of operations less all indebtedness of the acquisition subsidiary (including capital leases) at such time, times UCH's percentage interest in the acquisition subsidiary on the date of purchase, and (ii) the price paid by UCH for its interest in the acquisition subsidiary minus dividends or other distributions to UCH in respect of that interest.

11. Stock Based Compensation

As previously discussed, Vanguard used the minimum value pricing model permitted under SFAS 123 to determine stock compensation costs related to stock option grants prior to July 1, 2006. On July 1, 2006, Vanguard adopted the provisions of SFAS 123(R), to account for stock option grants subsequent to July 1, 2006. Vanguard adopted SFAS 123(R) on a prospective basis as required for companies that chose to adopt SFAS 123 using the transition guidance set forth in SFAS 148. During fiscal years 2006, 2007 and 2008, Vanguard incurred stock compensation of $1.7 million and $1.2 million and $2.5 million, respectively, related to grants under its 2004 Stock Incentive Plan.

2004 Stock Incentive Plan

After the Blackstone merger, Vanguard adopted the 2004 Stock Incentive Plan ("the 2004 Option Plan"). As of June 30, 2008, the 2004 Option Plan, as amended, allows for the issuance of up to 101,117 options to purchase common stock of Vanguard to its employees, members of its Board of Directors or other service providers of Vanguard or any of its affiliates. The stock options may be granted as Liquidity Event Options, Time Options or Performance Options at the discretion of the Board. The Liquidity Event Options vest 100% at the eighth anniversary of the date of grant and have an exercise price per share as determined by the Board or a committee thereof. The Time Options vest 20% at each of the first five anniversaries of the date of grant and have an exercise price per share as determined by the Board or a committee thereof. The Performance Options vest 20% at each of the first five anniversaries of the date of grant and have an exercise price equal to $3,000 per share or as determined by the Board. The Time Options and Performance Options immediately vest upon a change of control, while the Liquidity Event Options immediately vest only upon a qualifying Liquidity Event, as defined in the Plan Document. As of June 30, 2008, 88,698 options were outstanding under the 2004 Option Plan, as amended.

The following tables summarize options transactions during the years ended June 30, 2006, 2007 and 2008.

	2004 Stock Incentive Plan	
	# of Options	Wtd Avg Exercise Price
Options outstanding at June 30, 2005	38,184	$ 1,600.00
Options granted	41,297	1,675.81
Options exercised	(141)	1,000.00
Options cancelled	(8,683)	1,611.03
Options outstanding at June 30, 2006	70,657	1,644.12
Options granted	10,110	1,715.06
Options exercised	(195)	1,000.00
Options cancelled	(14,998)	1,624.81
Options outstanding at June 30, 2007	65,574	1,661.39
Options granted	30,583	1,611.90
Options exercised	(168)	1,038.49
Options cancelled	(7,291)	1,667.85
Options outstanding at June 30, 2008	88,698	$ 1,644.97
Options available for grant at June 30, 2008	11,915	$ 1,600.00
Options exercisable at June 30, 2008	16,993	$ 1,960.54

The following table provides information relating to the 2004 Option Plan during each period presented.

	Year ended June 30,		
	2006	2007	2008
Weighted average fair value of options granted during each year	$ 407.62	$ 590.70	$ 408.59
Intrinsic value of options exercised during each year (in millions)	$ 0.1	$ 0.1	$ 0.1
Fair value of outstanding options that vested during each year (in millions)	$ 0.5	$ 1.4	$ 1.7

The following table sets forth certain information regarding vested options at June 30, 2008, options expected to vest subsequent to June 30, 2008 and the total options expected to vest over the life of all options granted.

	Currently Vested	Additional Expected to Vest	Total Expected to Vest
Number of options at June 30, 2008	16,993	44,058	61,051
Weighted average exercise price	$ 1,960.54	$ 1,622.31	$ 1,716.45
Aggregate intrinsic value at June 30, 2008 (in millions)	$ 3.6	$ 13.1	$ 16.7
Weighted average remaining contractual term	7.0 years	8.1 years	7.8 years

12. Defined Contribution Plan

Effective June 1, 1998, Vanguard adopted its defined contribution employee benefit plan, the Vanguard 401(k) Retirement Savings Plan (the "401(k) Plan"). The 401(k) Plan is a multiple employer defined contribution plan whereby employees who are age 21 or older are eligible to participate.

The 401(k) Plan allows eligible employees to make contributions of 2% to 20% of their annual compensation. Employer matching contributions, which vary by employer, vest 20% after two years of service and continue vesting at 20% per year until fully vested. For purposes of determining vesting percentages in the 401(k) Plan, many employees received credit for years of service with their respective predecessor companies. Vanguard's matching expense for the years ended June 30, 2006, 2007 and 2008 was approximately $11.7 million, $13.8 million and $14.5 million, respectively.

13. Leases

Vanguard leases certain real estate properties and equipment under operating leases having various expiration dates. Future minimum operating lease payments at June 30, 2008 are approximately as follows (in millions).

	Operating Leases
2009	$ 33.6
2010	29.0
2011	24.6
2012	21.1
2013	15.9
Thereafter	55.8
Total minimum lease payments	$ 180.0

During the years ended June 30, 2006, 2007 and 2008, rent expense was approximately $33.9 million, $37.4 million and $41.8 million, respectively.

14. Contingencies and Healthcare Regulation

Contingencies

Vanguard is presently, and from time to time, subject to various claims and lawsuits arising in the normal course of business. In the opinion of management, the ultimate resolution of these matters will not have a material adverse effect on Vanguard's financial position or results of operations.

Reimbursement

Final determination of amounts earned under prospective payment and cost-reimbursement activities is subject to review by appropriate governmental authorities or their agents. In the opinion of Vanguard's management, adequate provision has been made for any adjustments that may result from such reviews.

Laws and regulations governing the Medicare and Medicaid and other federal healthcare programs are complex and subject to interpretation. Vanguard's management believes that it is in compliance with all applicable laws and regulations in all material respects and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing related to Medicare and Medicaid programs. While no such regulatory inquiries have been made, Vanguard's compliance with such laws and regulations is subject to future government review and interpretation. Non-compliance with such laws and regulations could result in significant regulatory action including fines, penalties, and exclusion from the Medicare, Medicaid and other federal healthcare programs.

Acquisitions

Vanguard has acquired and may continue to acquire businesses with prior operating histories. Acquired companies may have unknown or contingent liabilities, including liabilities for failure to comply with healthcare laws and regulations, such as billing and reimbursement, fraud and abuse and similar anti-referral laws. Although Vanguard institutes policies designed to conform practices to its standards following the completion of its acquisitions, there can be no assurance that it will not become liable for past activities of prior owners that may later be asserted to be improper by private plaintiffs or government agencies. Although Vanguard generally seeks to obtain indemnification from prospective sellers covering such matters, there can be no assurance that any such matter will be covered by indemnification, or if covered, that such indemnification will be adequate to cover potential losses and fines.

Employment-Related Agreements

Effective June 1, 1998, Vanguard executed employment agreements with three of its current senior executive officers. Vanguard executed an employment agreement with a fourth current senior executive officer on September 1, 1999. The employment agreements were amended on September 23, 2004 to extend the term of each employment agreement another 5 years and to provide that the Blackstone merger did not constitute a change of control, as defined in the agreements. On November 15, 2007, Vanguard entered into written employment agreements with two other executive officers for terms expiring on November 15, 2012. The employment agreements will renew automatically for additional one-year periods, unless terminated by Vanguard or the executive officer. The employment agreements provide, among other things, for minimum salary levels, for participation in bonus plans, and for amounts to be paid as liquidated damages in the event of a change in control or termination by Vanguard without cause.

Vanguard has executed severance protection agreements ("severance agreements") between Vanguard and each of its other officers who do not have employment agreements. The severance agreements are automatically extended for successive one year terms at the discretion of Vanguard unless a change in control occurs, as defined in the severance agreement, at which time the severance agreement continues in effect for a period of not less than three years beyond the date of such event. Vanguard may be obligated to pay severance payments as set forth in the

severance agreements in the event of a change in control and the termination of the executive's employment of Vanguard.

Guarantees

Physician Guarantees

Vanguard has entered into multiple physician relocation agreements and service agreements under which it provides minimum monthly revenues or collections guarantees or maximum expense guarantees to physicians during a specified period of time (typically 12 months to 24 months). In return for the physician guarantee payments, the physicians are required to practice in the community for a stated period of time (typically 3 to 5 years) or else return the payments to Vanguard. No community commitment provision or repayment provision exists for the service guarantees. In January 2006, Vanguard adopted Financial Accounting Standards Board Staff Position No. FIN 45-3, *Application of FASB Interpretation No. 45 to Minimum Revenue Guarantees Granted to a Business or Its Owners* ("FSP 45-3"). FSP 45-3 requires that a liability be recorded at fair value for all guarantees entered into on or after January 1, 2006. Vanguard determines this liability and an offsetting intangible asset by calculating an estimate of expected payments to be made over the guarantee period. Vanguard reduces the liability as it makes guarantee payments and amortizes the intangible asset over the term of the physicians' relocation or service agreements. As of June 30, 2008, Vanguard had a net intangible asset of $9.5 million and a remaining liability of $4.4 million related to these physician guarantees. The maximum amount of Vanguard's unpaid physician income and service guarantees under FSP 45-3 as of June 30, 2008 was approximately $6.7 million.

Other Guarantees

As part of its contract with AHCCCS, PHP is required to maintain a performance guarantee in the amount of $22.0 million, an amount determined based upon PHP's membership and capitation premiums received. As of June 30, 2008, Vanguard maintained this $22.0 million performance guarantee entirely in the form of surety bonds with independent third party insurers that expire on September 30, 2008. Vanguard is required to arrange for $2.9 million in letters of credit to collateralize its $22.0 million in surety bonds with the third party insurers. Vanguard expects this performance guarantee obligation to increase significantly when the new PHP AHCCCS contract commences on October 1, 2008. As of June 30, 2008, Vanguard provided a $0.6 million guarantee of the debt of a joint venture accounted for as an equity method investment and also from time to time enters into parent-subsidiary guarantee arrangements in the ordinary course of operating its business.

Variable Interest Entities

Vanguard is a party to one contractual agreement whereby it may be required to make monthly payments to the developer and manager of a medical office building located on one of its hospital campuses through a minimum rent revenue guarantee. Vanguard entered into this agreement to provide an incentive to the developer to fund the construction of a medical office building and manage the building upon its completion in order to make physician office space available near the hospital campus. The contract commenced in April 2005 for a period of 12 years. Vanguard deemed this contract a variable interest entity in which Vanguard is not the primary beneficiary. The maximum annual amount Vanguard would pay under the contract assuming zero occupancy would be approximately $1.5 million. Vanguard currently expects to make no rental shortfall payments during fiscal 2009 under this contract given current and expected future occupancy levels in the medical office building.

As of June 30, 2007, Vanguard had another minimum rent guarantee arrangement with an entity owning another medical office building located on the campus of another of its hospitals. Due to the significance of Vanguard's historical minimum rent revenue payments to the operations of the medical office building, Vanguard consolidated this entity for financial reporting purposes. During the quarter ended September 30, 2007, the entity that owned the medical office building sold the building to a third party, which terminated Vanguard's minimum rent guarantee obligation. Thus, Vanguard no longer included this entity in its consolidated financial statements as of June 30, 2008.

15. Related Party Transactions

Pursuant to the Blackstone merger agreement, Vanguard entered into a transaction and monitoring fee agreement with Blackstone and Metalmark Subadvisor LLC ("Metalmark"). Under the terms of the agreement, Vanguard agreed to pay Blackstone and Metalmark an annual monitoring fee of $4.0 million and $1.2 million, respectively, plus out of pocket expenses. The monitoring fee represents compensation to Blackstone and Metalmark for their advisory and consulting services with respect to financing transactions, strategic decisions, dispositions or acquisitions of assets and other Vanguard affairs from time to time. Blackstone also has the option under the agreement to elect at any time in anticipation of a change in control or initial public offering to require Vanguard to pay both Blackstone and Metalmark a lump sum monitoring fee, calculated as the net present value of future annual monitoring fees assuming a remaining ten-year payment period, in lieu of the remaining annual monitoring fee payments. If Blackstone chooses a lump sum payment, Metalmark is entitled to receive not less than 15% of the sum of the initial $20.0 million Blackstone transaction fee and the cumulative monitoring fees and lump sum monitoring fee paid to Blackstone less the cumulative aggregate monitoring fees paid to Metalmark to date. During both fiscal 2006 and 2007, Vanguard paid $4.0 million and $1.2 million in monitoring fees to Blackstone and Metalmark, respectively. During fiscal 2008, Vanguard paid approximately $5.2 million and $1.2 million in monitoring fees and expenses to Blackstone and Metalmark, respectively.

Blackstone and Metalmark have the ability to control Vanguard's policies and operations, and their interests may not in all cases be aligned with Vanguard's interests. Vanguard also conducts business with other entities controlled by Blackstone or Metalmark. Vanguard's results of operations could be materially different as a result of Blackstone and Metalmark's control than such results would be if Vanguard were autonomous.

16. Segment Information

Vanguard's acute care hospitals and related healthcare businesses are similar in their activities and economic environments in which they operate (i.e. urban markets). Accordingly, Vanguard's reportable operating segments consist of 1) acute care hospitals and related healthcare businesses, collectively, and 2) health plans consisting of MacNeal Health Providers, a contracting entity for MacNeal Hospital and Weiss Memorial Hospital in the metropolitan Chicago area, Phoenix Health Plan, a Medicaid managed health plan operating in Arizona, and Abrazo Advantage Health Plan, a Medicare and Medicaid dual eligible managed health plan operating in Arizona. The following tables provide financial information by business segment for the years ended June 30, 2006, 2007 and 2008.

	For the Year Ended June 30, 2006			
	Health Plans	Acute Care Services	Eliminations	Consolidated
		(In millions)		
Patient service revenues (1)	$ –	$ 2,043.6	$ –	$ 2,043.6
Premium revenues	375.0	–	–	375.0
Inter-segment revenues	–	40.0	(40.0)	–
Total revenues	375.0	2,083.6	(40.0)	2,418.6
Salaries and benefits (excludes stock compensation of $1.7 million)	13.6	976.1	–	989.7
Supplies	0.2	393.9	–	394.1
Medical claims expense (1)	270.3	–	–	270.3
Provision for doubtful accounts	–	156.8	–	156.8
Other operating expenses – external	18.3	334.7	–	353.0
Operating expenses – inter-segment	40.0	–	(40.0)	–
Total operating expenses	342.4	1,861.5	(40.0)	2,163.9
Segment EBITDA (2)	32.6	222.1	–	254.7
Depreciation and amortization	4.3	96.0	–	100.3
Interest, net	(2.3)	106.1	–	103.8
Minority interests	–	2.6	–	2.6
Equity method income	–	(0.2)	–	(0.2)
Stock compensation	–	1.7	–	1.7
Debt extinguishment costs	–	0.1	–	0.1
Loss on disposal of assets	–	1.5	–	1.5
Monitoring fees and expenses	–	5.2	–	5.2
Income from continuing operations before income taxes	$ 30.6	$ 9.1	$ –	$ 39.7
Segment assets	$ 161.9	$ 2,488.6	$ –	$ 2,650.5
Capital expenditures	$ 0.2	$ 275.3	$ –	$ 275.5

(1) Vanguard eliminates in consolidation those patient service revenues earned by its hospitals and related healthcare facilities attributable to services provided to enrollees in its owned health plans and also eliminates the corresponding medical claims expenses incurred by the health plans for those services.

(2) Segment EBITDA is defined as income before interest expense (net of interest income), income taxes, depreciation and amortization, minority interests, equity method income or loss, stock compensation, debt extinguishment costs, gain or loss on disposal of assets, monitoring fees and expenses, impairment loss and discontinued operations. Management uses Segment EBITDA to measure performance for Vanguard's segments and to develop strategic objectives and operating plans for those segments. Segment EBITDA eliminates the uneven effect of non-cash depreciation of tangible assets and amortization of intangible assets, much of which results from acquisitions accounted for under the purchase method of accounting. Segment EBITDA also eliminates the effects of changes in interest rates which management believes relate to general trends in global capital markets, but are not necessarily indicative of the operating performance of Vanguard's segments. Management believes that Segment EBITDA provides useful information about the financial performance of Vanguard's segments to investors, lenders, financial analysts and rating agencies. Additionally, management believes that investors and lenders view Segment EBITDA as an important factor in making investment decisions and assessing the value of Vanguard. Segment EBITDA is not a substitute for net income, operating cash flows or other cash flow statement data determined in accordance with accounting principles generally accepted in the United States. Segment EBITDA, as presented, may not be comparable to similarly titled measures of other companies.

	For the Year Ended June 30, 2007			
	Health Plans	Acute Care Services	Eliminations	Consolidated
		(In millions)		
Patient service revenues (1)	$ –	$ 2,179.3	$ –	$ 2,179.3
Capitation premiums	401.4	–	–	401.4
Inter-segment revenues	–	34.2	(34.2)	–
Total revenues	401.4	2,213.5	(34.2)	2,580.7
Salaries and benefits (excludes stock compensation of $1.2 million)	14.7	1,052.0	–	1,066.7
Supplies	0.2	421.6	–	421.8
Medical claims expense (1)	297.0	–	–	297.0
Provision for doubtful accounts	–	175.2	–	175.2
Other operating expenses – external	27.3	347.7	–	375.0
Operating expenses – inter-segment	34.2	–	(34.2)	–
Total operating expenses	373.4	1,996.5	(34.2)	2,335.7
Segment EBITDA (2)	28.0	217.0	–	245.0
Depreciation and amortization	4.3	114.3	–	118.6
Interest, net	(5.8)	129.6	–	123.8
Minority interests	–	2.6	–	2.6
Equity method income	–	(0.9)	–	(0.9)
Stock compensation	–	1.2	–	1.2
Gain on disposal of assets	–	(4.1)	–	(4.1)
Impairment loss	–	123.8	–	123.8
Monitoring fees and expenses	–	5.2	–	5.2
Income (loss) from continuing operations before income taxes	$ 29.5	$ (154.7)	$ –	$ (125.2)
Segment assets	$ 197.3	$ 2,340.8	$ –	$ 2,538.1
Capital expenditures	$ 0.2	$ 164.1	$ –	$ 164.3

(1) Vanguard eliminates in consolidation those patient service revenues earned by its hospitals and related healthcare facilities attributable to services provided to enrollees in its owned health plans and also eliminates the corresponding medical claims expenses incurred by the health plans for those services.

(2) Segment EBITDA is defined as income before interest expense (net of interest income), income taxes, depreciation and amortization, minority interests, equity method income or loss, stock compensation, debt extinguishment costs, gain or loss on disposal of assets, monitoring fees and expenses, impairment loss and discontinued operations. Management uses Segment EBITDA to measure performance for Vanguard's segments and to develop strategic objectives and operating plans for those segments. Segment EBITDA eliminates the uneven effect of non-cash depreciation of tangible assets and amortization of intangible assets, much of which results from acquisitions accounted for under the purchase method of accounting. Segment EBITDA also eliminates the effects of changes in interest rates which management believes relate to general trends in global capital markets, but are not necessarily indicative of the operating performance of Vanguard's segments. Management believes that Segment EBITDA provides useful information about the financial performance of Vanguard's segments to investors, lenders, financial analysts and rating agencies. Additionally, management believes that investors and lenders view Segment EBITDA as an important factor in making investment decisions and assessing the value of Vanguard. Segment EBITDA is not a substitute for net income, operating cash flows or other cash flow statement data determined in accordance with accounting principles generally accepted in the United States. Segment EBITDA, as presented, may not be comparable to similarly titled measures of other companies.

	For the Year Ended June 30, 2008			
	Health Plans	Acute Care Services	Eliminations	Consolidated
		(In millions)		
Patient service revenues (1)	$ –	$ 2,340.5	$ –	$ 2,340.5
Capitation premiums	450.2	–	–	450.2
Inter-segment revenues	–	31.2	(31.2)	–
Total revenues	450.2	2,371.7	(31.2)	2,790.7
Salaries and benefits (excludes stock compensation of $2.5 million)	16.0	1,134.2	–	1,150.2
Supplies	0.2	434.3	–	434.5
Medical claims expense (1)	328.2	–	–	328.2
Provision for doubtful accounts	–	205.6	–	205.6
Other operating expenses – external	29.9	375.9	–	405.8
Operating expenses – inter-segment	31.2	–	(31.2)	–
Total operating expenses	405.5	2,150.0	(31.2)	2,524.3
Segment EBITDA (2)	44.7	221.7	–	266.4
Depreciation and amortization	4.2	126.8	–	131.0
Interest, net	(4.5)	126.6	–	122.1
Minority interests	–	3.0	–	3.0
Equity method income	–	(0.7)	–	(0.7)
Stock compensation	–	2.5	–	2.5
Loss on disposal of assets	–	0.9	–	0.9
Monitoring fees and expenses	–	6.3	–	6.3
Income (loss) from continuing operations before income taxes	$ 45.0	$ (43.7)	$ –	$ 1.3
Segment assets	$ 181.5	$ 2,400.8	$ –	$ 2,582.3
Capital expenditures	$ 0.6	$ 121.0	$ –	$ 121.6

(1) Vanguard eliminates in consolidation those patient service revenues earned by its hospitals and related healthcare facilities attributable to services provided to enrollees in its owned health plans and also eliminates the corresponding medical claims expenses incurred by the health plans for those services.

(2) Segment EBITDA is defined as income before interest expense (net of interest income), income taxes, depreciation and amortization, minority interests, equity method income or loss, stock compensation, debt extinguishment costs, gain or loss on disposal of assets, monitoring fees and expenses, impairment loss and discontinued operations. Management uses Segment EBITDA to measure performance for Vanguard's segments and to develop strategic objectives and operating plans for those segments. Segment EBITDA eliminates the uneven effect of non-cash depreciation of tangible assets and amortization of intangible assets, much of which results from acquisitions accounted for under the purchase method of accounting. Segment EBITDA also eliminates the effects of changes in interest rates which management believes relate to general trends in global capital markets, but are not necessarily indicative of the operating performance of Vanguard's segments. Management believes that Segment EBITDA provides useful information about the financial performance of Vanguard's segments to investors, lenders, financial analysts and rating agencies. Additionally, management believes that investors and lenders view Segment EBITDA as an important factor in making investment decisions and assessing the value of Vanguard. Segment EBITDA is not a substitute for net income, operating cash flows or other cash flow statement data determined in accordance with accounting principles generally accepted in the United States. Segment EBITDA, as presented, may not be comparable to similarly titled measures of other companies.

17. Unaudited Quarterly Operating Results

The following table presents summarized unaudited quarterly results of operations for the fiscal years ended June 30, 2007 and 2008. Management believes that all necessary adjustments have been included in the amounts stated below for a fair presentation of the results of operations for the periods presented when read in conjunction with Vanguard's consolidated financial statements for the fiscal years ended June 30, 2007 and 2008. Results of operations for a particular quarter are not necessarily indicative of results of operations for an annual period and are not predictive of future periods (in millions).

	September 30, 2006	December 31, 2006	March 31, 2007	June 30, 2007
Total revenues	$ 618.3	$ 638.4	$ 672.9	$ 651.1
Net income (loss)	$ (7.7)	$ (118.7)	$ 3.3	$ (9.6)

	September 30, 2007	December 31, 2007	March 31, 2008	June 30, 2008
Total revenues	$ 662.5	$ 686.0	$ 725.6	$ 716.6
Net income (loss)	$ (6.9)	$ 0.5	$ 6.5	$ (0.8)

Total revenues disclosed above for the first three quarters during fiscal 2007 differ from the amounts disclosed in our previously filed fiscal 2007 Quarterly Reports on Form 10-Q due to the reclassification of PMH total revenues to discontinued operations as presented below (in millions).

	September 30, 2006	December 31, 2006	March 31, 2007
As previously reported	$ 634.9	$ 652.9	$ 684.5
Reclassification of PMH revenues	16.6	14.5	11.6
As disclosed above	$ 618.3	$ 638.4	$ 672.9

Item 9. Changes in and Disagreements With Accountants on Accounting and Financial Disclosure.

None.

Item 9A(T). Controls and Procedures.

Evaluation of Disclosure Control and Procedures

As of the end of the period covered by this report, our management conducted an evaluation, with the participation of our chief executive officer and chief financial officer, of the effectiveness of our disclosure controls and procedures (as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934 (the "Exchange Act")). Based on this evaluation, our chief executive officer and chief financial officer have concluded that our disclosure controls and procedures are effective to ensure that information required to be disclosed by us in the reports that we file or submit under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in Securities and Exchange Commission's rules and forms and that such information is accumulated and communicated to management, including our chief executive officer and chief financial officer, as appropriate to allow timely decisions regarding required disclosure.

Report of Management on Internal Control over Financial Reporting

The management of Vanguard Health Systems, Inc. is responsible for the preparation, integrity and fair presentation of the consolidated financial statements appearing in our periodic filings with the Securities and Exchange Commission. The consolidated financial statements were prepared in conformity with generally accepted accounting principles appropriate in the circumstances and, accordingly, include certain amounts based on our best judgments and estimates.

Management is also responsible for establishing and maintaining adequate internal control over financial reporting as such term is defined in Rules 13a-15(f) under the Securities and Exchange Act of 1934. Internal control over financial reporting is a process to provide reasonable assurance regarding the reliability of our financial reporting in accordance with accounting principles generally accepted in the United States of America. Our internal control over financial reporting includes a program of internal audits and appropriate reviews by management, written policies and guidelines, careful selection and training of qualified personnel including a dedicated Compliance department and a written Code of Business Conduct and Ethics adopted by our Board of Directors, applicable to all of our directors, officers and employees.

Internal control over financial reporting includes maintaining records that in reasonable detail accurately and fairly reflect our transactions; providing reasonable assurance that transactions are recorded as necessary for preparation of our financial statements; providing reasonable assurance that receipts and expenditures of company assets are made in accordance with management authorization; and providing reasonable assurance that unauthorized acquisition, use or disposition of company assets that could have a material effect on our financial statements would be prevented or detected in a timely manner. Because of its inherent limitations, including the possibility of human error and the circumvention or overriding of control procedures, internal control over financial reporting is not intended to provide absolute assurance that a misstatement of our financial statements would be prevented or detected. Therefore, even those internal controls determined to be effective can provide only reasonable assurance with respect to financial statement preparation and presentation.

Management conducted an evaluation of the effectiveness of our internal control over financial reporting based on the framework in *Internal Control – Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission. Based on this evaluation, management concluded that the Company's internal control over financial reporting was effective as of June 30, 2008.

This annual report does not include an attestation report of the Company's independent registered public accounting firm regarding internal control over financial reporting. Management's report was not subject to attestation by the Company's independent registered public accounting firm pursuant to temporary rules of the United States Securities and Exchange Commission that permit the Company to provide only management's report in this annual report for the year ended June 30, 2008.

Changes in Internal Control Over Financial Reporting

There was no change in our internal control over financial reporting during our fiscal quarter ended June 30, 2008 that materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

Item 9B. Other Information.

None.

PART III

Item 10. Directors, Executive Officers and Corporate Governance.

The table below presents information with respect to the members of our board of directors and our executive officers and their ages as of September 1, 2008.

Name	Age	Position
Charles N. Martin, Jr.	65	Chairman of the Board & Chief Executive Officer; Director
Kent H. Wallace	53	President & Chief Operating Officer
Keith B. Pitts	51	Vice Chairman
Joseph D. Moore	61	Executive Vice President
Phillip W. Roe	47	Executive Vice President, Chief Financial Officer & Treasurer
Ronald P. Soltman	62	Executive Vice President, General Counsel & Secretary
Dan F. Ausman	53	Senior Vice President-Operations
Reginald M. Ballantyne III	64	Senior Vice President-Market Strategy & Government Affairs
Bruce F. Chafin	52	Senior Vice President-Compliance & Ethics
Karen Flinn	47	Senior Vice President-Physician & Ambulatory Services
James Johnston	64	Senior Vice President-Human Resources
Joseph J. Mullany	44	Senior Vice President-Operations
Harold H. Pilgrim III	47	Senior Vice President-Operations
James H. Spalding	49	Senior Vice President, Assistant General Counsel & Assistant Secretary
Alan G. Thomas	54	Senior Vice President-Operations Finance
Thomas M. Ways	58	Senior Vice President-Managed Care
Gary D. Willis	43	Senior Vice President, Controller & Chief Accounting Officer
Deanna L. Wise	39	Senior Vice President & Chief Information Officer
Michael A. Dal Bello	37	Director
M. Fazle Husain	44	Director
Alan M. Muney, M.D.	55	Director
Michael J. Parsons	53	Director
James A. Quella	58	Director
Neil P. Simpkins	42	Director

Charles N. Martin, Jr. has served as Chairman of the board of directors and Chief Executive Officer of Vanguard since July 1997. Until May 31, 2001, he was also Vanguard's President. From January 1992 until January 1997, Mr. Martin was Chairman, President and Chief Executive Officer of OrNda HealthCorp ("OrNda"), a hospital management company. Prior thereto Mr. Martin was President and Chief Operating Officer of HealthTrust, Inc., a hospital management company, from September 1987 until October 1991. Mr. Martin is also a director of several privately held companies.

Kent H. Wallace has served as Vanguard's President & Chief Operating Officer since September 2005. Prior thereto he was a Senior Vice President - Operations of Vanguard from February 2003 until September 2005. Prior thereto from July 2001 to December 2002 he was Regional Vice President of Province Healthcare Company of Brentwood, Tennessee, an owner and operator of 20 non-urban, acute care hospitals in 13 states of the United States. During this time Mr. Wallace had managerial responsibility for seven of these hospitals. From June 1999 until June 2001 Mr. Wallace was President and Chief Executive Officer of Custom Curb, Inc. of Chattanooga, Tennessee, a family owned company which manufactured roof accessories. Prior thereto from January 1997 until May 1999 Mr. Wallace was a Vice President - Acquisitions and Development of Tenet Healthcare Corporation of Dallas, Texas, a hospital management company ("Tenet").

Keith B. Pitts has been Vanguard's Vice Chairman since May 2001, was a director of Vanguard from August 1999 until September 2004, and was an Executive Vice President of Vanguard from August 1999 until May 2001. Prior thereto, from November 1997 until June 1999, he was the Chairman and Chief Executive Officer of Mariner Post-Acute Network, Inc. and its predecessor, Paragon Health Network, Inc., which is a nursing home

management company. Prior thereto from August 1992 until January 1997, Mr. Pitts served as Executive Vice President and Chief Financial Officer of OrNda.

Joseph D. Moore has served as an Executive Vice President of Vanguard since November 2007. He served as Executive Vice President, Chief Financial Officer and Treasurer of Vanguard from July 1997 until November 2007 and was a director of Vanguard from July 1997 until September 2004. From February 1994 to April 1997, he was Senior Vice President - Development of Columbia/HCA Healthcare Corporation ("Columbia"), a hospital management company. Mr. Moore first joined Hospital Corporation of America (a predecessor of Columbia) in April 1970, rising to Senior Vice President - Finance and Development in January 1993.

Phillip W. Roe has been Executive Vice President, Chief Financial Officer and Treasurer since November 2007. He was Senior Vice President, Controller and Chief Accounting Officer of Vanguard from July 1997 to November 2007. Prior thereto he was Senior Vice President, Controller and Chief Accounting Officer of OrNda from September 1996 until January 1997 and was Vice President, Controller and Chief Accounting Officer of OrNda from October 1994 until September 1996.

Ronald P. Soltman has been Vanguard's Executive Vice President, General Counsel and Secretary since July 1997 and was a director of Vanguard from July 1997 until September 2004. From April 1994 until January 1997, he was Senior Vice President, General Counsel and Secretary of OrNda. From February 1994 until March 1994, he was Vice President and Assistant General Counsel of Columbia. From 1984 until February 1994, he was Vice President and Assistant General Counsel of Hospital Corporation of America.

Dan F. Ausman has served as a Senior Vice President - Operations of Vanguard since February 2006. Prior thereto from May 2005 to February 2006 he was Vice President - Operations of Vanguard. From 1998 to April 2005 Mr. Ausman was the President & Chief Executive Officer of Irvine Regional Hospital and Medical Center, a 176-bed acute care hospital in Irvine, CA which is owned by an affiliate of Tenet.

Reginald M. Ballantyne III, joined Vanguard in May 2001 and has served as Senior Vice President - Market Strategy & Government Affairs of Vanguard since January 2002. From 1984 to 2001, he served as President of PMH Health Resources, Inc., an Arizona based multi-unit healthcare system. Prior to 1984, Mr. Ballantyne served as President of Phoenix Memorial Hospital in Phoenix, Arizona. Mr. Ballantyne served as Chairman of the American Hospital Association ("AHA") in 1997 and as Speaker of the AHA House of Delegates in 1998. He is a Fellow of the American College of Healthcare Executives ("ACHE") and a recipient of the ACHE Gold Medal Award for Management Excellence. Mr. Ballantyne also served as a member of the national Board of Commissioners for the Joint Commission on Accreditation of Healthcare Organizations and as Chairman of the AHA Committee of Commissioners from 1992 until 1995. Mr. Ballantyne previously served as a director of Superior Consultant Holdings Corporation and is currently a director of several privately held companies.

Bruce F. Chafin has served as Senior Vice President - Compliance & Ethics of Vanguard since July 1997. Prior thereto, from April 1995 to January 1997, he served as Vice President - Compliance & Ethics of OrNda.

Karen Flinn has served as Senior Vice President - Physician & Ambulatory Services of Vanguard since September 11, 2007. Prior thereto from May 1999 until July 2007 she was Vice President - Physician Integration/Managed Care of Triad Hospitals, Inc., an investor owned hospital management company headquartered in Plano, Texas. Prior thereto from May 1996 until May 1999 she was Vice President - Physician Integration/Managed Care of the Central and Pacific Group of Columbia.

James Johnston has served as Senior Vice President - Human Resources of Vanguard since July 1997. Prior thereto from November 1995 to January 1997, he served as Senior Vice President - Human Resources of OrNda.

Joseph J. Mullany has served as a Senior Vice President - Operations of Vanguard since September 2005. Prior thereto from October 2002 to August 2005 he was a Regional Vice President of Essent Healthcare, Inc. of Nashville, TN, an investor-owned hospital management company, responsible for its New England Division. Prior thereto from October 1998 to October 2002 Mr. Mullany was a Division Vice President of Health Management

Associates, Inc. of Naples, Florida, an investor-owned hospital management company, responsible for its Mississippi Division.

Harold H. Pilgrim III has served as a Senior Vice President - Operations of Vanguard since September 2005. Prior thereto from February 2003 to September 2005 he was Vice President - Business Development of Vanguard, responsible for development for Vanguard's Texas operations. Prior thereto from November 2001 to January 2003 Mr. Pilgrim was Vanguard's Vice President - Investor Relations, and during that period he was also involved in Vanguard's acquisitions and development activities. From January 1, 2001 to October 2001 Mr. Pilgriin was Chief Development Officer for Velocity Health Capital, Inc., a Nashville, TN - based investment banking firm focused on the health care and bio-sciences industries.

James H. Spalding has served as Senior Vice President, Assistant General Counsel and Assistant Secretary of Vanguard since November 1998. Prior thereto he was Vice President, Assistant General Counsel and Assistant Secretary of Vanguard from July 1997 until November 1998. Prior thereto from April 1994 until January 1997, he served as Vice President, Assistant General Counsel and Assistant Secretary of OrNda.

Alan G. Thomas has been Senior Vice President - Operations Finance of Vanguard since July 1997. Prior thereto, Mr. Thomas was Senior Vice President - Hospital Financial Operations of OrNda from April 1995 until January 1997. Prior thereto he was Vice President - Reimbursement and Revenue Enhancement of OrNda from June 1994 until April 1995.

Thomas M. Ways has served as Senior Vice President - Managed Care of Vanguard since March 1998. Prior thereto from February 1997 to February 1998, he was Chief Executive Officer of MSO/Physician Practice Development for the Southern California Region of Tenet. Prior thereto from August 1994 to January 1997, he was Vice President - Physician Integration of OrNda.

Gary D. Willis has served as Senior Vice President, Controller and Chief Accounting Officer of Vanguard since May 2008. From February 2006 to May 2008, he was Senior Vice President and Chief Accounting Officer of LifePoint Hospitals ("LifePoint"), a hospital management company based in Brentwood, Tennessee. From December 2002 to February 2006, he was Vice President and Controller of LifePoint.

Deanna L. Wise has served as Senior Vice President and Chief Information Officer of Vanguard since November 2006. Prior thereto from August 2004 to October 2006 she was the Chief Information Officer of Vanguard's operating region managing its Phoenix-area healthcare facilities. From November 2002 until August 2004 she was chief information officer of the Maricopa Integrated Health System in Phoenix, Arizona, which was a county integrated health care system including an acute care hospital, health clinics and health plans. Prior thereto, from October 1997 to November 2002 she was the director of applications of Ascension Health –Central Indiana Health System in Indianapolis, Indiana, a regional healthcare management organization supervising the operations of twelve acute care hospitals.

Michael A. Dal Bello became a member of Vanguard's board of directors on September 23, 2004. Mr. Dal Bello has been a Principal in the Private Equity Group of Blackstone since December 2005 and from 2002 until December 2005, he was an Associate in this Group. While at Blackstone, Mr. Dal Bello has been actively involved in Blackstone's healthcare investment activities. Prior to joining Blackstone, Mr. Dal Bello received an M.B.A. from Harvard Business School in 2002. Mr. Dal Bello worked at Hellman & Friedman LLC from 1998 to 2000 and prior thereto at Bain & Company. He currently serves on the board of representatives or directors of Team Finance LLC, Biomet, Inc., Catalent Pharma Solutions, Inc. and Sithe Global.

M. Fazle Husain became a member of Vanguard's board of directors on November 7, 2007. Mr. Husain is a Managing Director of Metalmark Capital, the private equity division of Citigroup Alternative Investments. Prior to joining Metalmark, Mr. Husain was with Morgan Stanley & Co. for 18 years, where he was a Managing Director in the private equity and venture capital investment business. Mr. Husain currently also serves on the board of directors of Allscripts Healthcare Solutions, Inc. and SouthernCare Hospice.

Alan M. Muney, M.D. became a member of Vanguard's board of directors on May 6, 2008. Dr. Muney has served as an Executive Director in the Private Equity Group of Blackstone since October 2007. Before joining Blackstone Dr. Muney was the executive vice president and chief medical officer of Oxford Health Plans and the chief medical officer of United Healthcare (Northeast region) from 1998 to September 2007. He also currently serves as a member of the board of representatives of Team Finance LLC.

Michael J. Parsons became a member of Vanguard's board of directors on May 6, 2008. He is a private investor. From May 1999 until July 2007 he served as Executive Vice President and Chief Operating Officer of Triad Hospitals, Inc., an investor owned hospital management company headquartered in Plano, Texas, which was acquired by Community Health Systems, Inc. in July 2007.

James A. Quella became a member of Vanguard's board of directors on September 11, 2007. Mr. Quella is a Senior Managing Director and Senior Operating Partner in the Private Equity Group at Blackstone. Prior to joining Blackstone in 2004, Mr. Quella was a Managing Director and Senior Operating Partner with DLJ Merchant Banking Partners-CSFB Private Equity from June 2000 to February 2004. Prior to that, Mr. Quella worked at Mercer Management Consulting and Strategic Planning Associates, its predecessor firm, from September 1981 to January 2000 where he served as a Senior Consultant to chief executive officers and senior management teams, and was Co-Vice Chairman with shared responsibility for overall management of the firm. Mr. Quella currently serves as a director of Allied Waste Industries, Inc., Graham Packaging Holdings Company, Intelenet Global Services, The Nielsen Company and Michaels Stores, Inc.

Neil P. Simpkins became a member of Vanguard's board of directors on September 23, 2004. Mr. Simpkins has served as a Senior Managing Director in the Private Equity Group of Blackstone since December 1999. From 1993 until the time he joined Blackstone, Mr. Simpkins was a Principal at Bain Capital. Prior to joining Bain Capital, Mr. Simpkins was a consultant at Bain & Company in London and the Asia Pacific region. He currently serves as Chairman of the board of directors of TRW Automotive Holdings Corp. and is a member of the board of representatives of Team Finance LLC.

Composition of the Board of Directors

General

As of the date of this report, the board of directors of Vanguard consists of seven members, four of whom were nominated by Blackstone, one of whom was nominated by MSCP, one of whom is our chief executive officer (and, if our chief executive officer is not Charles N. Martin, Jr., such other person designated by senior management (the "Manager Representative")) and one independent director. Blackstone has the right to increase the size of Vanguard's board from seven to nine members, with one additional director to be designated by Blackstone and one additional director to be an independent person identified by our chief executive officer and acceptable to Blackstone. MSCP and, subject to the conditions above, senior management, will each continue to be entitled to nominate and elect one director unless and until the respective group ceases to own at least 50.0% of the Class A membership units in VHS Holdings LLC ("Holdings") owned on September 23, 2004. Holdings acquired Vanguard pursuant to a merger (the "Merger") on September 23, 2004. See "Item 1. Business – The Merger".

Committees

Our board of directors currently does not have any standing committees, including an audit committee. Our entire board of directors is acting as our audit committee to oversee our accounting and financial reporting processes and the audits of our financial statements, as allowed under the Securities Exchange Act of 1934 for issuers without securities listed on a national securities exchange or on an automated national quotation system. Additionally, because our securities are not so listed, our board of directors is not required to have on it a person who qualifies under the rules of the Securities and Exchange Commission as an "audit committee financial expert" or as having accounting or financial management expertise under the similar rules of the national securities exchanges. While our board of directors has not designated any of its members as an audit committee financial expert, we believe that each of the current board members is fully qualified to address any accounting, financial reporting or audit issues that may come before it.

Code of Ethics

We have adopted a Code of Business Conduct and Ethics that applies to all of our officers and employees, including our principal executive officer, principal financial officer and principal accounting officer, which has been posted on our Internet website at www.vanguardhealth.com/pdfs/codeofbusinessconductandethics.pdf. Our Code of Business Conduct and Ethics is a "code of ethics", as defined in Item 406(b) of Regulation S-K of the Securities and Exchange Commission. Please note that our Internet website address is provided as an inactive textual reference only. We will make any legally required disclosures regarding amendments to, or waivers of, provisions of our code of ethics on our Internet website.

Item 11. Executive Compensation.

COMPENSATION DISCUSSION AND ANALYSIS

Overview

This section discusses the principles underlying our executive compensation policies and decisions. It provides qualitative information regarding the manner in which compensation is earned by our executive officers and places in context the data presented in the tables that follow. In addition, in this section, we address the compensation paid or awarded during fiscal year 2008 to: Charles N. Martin, Jr., our Chief Executive Officer (principal executive officer); Phillip W. Roe, our Chief Financial Officer (principal financial officer); and three other executive officers who were our three other most highly compensated executive officers in fiscal year 2008, Keith B. Pitts, our Vice Chairman; Kent H. Wallace, our President and Chief Operating Officer; and Joseph D. Moore, one of our Executive Vice Presidents. We refer to these five executive officers as our "named executive officers."

On September 23, 2004, we were acquired in the Merger by private equity investment funds associated with Blackstone Group who invested $494.4 million in our equity for a 66% equity interest, with private equity funds associated with our former equity sponsor, MSCP, retaining a 17.3% equity interest in us by reinvesting $130 million in our equity and with 13 of our 16 current executive officers retaining a 11.8% equity interest in us by reinvesting $88.4 million in us (such $88.4 million exclusive of amounts invested by our executive officers in Holdings' Class B, C and D units, as discussed below). As a result of the Merger, we are privately held and controlled by private equity funds associated with Blackstone and MSCP (the "Sponsors") with a board of directors made up of five representatives of the Sponsors, one independent director and our Chief Executive Officer. As discussed in more detail below, various aspects of named executive officer compensation were negotiated and determined at the time of the Merger.

As a privately-owned company with a relatively small board of directors, our entire board of directors acts as our Compensation Committee (hereinafter referred to either as the "Committee", the "Compensation Committee" or the "board of directors"). Our executive compensation program is overseen and administered by the Compensation Committee. The Compensation Committee operates somewhat informally without a written charter and has responsibility for discharging the responsibilities of the board of directors relating to the compensation of our executive officers and related duties. As a member of the Compensation Committee, our Chief Executive Officer presents cash, equity and benefits compensation recommendations to the Compensation Committee for its consideration and approval. The Compensation Committee reviews these proposals and makes all final compensation decisions for executive officers by exercising its discretion in accepting, modifying or rejecting any such recommendations.

Philosophy of Executive Compensation Programs

Our overall executive compensation objective is to provide a comprehensive plan designed to focus on our strategic business initiatives, financial performance objectives and the creation and maintenance of equity value. The following are the principal objectives in the design of our executive compensation programs:

- Attract, retain, and motivate superior management talent critical to our long-term success with compensation that is competitive within the marketplace;

- Maintain a reasonable balance among base salary, annual incentive payments and long-term equity-based incentive compensation and other benefits;
- Ensure compensation levels reflect the internal value and future potential of each executive within the Company and the achievement of outstanding individual results;
- Link executive compensation to the creation and maintenance of long-term equity value;
- Promote equity ownership by executives in order to align their interests with the interests of our equity holders; and
- Ensure that incentive compensation is linked to the achievement of specific financial and strategic objectives, which are established in advance and approved by the Committee.

To meet these objectives, our compensation program balances short-term and long-term performance goals and mixes fixed and at-risk compensation that is directly related to stockholder value and overall performance.

During our fiscal year ended June 30, 2008, the Committee did not retain the services of any external compensation consultant. Our Chief Executive Officer, Charles N. Martin, Jr., as a member of the board of directors, is also a member of the Committee, presents his recommendations to the Committee on all executive compensation matters and participates in discussions and deliberations of the Committee. While other named executive officers may also attend the Committee meetings and participate in Committee discussions, they would do so only if and when required by the Committee and such attendance has been rare in recent years. Any deliberations and decisions by the Committee regarding compensation for Mr. Martin or other named executive officers take place while the Committee is in executive session without such persons in attendance.

The Committee believes that compensation to its executive officers should be aligned closely with our short-term and long-term financial performance goals. As a result, a portion of executive compensation is "at risk" and is tied to the attainment of previously established financial goals. However, the Committee also believes that it is prudent to provide competitive base salaries and benefits to attract and retain superior talent in order to achieve our strategic objectives.

Elements of Our Executive Compensation Program

In fiscal year 2008, the principal elements of our compensation for our executive officers, including our named executive officers were:

- Base Salary;
- Annual cash incentive opportunities;
- Long-term equity based incentives; and
- Benefits and executive perquisites.

Detail regarding each of these elements is discussed below.

Base Salaries

Annual base salaries reflect the compensation for an executive's ongoing contribution to the operating performance of his or her functional area of responsibility with us. We believe that base salaries must be competitive based upon the scope of responsibilities and market compensation of similar executives. We utilize as a tool the database provided by Salary.com's Job Analyzer. Job Analyzer includes data about 2,900 standard jobs using data from 7,500 organizations representing all industries of all types and sizes, both public and private companies. Other factors such as internal equity and comparability are also considered when establishing a base salary for a given executive. The Committee utilizes the experience, market knowledge and insight of its members in evaluating the

competitiveness of current salary levels. Our Human Resources Department is also a resource for such additional information as needed.

Generally, base salaries of all executive officers, including the named executive officers, are reviewed and adjusted by the Committee effective January 1 of each year based upon the recommendations of our Chief Executive Officer. In turn, our Chief Executive Officer bases his recommendations upon his assessment of each executive's performance and our overall budgetary guidelines. Upon the recommendation of our Chief Executive Officer, the Committee gave none of the named executive officers base salary increases as of January 1, 2008, but gave most of our other executive officers base salary increases as of January 1, 2008 which averaged 3.6% for all executive officers. In addition, based upon the recommendations of our Chief Executive Officer, the Committee may adjust base salaries at other times during the year in connection with promotions, increased responsibilities or to maintain competitiveness within the market. Thus, the Committee raised the base salary of one of our named executive officers, Phillip W. Roe, from $375,000 to $475,000, effective the November 7, 2007 date upon which he was promoted to the position of our Chief Financial Officer. The salary for each named executive officer for our fiscal year ended June 30, 2008 is reported in the Summary Compensation Table below.

Annual Incentive Compensation

Annual incentive awards are available to the named executive officers, as well as to Vanguard's other executive officers, under the Vanguard Health Systems, Inc. 2001 Annual Incentive Plan (the "Annual Incentive Plan"). The Annual Incentive Plan is designed to reward management for the achievement of annual financial performance level targets and other operational goals, which are linked to the creation of long-term equity value.

Each year under the Annual Incentive Plan the Committee establishes specific earnings-related or operations-related goals for all of our executive officers, including the named executive officers, for the fiscal year based upon the recommendations of our Chief Executive Officer. The executive officers are eligible to receive a cash award or awards based primarily on the extent to which the Company meets its pre-established earnings and/or cash flow and/or other operations-related goals. The Committee determines one or more target awards for each executive officer, designates a Company performance level or levels required to earn each target award and may also determine threshold performance levels at which minimum awards are earned and performance levels that result in maximum awards to be paid. Target awards may vary among executives based on competitive market practices for comparable positions, their decision-making authority and their ability to affect financial and operational performance. In addition to performance-related awards, the Committee may make and pay out discretionary awards at any time. Also, the Committee has the discretion to adjust the annual performance targets during the year in the event of acquisitions and divestitures, restructured or discontinued operations, or other extraordinary or unusual issues occurring during the year. The Committee evaluates the allocation factors within the Annual Incentive Plan on an annual basis and has the flexibility to adjust the structure including allocation percentages as needed in order to better align the incentives under the Annual Incentive Plan.

For fiscal year 2008, Annual Incentive Plan target awards for most executive officers (including all five of the named executive officers, Messrs. Martin, Roe, Moore, Pitts, and Wallace) were 50% based on the Company achieving a certain consolidated Adjusted EBITDA performance level target goal and 50% upon achieving a certain consolidated free cash flow performance level target goal. Award target levels for these executive officers ranged from 30% to 50% of their base salaries for meeting the Adjusted EBITDA target and 30% to 50% of their base salaries for meeting the free cash flow target. Award target levels for Mr. Martin were 50% of his base salary for meeting the Adjusted EBITDA target and 50% of his base salary for meeting the free cash flow target. Award target levels for Messrs. Pitts and Wallace were 45% of their respective base salaries for meeting the Adjusted EBITDA target and 45% of their respective base salaries for meeting the free cash flow target. Award target levels for Messrs. Moore and Roe were 35% of their respective base salaries for meeting the Adjusted EBITDA target and 35% of their respective base salaries for meeting the free cash flow target.

For executive officers responsible only for the operations of our various regions, their Annual Incentive Plan target awards were 50% based upon regional Adjusted EBITDA targets and 50% based upon their hospitals achieving certain specified quality, employee engagement and patient and physician satisfaction goals, with their target awards and maximum awards being set at 70% and 108%, respectively, of their base salaries depending on the

Adjusted EBITDA levels actually obtained by their operating regions as well as their attainment of the quality and satisfaction goals.

All of our five named executive officers earned their target awards with respect to their financial performance level target goals under our Annual Incentive Plan for fiscal year 2008. These target awards were approved by the Committee and paid to the named executive officers in September 2008 in the individual amounts set forth in the column of the Summary Compensation Table entitled "Non-Equity Incentive Plan Compensation". In addition, two of our named executive officers (Messrs. Pitts and Wallace) were also granted discretionary awards by the Committee under our Annual Incentive Plan for fiscal year 2008 at its September 2008 meeting in the individual amounts set forth in the column of the Summary Compensation Table entitled "Bonus" and such discretionary awards were paid to Messrs. Pitts and Wallace also in September 2008.

The Committee has historically attempted to maintain consistency year over year with respect to the difficulty of achieving the target performance levels under our Annual Incentive Plan. The financial performance targets used by the Committee in recent years for the annual incentive awards for most of our executive officers (Adjusted EBITDA and free cash flow) are identical to or derived from our consolidated annual Adjusted EBITDA and capital expenditures budgets approved each July by our board of directors. Our annual Adjusted EBITDA budget, and, thus, the annual Adjusted EBITDA financial target, typically increases each year to promote continuous growth consistent with our business plan. Despite such increase, the financial performance targets are designed to be realistic and attainable though slightly aggressive, requiring in each fiscal year strong performance and execution that in our view provides an annual incentive firmly aligned with stockholder interests. This balance is reflected in the fact that none of these named executive officers earned any awards under the Plan for fiscal year 2007 when our Company's financial performance was not strong, but, as stated above, they did earn their target awards under the Plan for fiscal year 2008 when our Company's financial performance was much stronger.

Long Term Incentive Compensation

The Committee provides equity incentives to executive officers and other key employees in order to directly align their interests with the long term interests of the other equity holders who are principally the Sponsors.

Holdings LLC Units Plan

Holdings acquired Vanguard in the Merger on September 23, 2004. The following contains a summary of the material terms of the Holdings LLC Units Plan, which we refer to as the 2004 Unit Plan, pursuant to which Holdings granted the right to purchase units to members of our management on September 23, 2004 in connection with consummation of the Merger. All of our named executive officers, and certain other members of our management, have been granted the right to purchase units under the 2004 Units Plan.

General

The 2004 Unit Plan permits the grant of the right to purchase Class A Units, Class B Units, Class C Units and Class D Units to employees of Holdings or its affiliates. A maximum of 117,067 Class A Units, 41,945 Class B Units, 41,945 Class C Units and 35,952 Class D Units may be subject to awards under the 2004 Unit Plan. Units covered by awards that expire, terminate or lapse will again be available for option or grant under the 2004 Unit Plan. On September 23, 2004, certain members of management purchased all 117,067 Class A Units for an aggregate purchase price of $117,067,000 and all 41,945 Class B units, all 41,945 Class C Units and all 35,952 of the Class D Units for an aggregate purchase price of $5.7 million.

Administration

The 2004 Unit Plan is administered by a committee of Holdings' board of representatives or, in the board of representatives' discretion, the board of representatives. The committee has the sole discretion to determine the employees to whom awards may be granted under the 2004 Unit Plan, the number and/or class of Units to be covered by an award, the purchase price, if any, of such awards, determine the terms and conditions of any award and determine under what circumstances awards may be settled or cancelled. The committee is authorized to interpret the 2004 Unit Plan, to establish, amend and rescind any rules and regulations relating to the 2004 Unit

Plan, and to make any other determinations that it deems necessary or desirable for the administration of the plan. The committee may correct any defect or supply any omission or reconcile any inconsistency in the 2004 Unit Plan in the manner and to the extent the committee deems necessary or desirable.

Adjustments Upon Certain Events

In the event of any changes in the Units by reason of any reorganization, recapitalization, merger, unit exchange or any other similar transaction, the board of representatives, in its sole discretion, may adjust (1) the number or kind of Units or other securities that may be issued or reserved for issuance pursuant to the 2004 Unit Plan or pursuant to any outstanding awards or (2) any other affected terms of such awards.

Amendment and Termination

The Holdings board of representatives may amend or terminate the 2004 Unit Plan at any time, provided that no amendment or termination is permitted that would diminish any rights of a management member pursuant to a previously granted award without his or her consent, subject to the committee's authority to adjust awards upon certain events as described in the previous paragraph. No awards may be made under the 2004 Unit Plan after the tenth anniversary of the effective date of the plan.

Holdings LLC Units Held by Certain of our Managers

The units of Holdings consist of Class A units, Class B units, Class C units and Class D units. As of September 1, 2008, approximately 59.2% of Holdings' Class A Units were held by Blackstone, approximately 20.8% were held by MSCP, approximately 15.4% were held by certain members of our management and approximately 4.6% were held by other investors. The Class B units, Class C units and Class D units are held exclusively by members of our senior management and all such units were purchased on September 23, 2004.

Of our named executive officers, Charles N. Martin, Jr. owns 40,000 class A units, 8,913 class B units, 8,913 class C units and 7,640 class D units; Kent H. Wallace owns 850 class A units, 2,622 class B units, 2,622 class C units and 2,247 class D units; Keith B. Pitts owns 11,000 class A units, 5,243 class B units, 5,243 class C units and 4,494 class D units; Joseph D. Moore owns 10,450 class A units, 3,146 class B units, 3,146 class C units and 2,696 class D units; and Phillip W. Roe owns 3,030 class A units, 2,097 class B units, 2,097 class C units and 1,798 class D units. As of September 1, 2008, none of the class C units are vested, but 60% of the Class B and D units are vested; and an additional 20% of such class B and D units will vest on September 23, 2008. See the vesting provisions in respect of the class A, B, C and D units in the discussion immediately below.

Terms of the Holdings' Class A Units, Class B Units, Class C Units and Class D Units

The following is a summary of certain terms of the Holdings' Class A units, Class B units, Class C units and Class D units and certain rights and restrictions applicable to those units.

Class A units have economic characteristics that are similar to those of shares of common stock in a private corporation. Subject to applicable law, only the holders of Class A units are entitled to vote on any matter. Class A units are fully vested. The Class B units, Class C units and Class D units are subject to the vesting provisions described below.

Class B units vest in five equal annual installments on the first five anniversaries of the date of purchase, subject to an employee's continued service with Holdings and its affiliates. However, the Class B units will vest earlier upon a change of control of Holdings. In the event of an employee's termination of employment with Vanguard, other than due to termination by Vanguard for "cause" or by the employee without "good reason", the employee shall be deemed vested in any Class B unit that would otherwise have vested in the calendar year in which such termination of employment occurs. No employee who holds Class B units will receive any distributions until the holders of the Class A units receive the aggregate amount invested for their Class A units. Following return of the aggregate amount invested for the Class A units, the holders of Class B units will be entitled to receive the amount of their investment in the Class B units and, once all the aggregate investment amount invested for all of the

units has been returned to their holders, the vested Class B units will share in any distributions pro rata with the Class A units and vested Class C units.

Class C units vest on the eighth anniversary of the date of purchase, subject to the employee's continued service with Holdings and its affiliates. However, the Class C units will vest earlier upon the occurrence of a sale by Blackstone of at least 25.0% of its Class A Units at a price per Class A unit exceeding two and one-half times the price per Class A Unit invested by Blackstone in connection with the Merger. No employee who holds Class C units will receive any distributions until the holders of the Class A units receive the aggregate amount invested for their Class A units. Following return of the aggregate amount invested for the Class A units, the holders of Class C units will be entitled to receive the amount of their investment in the Class C units and, once all the aggregate investment amount invested for all of the units has been returned to their holders, the vested Class C units will share in any distributions pro rata with the Class A units and vested Class B units.

Class D units vest in five equal annual installments on the fifth anniversary of the date of purchase, subject to an employee's continued service with Holdings and its affiliates. However, the Class D units will vest earlier upon a change of control of Holdings. In the event of an employee's termination of employment with Vanguard, other than due to termination by Vanguard for "cause" or by the employee without "good reason", the employee shall be deemed vested in any Class D unit that would otherwise have vested in the calendar year in which such termination of employment occurs. No employee who holds Class D units will receive any distributions until the holders of the Class A units receive the aggregate amount invested for their Class A units. Following return of the aggregate amount invested for the Class A units, the holders of Class D units will be entitled to receive the amount of their investment in the Class D units and, once all the aggregate investment amount invested for all of the units has been returned to their holders and the holders of the Class A units have received an amount representing a 300% return on their aggregate investment along with pro rata distributions to the vested Class B and Class C units, the vested Class D units will share in any distributions pro rata with the Class A units, the vested Class B units and the vested Class C units.

Certain Rights and Restrictions Applicable to the Units Held by Our Managers

The units held by members of our management are not transferable for a limited period of time except in certain circumstances. In addition, the units (other then Class A units) may be repurchased by Holdings, and in certain cases, Blackstone, in the event that the employees cease to be employed by us. Blackstone has the ability to force the employees to sell their units along with Blackstone if Blackstone decides to sell its units.

The employees that hold units are entitled to participate in certain sales by Blackstone. In addition, in the event that Holdings were to make a public offering of its equity securities, the employees would have limited rights to participate in subsequent registered public offerings.

Our 2004 Stock Incentive Plan

General

Since all Units have been granted under the 2004 Unit Plan, we intend for our option program pursuant to our 2004 Stock Incentive Plan to be the primary vehicle currently for offering long-term incentives and rewarding our executive officers, managers and key employees. Because of the direct relationship between the value of an option and the value of our stock, we believe that granting options is the best method of motivating our executive officers to manage our Company in a manner that is consistent with our interests and our stockholders' interests. We also regard our option program as a key retention tool.

We adopted the 2004 Stock Incentive Plan upon consummation of the Merger which permits the grant of non-qualified stock options, incentive stock options, stock appreciation rights, restricted stock and other stock-based awards to our employees or our affiliates' employees. The awards available under the 2004 Stock Incentive Plan, together with Holdings' equity incentive units, represent 20.0% of our fully-diluted equity at the closing of the Merger. Shares covered by awards that expire, terminate or lapse are again available for option or grant under the 2004 Stock Incentive Plan. The total number of shares of our common stock which may be issued under the 2004

Stock Incentive Plan is 101,117. All of our previous option plans were terminated upon consummation of the Merger on September 23, 2004.

Administration

The 2004 Stock Incentive Plan is administered by a committee of the board of directors or, in the sole discretion of the board of directors, the board of directors. The committee has the sole discretion to determine the employees, representatives and consultants to whom awards may be granted under the 2004 Stock Incentive Plan and the manner in which such awards will vest. Options, stock appreciation rights, restricted stock and other stock-based awards will be granted by the committee to employees, representatives and consultants in such numbers and at such times during the term of the 2004 Stock Incentive Plan as the committee shall determine. The committee is authorized to interpret the 2004 Stock Incentive Plan, to establish, amend and rescind any rules and regulations relating to the 2004 Stock Incentive Plan, and to make any other determinations that it deems necessary or desirable for the administration of the plan. The committee may correct any defect or supply any omission or reconcile any inconsistency in the 2004 Stock Incentive Plan in the manner and to the extent the committee deems necessary or desirable.

Stock Options and Stock Appreciation Rights

Options granted under the 2004 Stock Incentive Plan are vested and exercisable at such times and upon such terms and conditions as may be determined by the committee, but in no event will an option be exercisable more than 10 years after it is granted. Under the 2004 Stock Incentive Plan, the exercise price per share for any option awarded is determined by the committee, but may not be less than 100% of the fair market value of a share on the day the option is granted with respect to incentive stock options.

Stock option grants under the 2004 Stock Incentive Plan are generally made at the commencement of employment and occasionally following a significant change in job responsibilities or on a periodic basis to meet other special retention or performance objectives. All stock options granted by our board of directors to date under the 2004 Stock Incentive Plan have been granted at or above the fair market value of our common stock at the grant date based upon the most recent appraisal of our common stock. We have not back-dated any option awards.

As a privately-owned company, there has been no market for our common stock. Accordingly, in fiscal year 2007, we had no program, plan or practice pertaining to the timing of stock option grants to executive officers, coinciding with the release of material non-public information.

An option may be exercised by paying the exercise price in cash or its equivalent, and/or, to the extent permitted by the committee, shares, a combination of cash and shares or, if there is a public market for the shares, through the delivery of irrevocable instruments to a broker to sell the shares obtained upon the exercise of the option and to deliver to us an amount equal to the exercise price.

The committee may grant stock appreciation rights independent of or in conjunction with an option. The exercise price of a stock appreciation right is an amount determined by the committee. Generally, each stock appreciation right entitles a participant upon exercise to an amount equal to (i) the excess of (1) the fair market value on the exercise date of one share over (2) the exercise price, times (ii) the number of shares covered by the stock appreciation right. Payment will be made in shares or in cash or partly in shares and partly in cash (any shares valued at fair market value), as determined by the committee.

As of June 30, 2008, options to purchase 88,698 shares of our common stock (the "New Options") were outstanding under the 2004 Stock Incentive Plan. The New Options were granted in part as "time options," and in part as "performance options" which vest and become exercisable ratably on a yearly basis on each of the first five anniversaries following the date of grant (or earlier upon a change of control). 35% of the options granted were time options with an exercise price equal to the greater of the fair market price per share or $1,000 per share at the time of grant (a range of $1,000 to $1,167.50 per share). 30% of the options granted were performance options with an exercise price of $3,000 per share. 35% of the options granted were "liquidity options" with an exercise price equal to greater of the fair market price per share or $1,000 per share at the time of grant (a range of $1,000 to $1,167.50 per share) that become fully vested and exercisable upon the completion of any of certain designated business events

("liquidity events"), and in any event on the eighth anniversary of the date of grant. Any common stock for which such options are exercised are governed by a stockholders agreement, which is described below under "Item 13. Certain Relationships and Related Transactions - Stockholders Agreement."

Of our named executive officers, Messrs. Martin and Moore have been granted no New Options as of September 1, 2008, Mr. Pitts has been granted 1,500 New Options, Mr. Roe has been granted 3,008 New Options and Mr. Wallace has been granted 8,500 New Options. During fiscal year 2008 the Committee granted 2,000 New Options to Mr. Roe, 1,500 New Options to Mr. Pitts and 1,500 New Options to Mr. Wallace.

Other Stock-Based Awards

The committee, in its sole discretion, may grant restricted stock, stock awards, stock appreciation rights, unrestricted stock and other awards that are valued in whole or in part by reference to, or are otherwise based on the fair market value of our shares. Such other stock-based awards shall be in such form, and dependent on such conditions, as the committee shall determine, including, without limitation, the right to receive, or vest with respect to, one or more shares (or the equivalent cash value of such shares) upon the completion of a specified period of service, the occurrence of an event and/or the attainment of performance objectives.

Adjustments Upon Certain Events

In the event of any stock dividend or split, reorganization, recapitalization, merger, share exchange or any other similar transaction, the committee, in its sole discretion, may adjust (i) the number or kind of shares or other securities that may be issued or reserved for issuance pursuant to the 2004 Stock Incentive Plan or pursuant to any outstanding awards, (ii) the option price or exercise price and/or (iii) any other affected terms of such awards. In the event of a change of control, the committee may, in its sole discretion, provide for the (i) termination of an award upon the consummation of the change of control, but only if such award has vested and been paid out or the participant has been permitted to exercise the option in full for a period of not less than 30 days prior to the change of control, (ii) acceleration of all or any portion of an award, (iii) payment of a cash amount in exchange for the cancellation of an award, which, in the case of options and stock appreciation rights, may equal the excess, if any, of the fair market value of the shares subject to such options or stock appreciation rights over the aggregate option price or grant price of such option or stock appreciation rights, and/or (iv) issuance of substitute awards that will substantially preserve the otherwise applicable terms of any affected awards previously granted hereunder.

Amendment and Termination

The committee may amend or terminate the 2004 Stock Incentive Plan at any time, provided that no amendment or termination shall diminish any rights of a participant pursuant to a previously granted award without his or her consent, subject to the committee's authority to adjust awards upon certain events (described under "Adjustments Upon Certain Events" above). No awards may be made under the 2004 Stock Incentive Plan after the tenth anniversary of the effective date of the plan.

Benefits and Executive Perquisites

The Committee believes that attracting and retaining superior management talent requires an executive compensation program that is competitive in all respects with the programs provided at similar companies. In addition to salaries, incentive bonus and equity awards, competitive executive compensation programs include retirement and welfare benefits and reasonable executive perquisites.

Retirement Benefits

Substantially all of our salaried employees, including our named executive officers, participate in our 401(k) savings plan. Employees are permitted to defer a portion of their income under the 401(k) plan. At our discretion, we may make a matching contribution of either (1) up to 50%, subject to annual limits established under the Internal Revenue Code, of the first 6% of an employee's contributions under this 401(k) plan as determined each year or (2) in respect of a few of our employees who came to us with plans in place having a larger match than this match, a match of 100% of the first 5% of an employee's contributions under this 401(k) plan. Most recently, we

authorized such maximum discretionary amounts as a match on employees' aggregate 401(k) Plan contributions for calendar year 2007, including the named executive officers. Employee contributions are fully vested immediately. Our matching contributions vest to the employee's account over time related to the employee's years of service with us, with 20% of our contribution vesting after 2 years of service, 40% after 3 years, 60% after 4 years, 80% after 5 years and 100% after 6 years. Participants may receive distribution of their 401(k) accounts any time after they cease service with us.

We maintain no defined benefit plans.

Other Benefits

All executive officers, including the named executive officers, are eligible for other benefits including: medical, dental, life insurance, and short term disability. The executives participate in these plans on the same basis, terms, and conditions as other administrative employees. In addition, we provide long-term disability insurance coverage on behalf of the named executive officers at an amount equal to 60% of current base salary (up to $10,000 per month). The named executive officers also participate in our vacation, holiday and sick program which provides paid leave during the year at various amounts based upon the executive's position and length of service.

Perquisites

Our executive officers may have limited use of our corporate plane for personal purposes as well as very modest other usual and customary perquisites. All of such perquisites are reflected in the All Other Compensation column of the Summary Compensation Table and the accompanying footnotes.

Our Employment Agreements with Certain Named Executive Officers

We have entered into written employment agreements with all five of our named executive officers. On June 1, 1998, we entered into written employment agreements with our Chief Executive Officer and then Chief Financial Officer (Messrs. Martin and Moore, respectively), which were amended and restated on September 23, 2004, to extend the term of the employment agreements for five years, and to provide that the Merger did not constitute a change in control under the agreements. On September 1, 1999, we entered into a written employment agreement with Keith B. Pitts to be our Executive Vice President for a term expiring on September 1, 2004. Effective May 31, 2001, Mr. Pitts was promoted to the position of Vice Chairman, and on September 23, 2004, his employment agreement was amended and restated to extend the term of the employment agreement for five years, and to provide that the Merger did not constitute a change in control under the agreement. On November 15, 2007, we entered into written employment agreements with our Chief Operating Officer and our new Chief Financial Office (Messrs. Wallace and Roe, respectively) for terms expiring on November 15, 2012.

The term of each employment agreement will renew automatically for additional one-year periods, unless any such agreement is terminated by us or by the officer by delivering notice of termination no later than 90 days before the end of any such renewal term. The base salaries of Messrs. Martin, Moore, Pitts, Wallace and Roe under such written employment agreements are, during calendar year 2008, $1,050,291, $525,146, $641,844, $600,000 and $475,000, respectively. Pursuant to these agreements the officers are eligible to participate in an annual bonus plan giving each of them an opportunity to earn an annual bonus in such amount as our board of directors should determine, as well as pension, medical and other customary employee benefits. The terms of these agreements state that if the officer terminates his employment for Good Reason (as defined in the agreements) or if we terminate the officer's employment without Cause (as defined in the agreements), he will receive within a specified time after the termination a payment of up to three times the sum of (i) his annual salary plus (ii) the average of the bonuses given to him in the two years immediately preceding his termination.

Our Severance Protection Agreements

We provide our officers at the Vice President level and above (other than Messrs. Martin, Moore, Wallace and Roe and Ronald P. Soltman (our General Counsel), who each have a written employment agreement containing severance provisions) with severance protection agreements granting them severance payments in amounts of 200% to 250% of annual salary and bonus. Generally, severance payments are due under these agreements if a change in

control (as defined in the agreements) should occur and employment of the officer is terminated during the term of the agreement by us (or our successor) without Cause (as defined in the agreements) or by the executive for Good Reason (as defined in the agreement). In addition, these agreements state that in the event of a Potential Change in Control (defined as the time at which an agreement which would result in a change in control is signed, an acquisition attempt relating to us is publicly announced or there is an increase in the number of shares owned by one of our 10% shareholders by 5% or more), the executives have an obligation to remain in our employ until the earliest of (1) six months after the Potential Change in Control; (2) a change in control; (3) a termination of employment by us; or (4) a termination of employment by the employee for Good Reason (treating Potential Change in Control as a change in control for the purposes of determining whether the executive had a Good Reason) or due to death, disability or retirement. On September 23, 2004, all the outstanding severance protection agreements were amended and restated to provide that the Merger did not constitute a change in control under the agreements, and that we would not terminate the agreements prior to the third anniversary of the closing of the Merger.

Stock Ownership

We do not have a formal policy requiring stock ownership by management. Our senior managers, including all of our named executive officers, however, have committed significant personal capital to our Company in connection with the consummation of the Merger. See the beneficial ownership chart below under Item 12, "Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters". Our stock is not publicly traded and is subject to a stockholder agreement that limits a stockholder's ability to transfer his or her shares. See "Holdings Limited Liability Company Agreement" and "Stockholders Agreement" under Item 13, "Certain Relationships and Related Transactions, and Director Independence."

Impact of Tax and Accounting Rules

The forms of our executive compensation are largely dictated by our capital structure and have not been designed to achieve any particular accounting treatment. We do take tax considerations into account, both to avoid tax disadvantages, and obtain tax advantages where reasonably possible consistent with our compensation goals. (Tax advantages for our executives benefit us by reducing the overall compensation we must pay to provide the same after-tax income to our executives.) Thus our severance pay plans are designed or are being reviewed to take account of and avoid "parachute" excise taxes under Section 280G of the Internal Revenue Code. Similarly we have taken steps to structure and assure that our executive compensation program is applied in compliance with Section 409A of the Internal Revenue Code. Since we currently have no publicly traded common stock, we are not currently subject to the $1,000,000 limitation on deductions for certain executive compensation under Section 162(m) of the Internal Revenue Code, though that rule will be considered if our common stock becomes publicly traded. Incentives paid to executives under our annual incentive plan are taxable at the time paid to our executives.

The expenses associated with the stock options issued by us to our executive officers and other key employees are reflected in our consolidated financial statements. In the first quarter of the fiscal year ended June 30, 2007, we began accounting for these stock-based payments in accordance with the requirements of SFAS 123(R), which requires all share-based payments to employees, including grants of employee stock options, to be recognized as expense in the consolidated financial statements based on their fair values. For further discussion see "ITEM 8, Note 2-Summary of Critical and Significant Accounting Policies" under the heading "Stock-Based Compensation." We previously accounted for these awards under the provisions of SFAS 123, which allowed us to estimate the fair value of options using the minimum value method.

Recovery of Certain Awards

We do not have a formal policy for recovery of annual incentives paid on the basis of financial results which are subsequently restated. Under the Sarbanes-Oxley Act, our chief executive officer and chief financial officer must forfeit incentive compensation paid on the basis of financial statements for which they were responsible and which have to be restated. In that event we would expect to recover such bonuses and incentive compensation. If and when the situation arises in other events, we would consider our course of action in light of the particular facts and circumstances, including the culpability of the individuals involved.

Compensation Committee Report

The Committee has reviewed and discussed the Compensation Discussion and Analysis with management. Based upon the review and discussions, the Committee directed that the Compensation Discussion and Analysis be included in this annual report on Form 10-K.
Compensation Committee:

Michael Dal Bello
M. Fazle Husain
Charles N. Martin, Jr.
Alan M. Muney, M.D.
James A. Quella
Michael J. Parsons
Neil P. Simpkins

Summary Compensation Table

The following table sets forth, for the fiscal years ended June 30, 2008 and 2007, the compensation earned by the Chief Executive Officer and Chief Financial Officer and the three other most highly compensated executive officers of the registrant, Vanguard, at the end of Vanguard's last fiscal year ended June 30, 2008. We refer to these persons as our named executive officers.

Name and Principal Position	Year	Salary ($)	Bonus($)	Non-Equity Incentive Plan Compensation ($)(a)	Option Awards($)(b)	All Other Compensation ($)(c)	Total ($)
Charles N. Martin, Jr. Chairman of the Board & Chief Executive Officer	2008	1,050,291	–	1,050,291	–	13,608	2,114,190
	2007	1,050,291	–	–	–	10,164	1,060,455
Phillip W. Roe Executive Vice President, Chief Financial Officer & Treasurer	2008	440,192	–	332,500	9,359	7,620	789,671
	2007	350,000	–	–	4,683	7,410	362,093
Keith B. Pitts Vice Chairman	2008	641,845	100,000	577,661	3,507	7,992	1,331,005
	2007	641,845	–	–	–	7,410	649,255
Kent H. Wallace President & Chief Operating Officer	2008	600,000	100,000	540,000	35,827	7,992	1,283,819
	2007	600,000	–	–	32,319	230,212	862,531
Joseph D. Moore Executive Vice President	2008	583,495	–	408,447	–	3,564	995,506
	2007	583,495	–	–	–	3,564	587,059

(a) The Compensation Committee has determined the amount of the Annual Incentive Plan compensation that was earned by each of these named executive officers for fiscal year 2008. This amount was paid to the named executive officers in September 2008.

(b) Option Awards reflect the compensation expense recognized in our financial statements for fiscal years 2008 and 2007 in accordance with SFAS 123(R) with respect to options to purchase shares of our common stock which have been awarded under our 2004 Stock Incentive Plan in our 2006 and 2008 fiscal years to three of our named executive officers. See Note 12 to our consolidated financial statements for assumptions used in calculation of these amounts. The actual number of Option Awards granted in fiscal year 2008 is shown in the "Grants of Plan Based Awards in Fiscal Year 2008" table included below in this report. Because these amounts represent expense for financial reporting purposes, they are not representative of the actual value that the named executive officer would receive upon exercise of these options.

(c) The amounts disclosed under All Other Compensation in the Summary Compensation Table represent for the named executive officers in fiscal 2008 (i) the following amounts of our matching contributions made under our 401(k) Plan: Mr. Martin: $6,750; Mr. Roe: $6,750; Mr. Pitts: $6,750; Mr. Wallace $6,750; and Mr. Moore: $0; and (ii) the following amounts of insurance premiums paid by Vanguard with respect to group term life insurance: Mr. Martin: $6,858; Mr. Roe: $870; Mr. Pirts: $1,242; Mr. Wallace: $1,242; and Mr. Moore: $3,564. No amounts for perquisites and other personal benefits, or property, have been included in this column for 2008 for Messrs. Martin, Roe, Pitts, Wallace and Moore because the aggregate value thereof for each of these named executive officers was below the $10,000 reporting threshold established by the Securities and Exchange Commission for this column.

Grants of Plan-Based Awards in Fiscal Year 2008

Name	Grant Date	Estimated Future Payouts Under Non-Equity Incentive Plan Awards (a) Target	All Other Option Awards: Number of Securities Underlying Options(b)	Exercise or Base Price of Option Awards ($/sh)(b)	Grant Date Fair Value of Option Awards(b)
Charles N. Martin, Jr.	n/a	$ 1,050,291	–	–	–
Phillip W. Roe	n/a	$ 332,500	–	–	–
	2/5/08		700	$1,000.00	$244,293
	2/5/08		700	$1,000.00	$293,391
	2/5/08		600	$3,000.00	$ 0
Keith B. Pitts	n/a	$ 577,661	–	–	–
	2/5/08		525	$1,000.00	$183,220
	2/5/08		525	$1,000.00	$220,043
	2/5/08		450	$3,000.00	$ 0
Kent H. Wallace	n/a	$ 540,000	–	–	–
	2/5/08		525	$1,000.00	$183,220
	2/5/08		525	$1,000.00	$220,043
	2/5/08		450	$3,000.00	$ 0
Joseph D. Moore	n/a	$ 408,447	–	–	–

(a) There is solely a target award under the Annual Incentive Plan for the named executive officers. For fiscal year 2008 the named executive officers earned these target awards, the Committee approved them and they were paid in cash to the named executive officers in September 2008 and these amounts are reflected in the Summary Compensation Table. See the "Compensation Discussion and Analysis – Annual Incentive Compensation," for a detailed description of the Annual Incentive Plan.

(b) Stock options awarded under the 2004 Stock Incentive Plan by the Committee as part of the named executive officer's long term equity incentive award. None of these options were granted with exercise prices below the fair market value of the underlying common stock on the date of grant. Since we are a privately-held company, the Committee determines the fair market value of our common stock primarily from an independent appraisal of our common stock which we obtain no less frequently than annually. The terms of these option awards are described in more detail under "Compensation Discussion and Analysis – Long Term Incentive Compensation – Our 2004 Stock Incentive Plan." We utilize a Black-Scholes-Merton model to estimate the fair value of options granted. The compensation expense recognized in our financial statements for fiscal year 2008 in accordance with SFAS 123(R) with respect to these option grants is reflected in the "Option Awards" column of the Summary Compensation Table.

Outstanding Equity Awards at Fiscal 2008 Year-End

The following table summarizes the outstanding equity awards held by each named executive officer at June 30, 2008. The table reflects options to purchase common stock of Vanguard which were granted under the Vanguard Health Systems, Inc. 2004 Stock Incentive Plan.

Name	Number of Securities Underlying Unexercised Options (#) Exercisable(a)	Number of Securities Underlying Unexercised Options (#) Unexercisable(b)	Option Exercise Price ($)(c)	Option Expiration Date
Charles N. Martin, Jr.	–	–	–	–
Phillip W. Roe	142(d)	211(d)	1,150.37	11/3/15
	–	353(e)	1,150.37	11/3/15
	122(d)	180(d)	3,000.00	11/3/15
	–	700(f)	1,000.00	2/5/18
	–	700(g)	1,000.00	2/5/18
	–	600(f)	3,000.00	2/5/18
Keith B. Pitts	–	525(f)	1,000.00	2/5/18
	–	525(g)	1,000.00	2/5/18
	–	450(f)	3,000.00	2/5/18
Kent H. Wallace	344(d)	514(d)	1,150.37	11/3/15
	–	858(e)	1,150.37	11/3/15
	295(d)	441(d)	3,000.00	11/3/15
	638(h)	954(h)	1,150.37	11/28/15
	–	1,592(i)	1,150.37	11/28/15
	546(h)	818(h)	3,000.00	11/28/15
	–	525(f)	1,000.00	2/5/18
	–	525(g)	1,000.00	2/5/18
	–	450(f)	3,000.00	2/5/18
Joseph D. Moore	–	–	–	–

(a) This column represents the number of stock options that had vested and were exercisable as of June 30, 2008.

(b) This column represents the number of stock options that had not vested and were not exercisable as of June 30, 2008.

(c) The exereise price for the options was never less than the grant date fair market value of a share of Vanguard common stock as determined by the Compensation Committee.

(d) 20% of the options represented by this option grant vest and become exercisable on each of the first five anniversaries of the November 3, 2005 grant date of these options (or earlier upon a change of control). 40% of this option grant was vested as of June 30, 2008.

(e) 100% of the options represented by this option grant vest and become exercisable on the eighth anniversary of the November 3, 2005 grant date of these options (or earlier upon a liquidity event).

(f) 20% of the options represented by this option grant vest and become exercisable on each of the first five anniversaries of the February 5, 2008 grant date of these options (or earlier upon a change of control). None of this option grant was vested as of June 30, 2008.

(g) 100% of the options represented by this option grant vest and become exercisable on the eighth anniversary of the February 5, 2008 grant date of these options (or earlier upon a liquidity event).

(h) 20% of the options represented by this option grant vest and become exercisable on each of the first five anniversaries of the November 28, 2005 grant date of these options (or earlier upon a change of control). 40% of this option grant was vested as of June 30, 2008.

(i) 100% of the options represented by this option grant vest and become exercisable on the eighth anniversary of the November 28, 2005 grant date of these options (or earlier upon a liquidity event).

Option Exercises and Stock Vested

No named executive officer exercised any stock options of Vanguard during fiscal 2008 nor were any restricted stock awards vested during fiscal 2008. Vanguard has made no restricted stock awards of its common stock since the Merger.

Pension Benefits

Vanguard maintains a 401(k) plan as previously discussed in the Compensation Discussion and Analysis. Vanguard maintains no defined benefit plans.

Nonqualified Deferred Compensation

None of the named executive officers receive nonqualified deferred compensation benefits.

Employment and Severance Protection Agreements

As discussed above, we have entered into definitive employment or severance protection agreements with each of the named executive officers. The terms of these agreements are described above under Compensation Discussion and Analysis.

Potential Payments Upon Termination or Change of Control

The following table describes the potential payments and benefits under our compensation and benefit plans and arrangements to which the named executive officers would be entitled upon a termination of their employment under their employment agreement, if they have an employment agreement, or if they do not have an employment agreement, under their severance protection agreement. In accordance with SEC disclosure rules, dollar amounts below assume a termination of employment on June 30, 2008 (the last business day of our last completed fiscal year).

Current	Cash Severance Payment ($)	Continuation of Medical/Welfare Benefits (present value) ($)	Total Termination Benefits ($)
Charles N. Martin, Jr.			
·Voluntary retirement	0	0	0
·Involuntary termination	4,201,164	25,947	4,227,111
·Involuntary or Good Reason termination after change in control	6,301,746	25,947	6,327,693
Phillip W. Roe			
·Voluntary retirement	0	0	0
·Involuntary termination	1,615,000	25,848	1,640,848
·Involuntary or Good Reason termination after change in control	2,422,500	25,848	2,448,348
Keith B. Pitts			
·Voluntary retirement	0	0	0
·Involuntary termination	2,439,012	25,947	2,464,959
·Involuntary or Good Reason termination after change in control	3,658,518	25,947	3,684,465
Kent H. Wallace			
·Voluntary retirement	0	0	0
·Involuntary termination	2,280,000	25,947	2,305,947
·Involuntary or Good Reason termination after change in control	3,420,000	25,947	3,445,947
Joseph D. Moore			
·Voluntary retirement	0	0	0
·Involuntary termination	1,750,486	17,855	1,768,341
·Involuntary or Good Reason termination after change in control	2,625,729	17,855	2,643,584

Accrued Pay and Regular Retirement Benefits. The amounts shown in the table above do not include payments and benefits to the extent they are provided on a non-discriminatory basis to salaried employees generally upon termination of employment. These include:

- Accrued salary and vacation pay and earned but unpaid bonus.
- Distributions of plan balances under our 401(k) plan.

Death and Disability. A termination of employment due to death or disability does not entitle the named executive officers to any payments or benefits that are not available to salaried employees generally.

Involuntary Termination and Change-in-Control Severance Pay Program. As described above under "— Our Employment Agreements," all of the named executive officers are entitled to severance pay in the event that their employment is terminated by us without Cause or if the named executive officer terminates the agreement as a result of our breach of his employment agreement. Additionally, they are entitled to severance pay under their employment agreements in the event they terminate the agreements after a change in control if their termination is for Good Reason.

Under our executive severance pay program, no payments due in respect of a change of control are "single trigger", that is, payments of severance due to the named executive officers merely upon a change of control. All of our change of control payments are "double trigger", due to the executive only subsequent to a change of control and after a termination of employment has occurred.

Under their employment agreements, all of our named executive officers owe the following obligations to us:

- Not to disclose our confidential business information;
- Not to solicit for employment any of our employees for a period expiring two years after the termination of their employment; and
- Not to accept employment with or consult with, or have any ownership interest in, any hospital or hospital management entity for a period expiring two years after the termination of their employment, except there shall be not such prohibitions if (1) we terminate the executive under his employment agreement or (2) the executive terminates his agreement for Good Reason or because we have breached his agreement.

The amounts shown in the table are for such involuntary or Good Reason terminations for the named executive officers and are based on the following assumptions and provisions in the employment agreements.

• *Covered terminations following a Change in Control.* Eligible terminations for all of our named executive officers include an involuntary termination for reasons other than Cause both before and following a change of control, or a voluntary resignation by the executive as a result of Good Reason following a change in control.

• *Definitions of Cause and Good Reason*

A termination of a named executive officer by us is for Cause if it is for any of the following reasons:

(a) the conviction of the executive of a criminal act classified as a felony;

(b) the willful failure by the executive to substantially perform the executive's duties with us (other than any such failure resulting from the executive's incapacity due to physical or mental illness); or

(c) the willful engaging by the executive in conduct which is materially injurious to us monetarily or otherwise.

A termination by the executive officer is for Good Reason if it results from, after a change of control has occurred, one of the following events:

(a) a material diminution in the executive's base compensation;

(b) a material diminution in the executive's authority, duties or responsibilities;

(c) a material diminution in the authority, duties or responsibilities of the supervisor to whom the executive is required to report, including a requirement that the executive's supervisor

report to a corporate officer or employee instead of reporting directly to our Board of Directors;

(d) a material diminution in the budget over which the executive retains authority;

(e) a material change in the geographic location at which the executive must perform services, except for required travel on our business to an extent substantially consistent with his business travel obligations prior to the change in control; or

(f) any other action or inaction that constitutes a material breach by us of the terms of the employment agreement.

• *Cash severance payments; Timing.* Represents, for each of our named executive officers, (1) if it relates to an involuntary termination without Cause by us prior to a change of control, a payment of 2 times the named executive officer's base salary and average annual incentive actually paid during the last two years plus an additional amount equal to such officer's pro rata annual target incentive for the year of termination and (2) if it relates to an involuntary termination without cause by us or a Good Reason termination by the executive after a change of control, payment of 3 times the named executive officer's base salary and average annual incentive actually paid during the last two years plus an additional amount equal to such officer's pro rata annual target incentive for the year of termination. All of these severance payments are "lump sum" payments by us to the named executive officers due within 5 days of termination of employment, except that the amounts of severance described above payable in respect of a termination of their employment prior to a change of control are payable monthly in equal monthly installments starting with the month after employment terminates and ending with the month that their 5-year employment agreements terminate (which is September 2009 for Messrs. Martin, Pitts and Moore and November 2012 for Messrs. Roe and Wallace).

• *Continuation of health, welfare and other benefits.* Represents the value of coverage for 18 months following a covered termination equivalent to our current active employee medical, dental, life, long-term disability insurances and other covered benefits.

Director Compensation

During fiscal 2008, our directors who are either our employees or affiliated with our private equity Sponsors did not receive any fees or other compensation services as our directors. As described in the table below, Michael J. Parsons, a director who is not our employee or an affiliate of our Sponsors, receives our current standardized director compensation plan for our independent directors of $60,000 per annum in cash plus an initial grant, upon election to our board of directors, of 85 stock options pursuant to our 2004 Stock Incentive Plan, as described in this Item under the caption "Our 2004 Stock Incentive Plan". We do, however, reimburse all of our directors for travel expenses and other out-of-pocket costs incurred in connection with attendance at meetings of the board.

The following table summarizes all compensation for our non-employee directors for our fiscal year ended June 30, 2008.

Name	Fees Earned or Paid in Cash(1) ($)	Stock Awards ($)	Option Awards(2)(3) ($)	Non-Equity Incentive Plan Compensation ($)	Change in Pension Value and Nonqualified Deferred Compensation Earnings	All Other Compensation ($)	Total ($)
Michael J. Parsons	$ 10,000	–	$ 83	–	–	–	$ 10,083

(1) The director compensation in the above table reflects an annual cash retainer paid to each independent, non-employee director of $60,000, prorated for Mr. Parsons' election as one of our directors in May 2008. The employee and Sponsor-affiliated directors receive no additional compensation for serving on the board and, as a result, are not listed in the above table.

(2) The amount in this column reflects the dollar amount recorded for financial statement reporting purposes for the fiscal year ended June 30, 2008, in accordance with FAS 123(R), relating to Mr. Parsons' option award granted pursuant to our 2004 Stock Option Plan. Assumptions used in the calculation of this amount are included in Note 2 of the Notes to our consolidated financial statements for the fiscal year ended June 30, 2008 included in this report.

(3) This represents a grant of 85 stock options on May 6, 2008 under our 2004 Stock Option Plan. None of such options were exercisable on June 30, 2008. 30 of the options had an option exercise price of $1,000 per share and become exercisable 20% on each of the first five anniversaries of their May 6, 2008 grant date (or earlier upon a change of control). 30 of the options also had an option exercise price of $1,000 per share and become exercisable on the eighth anniversary of the May 6, 2008 grant date (or earlier upon a liquidity event). 25 of the options had an option exercise price of $3,000 per share and become exercisable 20% on each of the first five anniversaries of their May 6, 2008 grant date (or earlier upon a change of control). The exercise price for the options is not less than the fair market value of a share of our common stock as determined by the Compensation Committee. All of these 85 options have an expiration date of May 6, 2018. For more information about options granted under our 2004 Stock Option Plan, see information in this Item under the caption "Our 2004 Stock Incentive Plan".

Compensation Committee Interlocks and Insider Participation

During fiscal 2008, we had no compensation committee of our board of directors. Charles N. Martin, Jr., one of the named executive officers, participated in deliberations of our board of directors concerning executive officer compensation during fiscal 2008.

Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters.

As of September 1, 2008, VHS Holdings LLC ("Holdings") directly owned 624,550 of the outstanding shares of the common stock of Vanguard (representing a 83.3% ownership interest), certain investment funds affiliated with Blackstone directly owned 125,000 of the outstanding shares of the common stock of Vanguard (representing a 16.7% ownership interest) and no other person or entity had a direct beneficial ownership interest in the common stock of Vanguard, except for certain key employees who held an aggregate of 17,237 exercisable options into 17,237 shares of the common stock of Vanguard as of such date. However, ignoring only the direct ownership of Holdings in the common stock of Vanguard, the following table sets forth information with respect to the direct or indirect beneficial ownership of the common stock of Vanguard as of September 1, 2008 by (1) each person (other than Holdings) known to own beneficially more than 5.0% of the common stock of Vanguard, (2) each named executive officer, (3) each of our directors and (4) all executive officers and directors as a group. The indirect beneficial ownership of the common stock of Vanguard reflects the direct beneficial ownership of all Class A units and all vested Class B and D units of Holdings. None of the shares listed in the table are pledged as security pursuant to any pledge arrangement or agreement. Additionally, there are no arrangements with respect to the share, the operation of which may result in a change in control of Vanguard.

Notwithstanding the beneficial ownership of the common stock of Vanguard presented below, the limited liability company agreement of Holdings governs the holders' exercise of their voting rights with respect to election of Vanguard's directors and certain other material events. See "Item 13. Certain Relationships and Related Transactions - Holdings Limited Liability Company Agreement."

Name of Beneficial Owner	Beneficial Ownership	Ownership Percentage
Blackstone Funds(1)	494,930	66.0%
MSCP Funds(2)	130,000	17.3%
Charles N. Martin Jr.(3)	53,243	7.0%
Phillip W. Roe(4)	6,411	*
Keith B. Pitts(5)	18,791	2.5%
Kent H. Wallace(6)	6,569	*
Joseph D. Moore(7)	15,124	2.0%
M. Fazle Husain(8)	126,750	16.9%
James A. Quella(1)	494,930	66.0%
Neil P. Simpkins (1)	494,930	66.0%
Michael A. Dal Bello	—(9)	—(9)
Alan M. Muney, M.D.	—(9)	—(9)
Michael J. Parsons	—	—
All directors and executive officers as a group (24 persons) (10)	762,636	95.1%

* Less than 1% of shares of common stock outstanding (excluding, in the case of all directors and executive officers as a group, shares beneficially owned by Blackstone and by the MSCP Funds).

(1) Includes common stock interests directly and indirectly owned by each of Blackstone FCH Capital Partners IV L.P., Blackstone FCH Capital Partners IV-A L.P., Blackstone FCH Capital Partners IV-B L.P., Blackstone Capital Partners IV-A L.P., Blackstone Family Investment Partnership IV-A L.P., Blackstone Health Commitment Partners L.P. and Blackstone Health Commitment Partners-A L.P. (the "Blackstone Funds"), for which Blackstone Management Associates IV L.L.C. ("BMA") is the general partner having voting and investment power over the membership interests in Holdings and the shares in Vanguard held or controlled by each of the Blackstone Funds. Messrs. Quella and Simpkins are members of BMA, but disclaim any beneficial ownership of the membership interests or the shares beneficially owned by BMA. Messrs. Peter G. Peterson and Stephen A. Schwarzman are the founding members of BMA and as such may be deemed to share beneficial ownership of the membership interests or shares held or controlled by the Blackstone Funds. Each of BMA and Messrs. Peterson and Schwarzman disclaims beneficial ownership of such membership interests and shares. The address of BMA and the Blackstone Funds is c/o The Blackstone Group L.P., 345 Park Avenue, New York, New York 10154

(2) The MSCP Funds consist of the following six funds: Morgan Stanley Capital Partners III, L.P., MSCP III 892 Investors, L.P., Morgan Stanley Capital Investors, L.P., Morgan Stanley Dean Witter Capital Partners IV, L.P., MSDW IV 892 Investors, L.P., and Morgan Stanley Dean Witter Capital Investors IV, L.P. The address of each of Morgan Stanley Capital Partners III, L.P., MSCP III 892 Investors, L.P., Morgan Stanley Dean Witter Capital Partners IV, L.P. and MSDW IV 892 Investors, L.P. is c/o Metalmark Capital LLC, 1177 Avenue of the Americas, New York, New York 10036. The address of each of Morgan Stanley Capital Investors, L.P. and Morgan Stanley Dean Witter Capital Investors IV, L.P. is c/o Morgan Stanley, 1585 Broadway, New York, New York 10036. Metalmark Capital LLC shares investment and voting power with Morgan Stanley Capital Partners III, L.P., MSCP III 892 Investors, L.P., Morgan Stanley Dean Witter Capital Partners IV, L.P. and MSDW IV 892 Investors, L.P. over 126,750 of these 130,000 shares of Vanguard common stock indirectly owned by these four funds.

(3) Includes 7,131 B units and 6,112 D units in Holdings which are vested or vest within 60 days of September 1, 2008.

(4) Includes 264 options in Vanguard and 1,678 B units and 1,439 D units in Holdings which are vested or vest within 60 days of September 1, 2008.

(5) Includes 4,195 B units and 3,596 D units in Holdings which are vested or vest within 60 days of September 1, 2008.

(6) Includes 1,823 options in Vanguard and 2,098 B units and 1,798 D units in Holdings which are vested or vest within 60 days of September 1, 2008.

(7) Includes 2,517 B units and 2,157 D units in Holdings which are vested or vest within 60 days of September 1, 2008.

(8) Mr. Husain is a Managing Director of Metalmark Capital LLC and exercises shared voting or investment power over the membership interests in Holdings owned by Morgan Stanley Capital Partners III, L.P., MSCP III 892 Investors, L.P., Morgan Stanley Dean Witter Capital Partners IV, L.P., and MSDW IV 892 Investors, L.P. and, as a result, may be deemed to be the beneficial owner of such membership interests and the 126,750 shares of Vanguard common stock indirectly owned by these four funds. Mr. Husain disclaims beneficial ownership of such membership interests and shares of common stock as a result of his employment arrangements with Metalmark, except to the extent of his pecuniary interest therein ultimately realized. Metalmark Capital does not have investment and voting power with respect to 3,250 shares of Vanguard common stock indirectly owned by Morgan Stanley Capital Investors, L.P. and Morgan Stanley Dean Witter Capital Investors IV, L.P. and these 3,250 shares are not included in the 126,750 shares contained in this table for Mr. Husain.

(9) Mr. Dal Bello and Mr. Muney are employees of Blackstone, but do not have investment or voting control over the shares beneficially owned by Blackstone.

(10) Includes 7,741 options in Vanguard and 24,124 B units and 20,678 D units in Holdings which have vested or vest within 60 days of September 1, 2008.

Equity Compensation Plan Information

The following table gives information about our common stock that may be issued upon the exercise of options, warrants and rights under all of Vanguard's existing equity compensation plans as of June 30, 2008.

	Equity Compensation Plan Information		
Plan Category	Number of securities to be issued upon exercise of outstanding options, warrants and rights (a)	Weighted-average exercise price of outstanding options, warrants and rights (b)	Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a)) (c)
Equity compensation plans approved by security holders	88,698 (1)	$1,644.97	11,915 (1)
Equity compensation plans not approved by security holders	0	$ 0	0
Total	88,698	$1,644.97	11,915

(1) The material features of the equity compensation plan under which these options were issued are set forth in this report under "Item 11. Executive Compensation – Our 2004 Stock Incentive Plan."

Item 13. Certain Relationships and Related Transactions, and Director Independence.

Holdings Limited Liability Company Agreement

In the Merger, Blackstone invested, and MSCP, Baptist and the Rollover Management Investors re-invested, in our company by subscribing for and purchasing Class A membership units in Holdings. In addition, at the closing of the Merger, the board of representatives of Holdings issued to certain Rollover Management Investors Class B, C and D membership units in Holdings as part of a new equity incentive program.

Under the limited liability company agreement of Holdings, the board of representatives of Holdings consists of the same five individuals who constitute the sole members of our board of directors. At Blackstone's election, the size of the board of representatives may be increased to nine members, with two additional representatives to be designated by Blackstone and two additional representatives to be independent representatives identified by our chief executive officer and acceptable to Blackstone. If at any time our chief executive officer is not Charles N. Martin, Jr., the Rollover Management Investors shall have the right to designate one representative to the board (the "Manager Representative") so long as the Rollover Management Investors continue to own not less than 50% of the Class A units held by them immediately after the completion of the Merger. MSCP will continue to be entitled to nominate and elect one representative so long as MSCP continues to own not less than 50% of the Class A units it held immediately after the completion of the Merger.

The limited liability company agreement of Holdings also has provisions relating to restrictions on transfer of securities, rights of first refusal, tag-along, drag-along, preemptive rights and affiliate transactions. At the completion of the Merger, the Company issued Class B, C and D warrants to Holdings, exercisable for the proportional percentage of equity represented by the related classes of membership units in Holdings. With respect to the Class B, C and D units only, the limited liability company agreement also has call provisions applicable in the event of certain termination events relating to a Rollover Management Investor's employment.

Stockholders Agreement

Recipients of options to purchase the Company's common stock are required to enter into a stockholders agreement governing such grantees' rights and obligations with respect to the common stock underlying such options. The provisions of the stockholders agreement are, with limited exceptions, similar to those set forth in the

limited liability company agreement of Holdings, including certain restrictions on transfer of shares of common stock, rights of first refusal, call rights, tag-along rights and drag-along rights. The transfer restrictions apply until the earlier of the fifth anniversary of the date the stockholder becomes a party to the stockholders agreement, or a change in control of the Company. The right of first refusal provision gives the Company a right of first refusal at any time after the fifth anniversary of the date the stockholder became a party to the stockholders agreement and prior to the earlier of a change in control of the Company or a registered public offering of our common stock meeting certain specified criteria. The call provisions provide rights with respect to the shares of our common stock held by the stockholder, whether or not such shares were acquired upon the exercise of a New Option, except for shares received upon conversion of or in redemption for Class A membership units in Holdings pursuant to the limited liability company agreement of Holdings. Such call rights are applicable in the event of certain termination events relating to the grantee's employment with the Company.

Transaction and Monitoring Fee Agreement

In connection with the Merger, Vanguard entered into a transaction and monitoring fee agreement with affiliates of Blackstone and Metalmark pursuant to which these affiliates provide certain structuring, advisory and management services to us. Under this agreement, Vanguard paid to Blackstone Management Partners IV L.L.C. ("BMP") upon the closing of the Merger a transaction fee of $20.0 million. In consideration for ongoing consulting and management advisory services, Vanguard is required to pay to BMP an annual fee of $4.0 million. In consideration for on-going consulting and management services Vanguard is required to pay to Metalmark Subadvisor LLC ("Metalmark SA"), an affiliate of Metalmark, an annual fee of $1.2 million for the first five years and thereafter an annual fee of $600,000. In the event or in anticipation of a change of control or initial public offering, BMP may elect at any time to have Vanguard pay to BMP and Metalmark SA lump sum cash payments equal to the present value (using a discount rate equal to the yield to maturity on the date of notice of such event of the class of outstanding U.S. government bonds having a final maturity closest to the tenth anniversary of such written notice) of all then-current and future fees payable to each of BMP and Metalmark SA under the agreement (assuming that the agreement terminates on the tenth anniversary of the closing of the Merger). In the event that BMP receives any additional fees in connection with an acquisition or disposition involving Vanguard, Metalmark SA will receive an additional fee equal to 15.0% of such fees paid to BMP or, if both parties provide equity financing in connection with the transaction, Metalmark SA will receive a portion of the aggregate fees payable by Vanguard, if any, based upon the amount of equity financing provided by Metalmark SA. The transaction and monitoring fee agreement also requires Vanguard to pay or reimburse BMP and Metalmark SA for reasonable out-of-pocket expenses in connection with, and indemnify them for liabilities arising from, the engagement of BMP and Metalmark SA of independent professionals pursuant to and the performance by BMP and Metalmark SA of the services contemplated by the transaction and monitoring fee agreement. The transaction and monitoring fee agreement will remain in effect with respect to each of BMP and Metalmark SA until the earliest of (1) BMP and Metalmark SA, as the case may be, beneficially owning less than 5.0% of Vanguard's common equity on a fully diluted basis, (2) the completion of a lump-sum payout as described above or (3) termination of the agreement upon the mutual consent of BMP and/or Metalmark SA, as the case may be, and Vanguard. Upon termination of Metalmark SA as a party to the agreement, Metalmark SA will be entitled to the excess, if any, of 15.0% of the aggregate amount of fees paid to date to BMP under the agreement minus any monitoring fees already paid to Metalmark SA.

Under the transaction and monitoring fee agreement during fiscal year 2008, Vanguard paid to BMP the annual $4.0 million fee referred to above and reimbursed BMP approximately $1.2 million for expenses incurred by BMP on Vanguard's behalf. BMP is an affiliate of the Blackstone Funds which own 66.0% of the equity of Vanguard. Four of our seven directors, Messrs. Dal Bello, Muney, Quella and Simpkins, are employed by affiliates of BMP.

Under the transaction and monitoring fee agreement during fiscal year 2008, Vanguard paid to Metalmark SA the annual $1.2 million fee referred to above. Metalmark SA is an affiliate of Metalmark Capital LLC which manages the MSCP Funds and the MSCP Funds own 17.3% of the equity of Vanguard.

Registration Rights Agreement

In connection with the Merger, the Company entered into a registration rights agreement with Blackstone, MSCP and other investors and the Rollover Management Investors, pursuant to which Blackstone and MSCP are entitled to certain demand registration rights and pursuant to which Blackstone, MSCP and other investors and the Rollover Management Investors are entitled to certain piggyback registration rights.

Commercial Transactions with Sponsor Portfolio Companies

Blackstone, MSCP and Metalmark each sponsor private equity funds which have ownership interests in a broad range of companies. We have entered into commercial transactions in the ordinary course of our business with some of these companies, including the sale of goods and services and the purchase of goods and services. None of these transactions or arrangements is of great enough value to be considered material to us.

Policy on Transactions with Related Persons

The Vanguard board of directors recognizes the fact that transactions with related persons present a heightened risk of conflicts of interests and/or improper valuation (or the perception thereof). In February 2007, the board of directors adopted a written policy reflecting existing practices to be followed in connection with any transaction between the Company and a "related person."

Any transaction with the Company in which a director, executive officer or beneficial holder of more than 5% of the total equity of the Company, or any immediate family member of the foregoing (each, a "related person") has a direct or indirect material interest, and where the amount involved exceeds $120,000, must be specifically disclosed by the Company in its public filings. Any such transaction would be subject to the Company's written policy respecting the review, approval or ratification of related person transactions.

Under this policy:

- the Company or any of its subsidiaries may employ a related person in the ordinary course of business consistent with the Company's policies and practices with respect to the employment of non-related persons in similar positions; and

- any other related person transaction that would be required to be publicly disclosed must be approved or ratified by the board of directors, a committee thereof or if it is impractical to defer consideration of the matter until a board or committee meeting, by a non-management director who is not involved in the transaction.

If the transaction involves a related person who is a director or an immediate family member of a director, that director may not participate in the deliberations or vote. In approving or ratifying a transaction under this policy, the board of directors, the committee or director considering the matter must determine that the transaction is fair to the Company and may take into account, among other factors deemed appropriate, whether the transaction is on terms not less favorable than terms generally available to an unaffiliated third-party under the same or similar circumstances and the extent of the related person's interest in the transaction.

During fiscal year 2008, there were no transactions between the Company and a related person requiring approval under this policy.

Director Independence

Our board of directors has not made a formal determination as to whether each director is "independent" because we have no equity securities listed for trading on a national securities exchange or in an automated inter-dealer quotation system of a national securities association, which has requirements that a majority of its board of directors be independent. Six of our seven directors have either been appointed by our equity Sponsors or are employed by us (Mr. Martin, our chairman and chief executive officer). Our seventh director (Michael J. Parsons) is neither our employee or otherwise affiliated with us in any significant way. Thus, we do not believe any of our

directors would be considered independent under the New York Stock Exchange's definition of independence, except for Mr. Parsons.

Item 14. Principal Accounting Fees and Services.

Fees Paid to the Independent Auditor

The following table presents fees for professional services rendered by Ernst & Young LLP for the audit of Vanguard's annual financial statements for 2007 and 2008, and fees billed for audit-related services, tax services and all other services rendered by Ernst & Young LLP for 2007 and 2008.

	2007	2008
Audit fees[1]	$ 834,133	$ 856,929
Audit-related fees	–	–
Audit and audit-related fees	834,133	856,929
Tax fees[2]	34,316	64,263
All other fees[3]	1,870,901	1,109,572
Total fees[4]	$ 2,739,350	$ 2,030,764

(1) Audit fees for 2007 and 2008 include fees for the audit of the annual consolidated financial statements, reviews of the condensed consolidated financial statements included Vanguard's quarterly reports and statutory audits.

(2) Tax fees for 2007 and 2008 consisted principally of fees for tax advisory services.

(3) All other fees for 2007 and 2008 consisted of assistance in identification of Medicaid eligible days for inclusion in the Medicare cost reports for Medicare disproportionate share reimbursement; assistance in validating average wage rates in our markets used in Medicare reimbursement; assistance in preparing reports for us relating to payer matters; and assistance in preparing occupational mix survey data in accordance with CMS requirements.

(4) Ernst & Young LLP full time, permanent employees performed all of the professional services described in this chart.

Pre-Approval Policies and Procedures

In February 2004, our board of directors first adopted an audit and non-audit services pre-approval policy and in November 2004 and May 2006 the board amended and restated this policy. This policy sets forth the Board's procedures and conditions pursuant to which services proposed to be performed by the Company's regular independent auditor (and those other independent auditors for whom pre-approvals are legally necessary) are presented to the Board for pre-approval. Normally, the policy would have been approved by the audit committee and ratified by the board of directors, but in February 2004, November 2004 and May 2006 we had no audit committee and, as a result, the full board of directors has the responsibility for all matters that are usually the responsibility of the audit committee.

The policy provides that the board of directors shall pre-approve audit services, audit-related services, tax services and those other services that it believes to be routine and recurring services that do not impair the independence of the auditor. Under the policy, our Chief Accounting Officer is responsible for determining whether services provided by the independent auditor are included as part of those services already pre-approved or whether separate approval from the board of directors is required. All services performed for us by Ernst & Young LLP, our independent registered public accounting firm, subsequent to the adoption of the policy have been pre-approved by the board of directors. The board of directors has concluded that the audit-related services, tax services and other non-audit services provided by Ernst & Young LLP in fiscal year 2008 were compatible with the maintenance of the firm's independence in the conduct of its auditing functions. In addition, to safeguard the continued independence of the independent auditors, the policy prevents our independent auditors from providing services to us that are prohibited under Section 10A(g) of the Securities Exchange Act of 1934, as amended.

PART IV

Item 15. Exhibits and Financial Statement Schedules.

(a) List of documents filed as part of this report.

(1) Financial Statements. The accompanying index to financial statements on page 78 of this report is provided in response to this item.

(2) Financial Statement Schedules. All schedules are omitted because the required information is either not present, not present in material amounts or presented within the consolidated financial statements.

(3) Exhibits. The exhibits filed as part of this report are listed in the Exhibit Index which is located at the end of this report.

(b) Exhibits.
See Item 15(a)(3) of this report.

(c) Financial Statement Schedules.
See Item 15(a)(2) of this report.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

VANGUARD HEALTH SYSTEMS, INC.	Date
By: /s/ Charles N. Martin, Jr. Charles N. Martin, Jr. Chairman of the Board & Chief Executive Officer	September 23, 2008

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/s/ Charles N. Martin, Jr. Charles N. Martin, Jr.	Chairman of the Board & Chief Executive Officer; Director (Principal Executive Officer)	September 23, 2008
/s/ Phillip W. Roe Phillip W. Roe	Executive Vice President, Chief Financial Officer & Treasurer (Principal Financial Officer)	September 23, 2008
/s/ Gary D. Willis Gary D. Willis	Senior Vice President, Controller & Chief Accounting Officer (Principal Accounting Officer)	September 23, 2008
/s/ Michael A. Dal Bello Michael A. Dal Bello	Director	September 23, 2008
/s/ M. Fazle Husain M. Fazle Husain	Director	September 23, 2008
/s/ Alan M. Muney, M.D. Alan M. Muney, M.D.	Director	September 23, 2008
/s/ Michael J. Parsons Michael J. Parsons	Director	September 23, 2008
/s/ James A. Quella James A. Quella	Director	September 23, 2008
/s/ Neil P. Simpkins Neil P. Simpkins	Director	September 23, 2008

Supplemental Information to be Furnished With Reports Filed Pursuant to Section 15(d) of the Act by Registrants Which Have Not Registered Securities Pursuant to Section 12 of the Act.

No annual report or proxy material has been sent to security holders.

EXHIBIT INDEX

Exhibit No.	Description
2.1	Agreement and Plan of Merger, dated as of July 23, 2004, among VHS Holdings LLC, Health Systems Acquisition Corp. and Vanguard Health Systems, Inc.(1)
2.2	First Amendment to the Agreement and Plan of Merger, dated as of September 23, 2004, among VHS Holdings LLC, Health Systems Acquisition Corp. and Vanguard Health Systems, Inc.(1)
2.3	Indemnification Agreement, dated as of July 23, 2004, among VHS Holdings LLC, Vanguard Health Systems, Inc., and the stockholders and holders of options set forth therein(1)(3)
3.1	Amended and Restated Certificate of Incorporation of Vanguard Health Systems, Inc.(1)
3.2	By-Laws of Vanguard Health Systems, Inc.(10)
4.1	Indenture, relating to the 9% Senior Subordinated Notes, dated as of September 23, 2004, among Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the Guarantors party thereto and the Trustee(1)
4.2	First Supplemental Indenture, dated as of November 5, 2004, among Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the Guarantors party thereto and the Trustee(1)
4.3	Indenture, relating to the 11 1/4% Senior Discount Notes, dated as of September 23, 2004, among Vanguard Health Holding Company I, LLC, Vanguard Holding Company I, Inc, Vanguard Health Systems, Inc. and the Trustee(1)
4.4	Registration Rights Agreement relating to the 9% Senior Subordinated Notes, dated as of September 23, 2004, among Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the Guarantors party thereto, Citigroup Global Markets Inc., Banc of America Securities LLC, Bear Stearns & Co., Inc., J.P. Morgan Securities Inc., Merrill Lynch, Pierce, Fenner & Smith Incorporated, Wachovia Capital Markets, LLC and ABN AMRO Incorporated(1)
4.5	Registration Rights Agreement, relating to the 11 1/4% Senior Discount Notes, dated as of September 23, 2004, among Vanguard Health Holding Company I, LLC, Vanguard Holding Company I, Inc., Vanguard Health Systems, Inc., Citigroup Global Markets Inc., Banc of America Securities LLC, Bear Stearns & Co., Inc., J.P. Morgan Securities Inc., Merrill Lynch, Pierce, Fenner & Smith Incorporated, Wachovia Capital Markets, LLC and ABN AMRO Incorporated(1)
4.6	Registration Rights Agreement, concerning Vanguard Health Systems, Inc., dated as of September 23, 2004(1)
4.7	Second Supplemental Indenture, dated as of March 28, 2005, among Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the Guarantors party thereto and the Trustee (8)
4.8	Third Supplemental Indenture, dated as of July 13, 2006, among Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the Guarantors party thereto and the Trustee (15)
4.9	Fourth Supplemental Indenture, dated as of June 25, 2007, among Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the Guarantors party thereto and the Trustee(19)

4.10	Fifth Supplemental Indenture, dated as of July 1, 2007, among Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the Guarantors party thereto and the Trustee(19)
4.11	Sixth Supplemental Indenture, dated as of October 2, 2007, among Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the Guarantors party thereto and the Trustee (20)
10.1	Credit Agreement, dated as of September 23, 2004, among Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., Vanguard Health Holding Company I, LLC, the lenders party thereto, Bank of America, N.A. as administrative agent, Citicorp North America, Inc., as syndication agent, the other agents named therein, and Banc of America Securities LLC and Citigroup Global Markets Inc., as joint lead arrangers and book runners(1)
10.2	Security Agreement, dated as of September 23, 2004, made by each assignor party thereto in favor of Bank of America, N.A., as collateral agent(1)
10.3	Vanguard Guaranty, dated as of September 23, 2004, made by and among Vanguard Health Systems, Inc. in favor of Bank of America, N.A., as administrative agent(1)
10.4	Subsidiaries Guaranty, dated as of September 23, 2004, made by and among each of the guarantors party thereto in favor of Bank of America, N.A., as administrative agent(1)
10.5	Pledge Agreement, dated as of September 23, 2004, among each of the pledgors party thereto and Bank of America, N.A., as collateral agent(1)
10.6	Transaction and Monitoring Fee Agreement, dated as of September 23, 2004, among Vanguard Health Systems, Inc., Blackstone Management Partners IV L.L.C., and Metalmark Management LLC(1)
10.7	Amended and Restated Limited Liability Company Operating Agreement of VHS Holdings LLC, dated as of September 23, 2004(1)
10.8	Vanguard Health Systems, Inc. 2004 Stock Incentive Plan(1)(3)
10.9	VHS Holdings LLC 2004 Unit Plan(1)(3)
10.10	Vanguard Health Systems, Inc. 2001 Annual Incentive Plan(2)(3)
10.11	Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Charles N. Martin, Jr., dated as of September 23, 2004(1)(3)
10.12	Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Joseph D. Moore, dated as of September 23, 2004(1)(3)
10.13	Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Ronald P. Soltman, dated as of September 23, 2004(1)(3)
10.14	Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Keith B. Pitts, dated as of September 23, 2004(1)(3)
10.15	Form of Amended and Restated Severance Protection Agreement of Vanguard Health Systems, Inc. dated as of September 23, 2004 for Vice Presidents and above (1)(3)
10.16	Arizona Health Care Cost Containment System Administration RFP re Contract No. YH04-0001-06 with VHS Phoenix Health Plan, awarded May 1, 2003(4)

10.17 Solicitation Amendments to RFP numbers One, Two, Three and Four and Contract Amendment No. 01 dated May 1, 2003, to Arizona Health Care Cost Containment System Administration Contract No. YH04-0001-06 with VHS Phoenix Health Plan(4)

10.18 Contract Amendments Numbered 02, 03, 04 and 05, each effective October 1, 2003, to the Arizona Health Care Cost Containment System Administration Contract No. YH04-0001-06 with VHS Phoenix Health Plan(5)

10.19 Contract Amendment Number 06, executed on November 10, 2003, but effective as of October 1, 2003, to the Arizona Health Care Cost Containment System Administration Contract No. YH04-0001-06 between VHS Phoenix Health Plan and the Arizona Health Care Cost Containment System(6)

10.20 Contract Amendment Number 07, executed on April 28, 2004, but effective as of April 1, 2004, to the Arizona Health Care Cost Containment System Administration Contract No. YH04-0001-06 between VHS Phoenix Health Plan and the Arizona Health Care Cost Containment System(1)

10.21 Contract Amendment Number 08, executed on September 16, 2004, but effective as of October 1, 2004, to the Arizona Health Care Cost Containment System Administration Contract No. YH04-0001-06 between VHS Phoenix Health Plan and the Arizona Health Care Cost Containment System(1)

10.22 Contract Amendment Number 09, executed on November 4, 2004, but effective as of October 1, 2004, to the Arizona Health Care Cost Containment System Administration Contract No. YH04-0001-06 between VHS Phoenix Health Plan and the Arizona Health Care Cost Containment System(1)

10.23 Amended and Restated Agreement Between the Shareholders of VHS Acquisition Subsidiary Number 5, Inc. executed on September 8, 2004, but effective as of September 1, 2004(1)

10.24 Certificate of Designations, Preferences and Rights of Series A Preferred Stock of VHS Acquisition Subsidiary Number 5, Inc., dated as of September 8, 2004(1)

10.25 License Agreement between Baptist Health System and VHS San Antonio Partners, L.P. dated as of January 1, 2003(7)

10.26 Form of Performance Option Under 2004 Stock Incentive Plan(1)(3)

10.27 Form of Time Option Under 2004 Stock Incentive Plan(1)(3)

10.28 Form of Liquidity Event Option Under 2004 Stock Incentive Plan(1)(3)

10.29 Stockholders Agreement Concerning Vanguard Health Systems, Inc., dated as of November 4, 2004, by and among Vanguard Health Systems, Inc., VHS Holdings LLC, Blackstone FCH Capital Partners IV L.P. and its affiliates identified on the signature pages thereto and the employees identified on the signature pages thereto(1)

10.30 Amendment No. 1 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Charles N. Martin, Jr., dated as of December 1, 2004(1)(3)

10.31 Amendment No. 1 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Joseph D. Moore, dated as of December 1, 2004(1)(3)

10.32 Amendment No. 1 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Ronald P. Soltman, dated as of December 1, 2004(1)(3)

10.33 Amendment No. 1 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Keith B. Pitts, dated as of December 1, 2004(1)(3)

10.34 Restatement dated October 22, 2004, but effective as of October 1, 2004, of Arizona Health Care Cost Containment System Administration ("AHCCCS") Contract No. YH04-0001-06 with VHS Phoenix Health Plan, to reflect Solicitation Amendments One through Four and Contract Amendments Numbers 01 through 09 (unofficial and never executed, but prepared by AHCCCS and distributed to VHS Phoenix Health Plan for ease of contract administration)(1)

10.35 First Amendment of VHS Holdings LLC 2004 Unit Plan(3)(10)

10.36 First Amendment to Credit Agreement, dated as of August 15, 2005, among Vanguard Health Holding Company I, LLC, Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the lenders party to the Credit Agreement referred to therein, and Bank of America, N.A. as administrative agent(9)

10.37 First Amendment to Credit Agreement, dated as of August 15, 2005, among Vanguard Health Holding Company I, LLC, Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the lenders party to the Credit Agreement referred to therein, and Bank of America, N.A. as administrative agent(11)

10.38 Contract Amendment Number 10, executed on September 7, 2005, but effective as of October 1, 2005, to the Arizona Health Care Cost Containment System Administration Contract No. YH04-0001-06 between VHS Phoenix Health Plan and the Arizona Health Care Cost Containment System(12)

10.39 Contract Amendment Number 11, executed on September 7, 2005, but effective as of September 1, 2005, to the Arizona Health Care Cost Containment System Administration Contract No. YH04-0001-06 between VHS Phoenix Health Plan and the Arizona Health Care Cost Containment System(12)

10.40 Amendment No. 2 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Charles N. Martin, Jr., dated as of December 1, 2005(3)(13)

10.41 Amendment No. 2 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Joseph D. Moore , dated as of December 1, 2005(3)(13)

10.42 Amendment No. 2 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Ronald P. Soltman, dated as of December 1, 2005(3)(13)

10.43 Amendment No. 2 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Keith B. Pitts, dated as of December 1, 2005(3)(13)

10.44 Amendment No. 1, dated as of November 3, 2005, to Amended and Restated Limited Liability Company Operating Agreement of VHS Holdings LLC(13)

10.45 Amendment Number 1 to the Vanguard Health Systems, Inc. 2004 Stock Incentive Plan, effective November 28, 2005(3)(13)

10.46 Contract Amendment Number 12, executed on December 21, 2005, but effective as of January 1, 2006, to the Arizona Health Care Cost Containment System Administration Contract No. YH04-0001-06 between VHS Phoenix Health Plan and the Arizona Health Care Cost Containment System(13)

10.47 Amendment Number 2 to the Vanguard Health Systems, Inc. 2004 Stock Incentive Plan, effective February 15, 2006(3)(14)

10.48 Amendment Number 3 to the Vanguard Health Systems, Inc. 2004 Stock Incentive Plan, effective April 15, 2006(3)(14)

10.49 Contract Amendment Number 13, executed on April 4, 2006, but effective as of October 1, 2005, to the Arizona Health Care Cost Containment System Administration Contract No. YH04-0001-06 between VHS Phoenix Health Plan and the Arizona Health Care Cost Containment System(14)

10.50 Contract Amendment Number 14, executed on April 26, 2006, but effective as of October 1, 2005, to the Arizona Health Care Cost Containment System Administration Contract No. YH04-0001-06 between VHS Phoenix Health Plan and the Arizona Health Care Cost Containment System(14)

10.51 Contract Amendment Number 15, executed on September 5, 2006, but effective as of October 1, 2006, to the Arizona Health Care Cost Containment System Administration Contract No. YH04-0001-06 between VHS Phoenix Health Plan and the Arizona Health Care Cost Containment System (16)

10.52 Amendment Number 4 to the Vanguard Health Systems, Inc. 2004 Stock Incentive Plan, effective November 13, 2006(3)(17)

10.53 Contract Amendment Number 16, executed on April 27, 2007, but effective as of October 1, 2006, to the Arizona Health Care Cost Containment System Administration Contract No. YH04-0001-06 between VHS Phoenix Health Plan and the Arizona Health Care Cost Containment System(18)

10.54 Contract Amendment Number 17, executed on September 6, 2006, but effective as of October 1, 2007, to the Arizona Health Care Cost Containment System Administration Contract No. YH04-0001-06 between VHS Phoenix Health Plan and the Arizona Health Care Cost Containment System(21)

10.55 Amendment No. 3 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Charles N. Martin, Jr., dated as of October 1, 2007(3)(22)

10.56 Amendment No. 3 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Keith B. Pitts, dated as of October 1, 2007(3)(22)

10.57 Amendment No. 3 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Joseph D. Moore, dated as of October 1, 2007(3)(22)

10.58 Amendment No. 4 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Joseph D. Moore, dated as of November 7, 2007(3)(22)

10.59 Amendment No. 3 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Ronald P. Soltman, dated as of October 1, 2007(3)(22)

10.60 Employment Agreement between Vanguard Health Systems, Inc. and Kent H. Wallace dated as of November 15, 2007(3)(22)

10.61 Employment Agreement between Vanguard Health Systems, Inc. and Phillip W. Roe dated as of November 15, 2007(3)(22)

10.62 Form of Amendment No. 1 to Severance Protection Agreement dated as of October 1, 2007, entered into between Vanguard Health Systems, Inc. and each of its executive officers (other than Messrs. Martin, Pitts, Moore, Soltman, Wallace and Roe who each have entered into employment agreements with the registrant)(3)(22)

10.63	Amendment Number 5 to the Vanguard Health Systems, Inc. 2004 Stock Incentive Plan, effective May 6, 2008(3)(23)
10.64	Letter dated May 13, 2008, from the Arizona Health Care Cost Containment System to VHS Phoenix Health Plan, LLC, countersigned by VHS Phoenix Health Plan, LLC on May 13, 2008 awarding Contract No. YH09-0001-07(24)
10.65	Waiver No. 1 dated as of May 22, 2008, to Amended and Restated Limited Liability Company Operating Agreement of VHS Holdings LLC, dated as of September 23, 2004, as amended by Amendment No. 1, dated as of November 3, 2005
10.66	Amendment No. 5 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Joseph D. Moore, dated as of June 30, 2008(3)
10.67	Form of Severance Protection Agreement of Vanguard Health Systems, Inc. in current use for Vice Presidents and above(3)
10.68	Contract Amendment Number 18, executed on May 5, 2008, but effective as of April 1, 2008, to the Arizona Health Care Cost Containment System Administration Contract No. YH04-0001-06 between VHS Phoenix Health Plan and the Arizona Health Care Cost Containment System
10.69	Contract Amendment Number 19, executed on May 5, 2008, but effective as of June 1, 2008, to the Arizona Health Care Cost Containment System Administration Contract No. YH04-0001-06 between VHS Phoenix Health Plan and the Arizona Health Care Cost Containment System
10.70	Arizona Health Care Cost Containment System Administration RFP re Contract No. YH09-0001-07 with VHS Phoenix Health Plan, LLC awarded May 13, 2008
10.71	Solicitation Amendments to RFP numbers One, Two, Three, Four and Five dated February 29, 2008, March 14, 2008, March 26, 2008, March 28, 2008 and April 10, 2008, respectively, to Arizona Health Care Cost Containment System Administration Contract No. YH09-0001-07 with VHS Phoenix Health Plan, LLC
12.1	Computation of Ratio of Earnings to Fixed Charges
21.1	Subsidiaries of Vanguard Health Systems, Inc.
31.1	Certification of CEO pursuant to Rule 13a-14(a)/15d-14(a) as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
31.2	Certification of CFO pursuant to Rule 13a-14(a)/15d-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
32.1	Certification of CEO pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
32.2	Certification of CFO pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002

(1) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Registration Statement on Form S-4 first filed on November 12, 2004 (Registration No. 333-120436).

(2) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Registration Statement on Form S-1 first filed on October 19, 2001 (Registration No. 333-71934).

(3) Management compensatory plan or arrangement.

(4) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Annual Report on Form 10-K for the annual period ended June 30, 2003, File No. 333-71934.

(5) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended September 30, 2003, File No. 333-71934.

(6) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended December 31, 2003, File No. 333-71934.

(7) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Current Report on Form 8-K dated January 14, 2003, File No. 333-71934.

(8) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended March 31, 2005, File No. 333-71934.

(9) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Current Report on Form 8-K dated August 26, 2005, File No. 333-71934.

(10) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Annual Report on Form 10-K for the annual period ended June 30, 2005, File No. 333-71934.

(11) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Current Report on Form 8-K dated September 27, 2005, File No. 333-71934.

(12) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended September 30, 2005, File No. 333-71934.

(13) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended December 31, 2005, File No. 333-71934.

(14) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended March 31, 2006, File No. 333-71934.

(15) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Annual Report on Form 10-K for the annual period ended June 30, 2006, File No. 333-71934.

(16) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Current Report on Form 8-K dated September 8, 2006, File No. 333-71934.

(17) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended December 31, 2006, File No. 333-71934.

(18) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended March 31, 2007, File No. 333-71934.

(19) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Annual Report on Form 10-K for the annual period ended June 30, 2007, File No. 333-71934.

(20) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended September 30, 2007, File No. 333-71934.

(21) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Current Report on Form 8-K dated September 7, 2007, File No. 333-71934.

(22) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended December 31, 2007, File No. 333-71934.

(23) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Current Report on Form 8-K dated May 9, 2008, File No. 333-71934.

(24) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Current Report on Form 8-K dated May 16, 2008, File No. 333-71934.

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, D.C. 20549

FORM 10-K

(Mark One)

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the fiscal year ended June 30, 2007

OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from _____ to _____

Commission File Number: 333-71934

VANGUARD
HEALTH SYSTEMS

VANGUARD HEALTH SYSTEMS, INC.

(Exact name of registrant as specified in its charter)

Delaware	**62-1698183**
(State or other jurisdiction of incorporation or organization)	*(I.R.S. Employer Identification No.)*

20 Burton Hills Boulevard, Suite 100
Nashville, TN 37215
(Address and zip code of principal executive offices)

(615) 665-6000
(Registrant's telephone number, including area code)

Securities Registered Pursuant to Section 12(b) of the Act: None
Securities Registered Pursuant to Section 12(g) of the Act: None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. ☐Yes ☒No

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. ☒Yes ☐No

Indicate by check mark whether the registrant (1) has filed all reports required to be filed under Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports) and (2) has been subject to such filing requirements for the past 90 days. ☒Yes ☐No

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, or a non-accelerated filer. See definition of "accelerated filer and large accelerated filer" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☐ Accelerated filer ☐ Non-accelerated filer ☒

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). ☐Yes ☒No

There were 749,550 shares of registrant's common stock outstanding as of September 15, 2007 (all of which are privately owned and not traded on a public market).

VANGUARD HEALTH SYSTEMS, INC.
ANNUAL REPORT ON FORM 10-K
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VANGUARD HEALTH SYSTEMS, INC.

CAUTIONARY STATEMENT REGARDING FORWARD-LOOKING STATEMENTS

This annual report on Form 10-K contains "forward-looking statements" within the meaning of the federal securities laws that are intended to be covered by safe harbors created thereby. Forward-looking statements are those statements that are based upon management's plans, objectives, goals, strategies, future events, future revenue or performance, capital expenditures, financing needs, plans or intentions relating to acquisitions, business trends and other information that is not historical information. These statements are based upon estimates and assumptions made by the Company's management that, although believed to be reasonable, are subject to numerous factors, risks and uncertainties that could cause actual outcomes and results to be materially different from those projected. When used in this annual report on Form 10-K, the words "estimates," "expects," "anticipates," "projects," "plans," "intends," "believes," "forecasts," "continues," or future or conditional verbs, such as "will," "should," "could" or "may," and variations of such words or similar expressions are intended to identify forward-looking statements.

These factors, risks and uncertainties include, among other things, statements relating to:

- Our high degree of leverage
- Our ability to incur substantially more debt
- Operating and financial restrictions in our debt agreements
- Our ability to successfully implement our business strategies
- Our ability to successfully integrate our recent and any future acquisitions
- The highly competitive nature of the healthcare industry
- Governmental regulation of the industry, including Medicare and Medicaid reimbursement levels
- Pressures to contain costs by managed care organizations and other insurers and our ability to negotiate acceptable terms with these third party payers
- Our ability to attract and retain qualified management and healthcare professionals, including physicians and nurses
- Potential federal or state reform of healthcare
- Future governmental investigations
- Potential management information systems failures and the significant costs of systems integrations
- The availability of capital to fund our corporate growth strategy
- Potential lawsuits or other claims asserted against us
- Our ability to maintain or increase patient membership and control costs of our managed healthcare plans
- Changes in general economic conditions
- Our exposure to the increased amounts of and collection risks associated with uninsured accounts and the co-pay and deductible portions of insured accounts
- Cost of professional and general liability insurance and increases in the quantity and severity of professional liability claims
- Our ability to maintain and increase patient volumes and control the costs of providing services, including salaries and benefits, supplies and bad debts
- Our failure to comply, or allegations of our failure to comply, with applicable laws and regulations
- The geographic concentration of our operations
- Technological and pharmaceutical improvements that increase the cost of providing, or reduce the demand for, healthcare services
- Potential substantial liabilities arising from unfavorable retrospective reviews by governmental or other payers of the medical necessity of medical procedures performed at our hospitals
- Lost future revenues from payer contract terminations resulting from their unfavorable retrospective reviews of the medical necessity of medical procedures performed at our hospitals

See "Item 1A – Risk Factors" for further discussion. We assume no obligation to update any forward-looking statements.

PART I

Item 1. Business.

Company Overview

We own and operate acute care hospitals and complementary outpatient facilities principally located in urban and suburban markets. We currently operate 15 acute care hospitals which, as of June 30, 2007, had a total of 4,143 beds in the following four locations:

- San Antonio, Texas
- metropolitan Phoenix, Arizona
- metropolitan Chicago, Illinois
- Massachusetts

Historically, we have concentrated our operations in markets with high population growth and median income in excess of the national average. Our objective is to provide high-quality, cost effective healthcare services through an integrated delivery platform serving the needs of the communities in which we operate. During the year ended June 30, 2007, we generated revenues from continuing operations of $2,580.7 million. During this period 84.4% of our total revenues were derived from acute care hospitals and complementary outpatient facilities.

Our general acute care hospitals offer a variety of medical and surgical services including emergency services, general surgery, internal medicine, cardiology, obstetrics, orthopedics and neurology. In addition, certain of our facilities provide on-campus and off-campus services including outpatient surgery, physical therapy, radiation therapy, diagnostic imaging and laboratory services. We also own three strategically important managed care health plans: a Medicaid managed health plan, Phoenix Health Plan, that served approximately 98,300 members as of June 30, 2007 in Arizona; Abrazo Advantage Health Plan, a managed Medicare and dual-eligible health plan that served approximately 3,400 members as of June 30, 2007; and MacNeal Health Providers a preferred provider network that served approximately 43,900 member lives in metropolitan Chicago as of June 30, 2007 under capitated contracts covering only outpatient and physician services.

We are a Delaware corporation formed in July 1997. Our principal executive offices are located at 20 Burton Hills Boulevard, Suite 100, Nashville, Tennessee, 37215 and our telephone number at that address is (615) 665-6000. Our corporate website address is www.vanguardhealth.com. Information contained on our website does not constitute part of this Annual Report on Form 10-K. The terms "we", "our", "the Company", "us", "registrant" and "Vanguard" as used in this report refer to Vanguard Health Systems, Inc. and its subsidiaries as a consolidated entity, except where it is clear from the context that such terms mean only Vanguard Health Systems, Inc. "Subsidiaries" means direct and indirect corporate subsidiaries of Vanguard Health Systems, Inc. and partnerships, joint ventures and limited liability companies in which such subsidiaries are partners or members. The term "predecessor" as used in our consolidated financial statements refers to the Company prior to the September 23, 2004 Merger discussed immediately below.

The Merger

On July 23, 2004, Vanguard executed an agreement and plan of merger (the "Merger Agreement") with VHS Holdings LLC ("Holdings") and Health Systems Acquisition Corp., a newly formed Delaware corporation ("Acquisition Corp."), pursuant to which on September 23, 2004 Acquisition Corp. merged with and into Vanguard, with Vanguard being the surviving corporation (the "Merger"). In the Merger, holders of the outstanding Vanguard capital stock, options to acquire Vanguard common stock and other securities convertible into Vanguard common stock received aggregate consideration of approximately $1,248.6 million.

The Blackstone Group, together with its affiliates (collectively, "Blackstone"), funded the Merger in part by subscribing for and purchasing approximately $494.9 million aggregate amount of (1) Class A membership units

in Holdings and (2) common stock of Acquisition Corp. (merged with and into Vanguard), in an amount equal to $125.0 million of such common stock. In addition, Morgan Stanley Capital Partners, together with its affiliates (collectively, "MSCP"), subscribed for and purchased Class A membership units in Holdings by contributing to Holdings a number of shares of Vanguard common stock equal to (1) $130.0 million divided by (2) the per share consideration payable for each share of Vanguard common stock in connection with the Merger. Certain senior members of management and certain other stockholders of Vanguard (the "Rollover Management Investors") subscribed for and purchased Class A membership units in Holdings, having an aggregate purchase price of approximately $119.1 million, by (a) paying cash using the proceeds of consideration received in connection with the Merger and/or (b) contributing shares of Vanguard common stock in the same manner as MSCP. Baptist Health Services ("Baptist"), the former owner of our division, Baptist Health System of San Antonio, also purchased $5.0 million of Class A membership units in Holdings. Immediately after completion of the Merger in September 2004, Blackstone, MSCP (together with Baptist) and the Rollover Management Investors held approximately 66.1%, 18.0% and 15.9%, respectively, of the common equity of Vanguard (most of which is indirectly held through the ownership of the Class A membership units in Holdings). Certain members of senior management also purchased $5.7 million of the equity incentive units in Holdings.

Concurrently with the Merger, we consummated certain related financing transactions, including the issuance by our affiliates of $575.0 million principal amount of 9% Senior Subordinated Notes due 2014, $216.0 million principal amount at maturity of 11.25% Senior Discount Notes due 2015 and the entrance into senior credit facilities pursuant to which we borrowed $475.0 million of term loans and obtained a $250.0 million revolving loan facility and two delayed draw term loan facilities aggregating $325.0 million.

Our Competitive Strengths

Concentrated Local Market Positions in Attractive Markets. We believe that our markets are attractive because of their favorable demographics, competitive landscape, payer mix and opportunities for expansion. Ten of our 15 hospitals are located in markets with population growth rates in excess of the national average and all of our acute care hospitals are located in markets in which the median household income is above the national average. For the fiscal year ended June 30, 2007, we derived approximately 64.1% of our total revenues from the high-growth markets of San Antonio and metropolitan Phoenix, in which we own five hospitals each. Our facilities in these markets primarily serve Bexar County, Texas, which encompasses most of the metropolitan San Antonio area and Maricopa County, Arizona, which encompasses most of the metropolitan Phoenix area. The U.S. Census Bureau and other data sources estimate that the population for Bexar County and Maricopa County will grow by 13.9% and 41.7%, respectively, between 2006 and 2020, rates that exceed the projected national average of 12.2%. Our strong market positions provide us with opportunities to offer integrated services to patients, receive more favorable reimbursement terms from a broader range of third party payers and realize regional operating efficiencies.

Proven Ability to Complete and Integrate Acquisitions. Including our first acquisition in 1998, we have selectively acquired 18 hospitals, 12 of which were formerly not-for-profit hospitals. We have subsequently sold 3 of these hospitals and ceased acute care operations in another. We believe our success in completing acquisitions is due in large part to our disciplined approach to making acquisitions. Prior to completing an acquisition, we carefully review the operations of the target facility and develop a strategic plan to improve performance. We have routinely rejected acquisition candidates that did not meet our financial and operational criteria.

We believe our historical performance demonstrates our ability to identify underperforming facilities and improve the operations of acquired facilities. When we acquire a hospital, we generally implement a number of measures to lower costs, and we often make significant investments in the facility to expand existing services and introduce new services, strengthen the medical staff and improve our overall market position. We expect to continue to grow revenues and profitability in the markets in which we operate by increasing the depth and breadth of services provided and through the implementation of additional operational enhancements.

Strong Management Team with Significant Equity Investment. Our senior management has an average of more than 20 years of experience in the healthcare industry at various organizations, including OrNda Healthcorp, HCA Inc. and HealthTrust, Inc. Many of our senior managers have been with Vanguard since its founding in 1997, and 12 of our 16 members of senior management have worked together managing healthcare companies for up to 20 years, either continuously or from time to time. In connection with the Merger, our management and certain other

shareholders contributed in September 2004 approximately $119.1 million for an approximately 15.9% equity interest in our company. In addition, certain members of senior management also purchased $5.7 million of the equity incentive units in Holdings in September 2004.

Business Strategy

The key elements of our business strategy include the following:

Continue our Commitment to Quality of Care. We have implemented and continue to implement various programs to improve the quality of care we provide. We have invested significant resources to develop clinical information systems to allow us to standardize compliance reporting of multiple quality indicators across our facilities, and we currently conduct a monthly review of 21 quality indicators set forth by CMS. We have developed training programs for our staff and share information among our hospital management to implement best practices and assist in complying with regulatory requirements. Corporate support is provided to each hospital to assist with accreditation reviews.

All hospitals conduct patient, physician and staff satisfaction surveys to help identify methods of improving the quality of care. We have appointed licensed physicians in each of our markets to the position of chief medical officer charged with driving best practices and clinical quality to improve the level of satisfaction among physicians and patients and promote cost-efficient provision of care. We have established rapid response teams and hourly nursing rounds in all of our hospitals to improve patient care.

We believe quality of care is becoming an increasingly important factor in governmental and managed care reimbursement. We continuously review patient care evaluations and maintain other quality assurance programs to support and monitor quality of care standards and to meet and exceed Medicare and Medicaid accreditation and regulatory requirements. Furthermore, as part of the Medicare Modernization Act, CMS identified three conditions, and 10 measures within those conditions, for which hospitals are encouraged to submit data in order to measure the quality of patient care. Those hospitals who submit quality data for these measures will be entitled to receive a full market basket update. We have submitted quality data reports within all three conditions at all of our hospitals to the CMS National Voluntary Hospital Reporting Initiative, and we have qualified for the maximum allowable reimbursement rate established by CMS for federal fiscal years 2006 and 2007. We expect to continue to participate in the CMS National Voluntary Hospital Reporting Initiative for federal fiscal year 2008 and the foreseeable future. However, further legislation expanded the reporting requirements and increased the penalties for non-compliance for federal fiscal years 2008 and 2009.

We believe that pay for performance reimbursement will continue to evolve, and the quality measures themselves will determine reimbursement. Our ability to meet our quality goals requires not only information systems to monitor compliance with quality indicators, but more importantly requires clinical programs and physician integration to improve quality.

Expand Services to Increase Revenues and Profitability. We will continue to invest in our facilities to expand the range and improve the quality of services provided based on our understanding of the needs of the communities we serve. Our local management teams work closely with patients, payers, physicians and other medical personnel to identify and prioritize the healthcare needs of individual communities. We intend to increase our revenues and profitability by expanding the range of services we offer at certain of our hospitals. We plan to:

- expand emergency room and operating room capacity;
- improve the convenience, quality and breadth of our outpatient services;
- upgrade and expand high margin and high volume specialty services, including cardiology, oncology, neurosurgery, orthopedics, and women's services;
- update our medical equipment technology, including diagnostic and imaging equipment;
- increase the availability of private rooms for our patients; and
- continue evaluating the construction of new facilities in underserved areas of the community.

To further these strategies, our board of directors has approved major expansion projects at six of our existing hospitals in San Antonio and metropolitan Phoenix, for which we expect to expend a total of approximately $337.0 million, including approximately $296.1 million already spent through June 30, 2007.

We believe that our disciplined expansion strategy will grow volumes, increase acuity mix, improve managed care pricing and enhance operating margins at our existing facilities, and at the same time reduce patient out-migration and satisfy unmet demand within our existing markets.

Improve Operating Margins and Efficiency. We seek to position ourselves as a cost effective provider of healthcare services in each of our markets. We intend to generate operational efficiencies and improve operating margins by:

- implementing more efficient care management, supply utilization and inventory management such as eliminating arrangements that have built in margins, including dietary, rehabilitation, housekeeping and plant maintenance;
- improving our billing and collection processes;
- capitalizing on purchasing efficiencies;
- optimizing staffing and outsourcing arrangements; and
- centralizing certain administrative and business office functions within a local market or at the corporate level.

Recruit New Physicians and Maintain Strong Relationships with Existing Physicians. We recruit both primary and specialty physicians who can provide services that we believe are currently underserved and in demand in the communities we serve. In addition to providing strong local and regional management teams, we intend to sustain and strengthen our recruitment and retention initiatives by:

- providing physicians with high quality facilities in which to practice;
- providing a broad array of services within the integrated health network;
- offering quality training programs;
- providing remote access to clinical information; and
- arranging for convenient medical office space adjacent to our facilities.

Continue to Develop Favorable Managed Care Relationships. We plan to increase the number of patients at our facilities and improve our profitability by negotiating more favorable terms with managed care plans. We believe that we are attractive to managed care plans because of the geographic and demographic coverage of our facilities in their respective markets, the quality and breadth of our services and the expertise of our physicians. Further, we believe that as we increase our presence and improve our competitive position in our markets, particularly as we develop our networks of hospitals, we will be even better positioned to negotiate more favorable managed care contracts.

Grow Through Selective Acquisitions. We will continue to pursue acquisitions and enter into partnerships or affiliations with other healthcare service providers that either expand our network and presence in our existing markets or allow us to enter new urban and suburban markets. We intend to selectively pursue acquisitions of networks of hospitals and other complementary facilities or single-well positioned facilities where we believe we can improve operating performance, profitability and increase market share. We believe that we will continue to have substantial acquisition opportunities as other healthcare providers choose to divest facilities and as independent hospitals, particularly not-for-profit hospitals, seek to capitalize on the benefits of becoming part of a larger hospital company.

Our Markets

San Antonio, Texas

In the San Antonio market, as of June 30, 2007, we owned and operated 5 hospitals with a total of 1,673 licensed beds and related outpatient service locations complementary to the hospitals. We acquired these hospitals in January 2003 from the non-profit Baptist Health Services (formerly known as Baptist Health System) and continue to operate the hospitals as the Baptist Health System. The acquisition followed our strategy of acquiring a significant market share in a growing market, San Antonio, Texas. Our facilities primarily serve Bexar County which encompasses most of the metropolitan San Antonio area. The population in Bexar County has grown and is projected to continue to grow well in excess of the national average as illustrated in the following table.

	Bexar County	% increase	U.S. Average	% increase
1990 actual population	1,185,000		248,710,000	
2000 actual population	1,393,000	17.5%	281,422,000	13.2%
2006 estimated population	1,556,000	11.7%	299,398,000	6.4%
2010 projected population	1,593,000	2.4%	308,936,000	3.2%
2020 projected population	1,772,000	11.2%	335,805,000	8.7%

During the years ended June 30, 2006 and 2007, we generated approximately 30.4% and 31.2% of our total revenues, respectively, in this market. In our acquisition agreement for the Baptist Health System we committed to fund not less than $200.0 million in capital expenditures in respect of the acquired businesses in the San Antonio metropolitan area during the first six years of our ownership, with $75.0 million of such expenditures being required in the first two years. By the end of our fiscal year ended June 30, 2005, we had funded or committed to fund all $200.0 million of this capital commitment.

Metropolitan Phoenix, Arizona

In the Phoenix market, as of June 30, 2007, we owned and operated 5 hospitals with a total of 970 licensed beds and related outpatient service locations complementary to the hospitals, a prepaid Medicaid managed health plan, Phoenix Health Plan ("PHP"), and a managed Medicare and dual-eligible health plan, Abrazo Advantage Health Plan ("AAHP"). Phoenix is the fifth largest city in the U.S. and has been one of the fastest growing major metropolitan areas in recent years. Our facilities primarily serve Maricopa County, which encompasses most of the metropolitan Phoenix area. The table below illustrates the significant historical and projected future growth of Maricopa County compared to the national average.

	Maricopa County	% increase	U.S. Average	% increase
1990 actual population	2,122,000		248,710,000	
2000 actual population	3,072,000	44.8%	281,422,000	13.2%
2006 estimated population	3,768,000	22.7%	299,398,000	6.4%
2010 projected population	4,145,000	10.0%	308,936,000	3.2%
2020 projected population	5,210,000	25.7%	335,805,000	8.7%

During the years ended June 30, 2006 and 2007, exclusive of PHP and AAHP, we generated approximately 19.6% and 19.5% of our total revenues, respectively, in this market. Three of our hospitals in this market were formerly not-for-profit hospitals. We believe that payers will choose to contract with us in order to give their enrollees a comprehensive choice of providers in the western and northeastern Phoenix areas. There have been recent improvements in payer rates generally and the substantial increase in Medicaid eligibility for low income patients provided by Proposition 204, which expanded Medicaid coverage to approximately 400,000 additional individuals in Arizona since January 1, 2001. We believe our network strategy will position us to negotiate rate increases with managed care payers and to develop our five hospitals into a network providing a comprehensive

range of integrated services, from primary care to tertiary hospital services, to payers and their patients. In addition, our ownership of the PHP and AAHP will allow us to enroll eligible patients, who would not otherwise be able to pay for their expenses at local hospitals, into our health plan or into other state-approved plans.

Metropolitan Chicago, Illinois

In the Chicago metropolitan area, as of June 30, 2007, we owned and operated 2 hospitals with 784 licensed beds, and related outpatient service locations complementary to the hospitals. These hospitals, MacNeal Hospital and Weiss Hospital, are located in areas serving relatively well-insured populations. Weiss Hospital is operated by us in a consolidated joint venture corporation in which we own 80.1% and the University of Chicago Hospitals owns 19.9% of the equity interests. During the years ended June 30, 2006 and 2007, we generated approximately 15.9% and 15.6%, respectively, of our total revenues in this market.

We chose MacNeal and Weiss Hospitals, both former not-for-profit facilities, as our first two entries into the largely not-for-profit metropolitan Chicago area. Both MacNeal and Weiss Hospitals are large, well-equipped, university-affiliated hospitals with strong reputations and medical staffs. We believe we have captured a large share of the patients in MacNeal Hospital's immediate surrounding service area, which encompasses the cities of Berwyn and Cicero, Illinois. MacNeal offers tertiary services such as open heart surgery that patients would otherwise have to travel outside the local community to receive. We have also established a fully-integrated healthcare system at MacNeal and Weiss Hospitals by operating free-standing primary care and occupational medicine centers and a large commercial laboratory and by employing 110 physicians on our medical staffs there, including 44 primary care physicians. Our network of 25 primary care and occupational medicine centers allows us to draw patients to MacNeal and Weiss Hospital from around the metropolitan Chicago area. These hospitals also enjoy the distinction of being two of the few community hospitals in which the prestigious University of Chicago Medical School has placed its medical students and residents. Currently, MacNeal Hospital participates in the University of Chicago's residency programs in internal medicine, general surgery, obstetrics/gynecology and psychiatry and Weiss Hospital participates in the University of Chicago's residency program in surgery. In addition, MacNeal Hospital runs a successful free-standing program in family practice, one of the oldest such programs in the state of Illinois, and Weiss Hospital also runs a successful free-standing residency program in internal medicine. Our medical education programs help us to attract quality physicians to both the hospitals and our network of primary care and occupational medicine centers.

Massachusetts

In Massachusetts, as of June 30, 2007, we owned and operated 3 hospitals with a total of 716 licensed beds and related healthcare services complementary to the hospitals. These hospitals include Saint Vincent Hospital located in Worcester and MetroWest Medical Center, a two-campus hospital system comprised of Framingham Union Hospital in Framingham and Leonard Morse Hospital in Natick. These hospitals were acquired from subsidiaries of Tenet Healthcare Corporation on December 31, 2004. We believe that opportunities for growth through increased market share exist in the Massachusetts area through the possible addition of new services, partnerships and the implementation of a strong primary care physician strategy. During the years ended June 30, 2006 and 2007, the Massachusetts facilities represented 20.2% and 19.8% of our total revenues, respectively.

Saint Vincent Hospital, located in Worcester, is a 348-bed teaching hospital with a strong residency program. Worcester is located in central Massachusetts and is the second largest city in Massachusetts. The service area is characterized by a patient base that is older, more affluent and well-insured. Saint Vincent Hospital is focused on strengthening its payer relationships, developing its primary care physician base and expanding its offerings in cardiology, orthopedics, radiology and minimally-invasive surgery capabilities.

MetroWest Medical Center's two campus system has a combined total of 368 licensed beds with locations in Framingham and Natick, in the suburbs west of Boston. These facilities serve communities that are generally well-insured. We are seeking to develop strong ambulatory care capabilities in these service areas, as well as expansion of oncology, radiology, women's services and cardiology services.

Our Facilities

We owned and operated 15 acute care hospitals as of June 30, 2007. The following table contains information concerning our hospitals:

Hospital	City	Licensed Beds	Date Acquired
Texas			
Baptist Medical Center	San Antonio	612	January 1, 2003
Northeast Baptist Hospital	San Antonio	291	January 1, 2003
North Central Baptist Hospital	San Antonio	268	January 1, 2003
Southeast Baptist Hospital	San Antonio	175	January 1, 2003
St. Luke's Baptist Hospital	San Antonio	327	January 1, 2003
Arizona			
Maryvale Hospital	Phoenix	232	June 1, 1998
Arrowhead Hospital	Glendale	220	June 1, 2000
Phoenix Baptist Hospital	Phoenix	236	June 1, 2000
Paradise Valley Hospital	Phoenix	151	November 1, 2001
West Valley Hospital (1)	Goodyear	131	September 4, 2003
Illinois			
MacNeal Hospital	Berwyn	427	February 1, 2000
Louis A. Weiss Memorial Hospital (2)	Chicago	357	June 1, 2002
Massachusetts			
MetroWest Medical Center – Leonard Morse Hospital	Natick	141	December 31, 2004
MetroWest Medical Center - Framingham Union Hospital	Framingham	227	December 31, 2004
Saint Vincent Hospital at Worcester Medical Center	Worcester	348	December 31, 2004
Total Licensed Beds		4,143	

(1) This hospital was constructed, not acquired.

(2) This hospital is operated by us in a consolidated joint venture corporation in which we own 80.1% of the equity interests and the University of Chicago Hospitals owns 19.9% of the equity interests.

In addition to the hospitals listed in the table above, as of June 30, 2007, we owned certain outpatient service locations complementary to our hospitals and two surgery centers in California. We also own and operate a limited number of medical office buildings in conjunction with our hospitals which are primarily occupied by physicians practicing at our hospitals. Our headquarters are located in approximately 40,500 square feet of leased space in one office building in Nashville, Tennessee.

Our hospitals and other facilities are suitable for their respective uses and are, in general, adequate for our present needs.

In certain circumstances involving the purchase of a not-for-profit hospital, we have agreed and in the future may agree to certain limitations on our ability to sell those facilities. In particular, when we acquired Phoenix Baptist Hospital and Arrowhead Hospital in June 2000, we agreed not to sell either hospital for five years after closing until June 1, 2005, and granted to a foundation affiliated with the seller for 10 years after closing a right of first refusal to purchase either hospital if we agreed to sell it to a third party, at the same price on which we agreed to

sell that hospital to the third party. In addition, upon the purchase of the Baptist Health System hospitals, we agreed not to sell the hospitals for seven years until January 1, 2010 without the consent of the seller.

Major Expansion Projects

In May 2004 and July 2005, our board of directors approved major expansion projects at six of our existing hospitals in San Antonio and metropolitan Phoenix. We estimate that these projects will cost a total of approximately $337.0 million, including capitalized interest costs. Through June 30, 2007, we have spent approximately $296.1 million related to these projects and expect to incur the remaining $40.9 million during our next two fiscal years. All of these projects will result in additional capacity at each of the six hospitals. In addition, most of the projects will facilitate an expansion of clinical service capabilities.

The following table summarizes these major expansion projects as of September 1, 2007.

Hospital	Estimated Construction Period		Approximate Additional Licensed Bed Capacity	Approximate Additional Licensed Beds Completed	Additional Emergency Room Positions	Additional Operating Rooms	Additional Labor & Delivery Rooms
	Begin	Completed					
Phoenix							
Arrowhead Hospital	Q4 FY 04	Q1 FY 07	100	100	✓	✓	✓
Paradise Valley Hospital	Q1 FY 07	Q3 FY 09	22 (4)	0	(2)	✓	✓
West Valley Hospital	Q1 FY 06	Q4 FY 07	57	57	✓	✓	(1)
San Antonio							
North Central Baptist Hospital	Q4 FY 04	Q2 FY 07	140	140	✓	✓	✓
Northeast Baptist Hospital	Q4 FY 04	Q2 FY 07	33 (3)	33	✓	✓	✓
St. Luke's Baptist Hospital	Q2 FY 06	Q4 FY 07	27	27			

(1) Increased post partum capacity to better utilize labor, delivery and recovery suites.
(2) An expanded emergency room was opened in July 2004, expanding capacity from 16 to 28 bays.
(3) In addition to increasing the number of licensed beds by 33, the expansion project allows for the utilization of an additional 67 previously licensed beds.
(4) In addition to increasing the number of licensed beds by 22, the expansion will allow for the utilization of an additional 18 previously licensed beds.

Arrowhead Hospital

Arrowhead Hospital was a capacity-constrained facility with a service area that we believe is marked by significant population growth. The expansion project at this facility, which began in the fourth quarter of fiscal 2004 and was completed during fiscal 2007, consisted of relocating and expanding the intensive care unit (ICU) to be close to the emergency room and operating rooms. In addition, the project expanded operating room capacity, emergency room capacity, medical/surgical bed capacity and obstetrics capacity, which allowed for increased clinical complexity at the facility.

Paradise Valley Hospital

Paradise Valley Hospital currently has capacity constraints in its labor/delivery rooms, operating rooms and ICU. This facility is located in an area that we believe has relatively high population growth and favorable demographics. In addition, recently completed highway construction improves access to this facility. A portion of this expansion project began in the first quarter of fiscal 2007, and the entire project is expected to be completed in the third quarter of fiscal 2009. This project adds significant capacity in operating room suites, critical care (ICU) and obstetrics and will also allow for a conversion to a largely private room model from a predominately semi-private model. In addition, the expansion will enable the hospital to add more complex clinical programs, such as interventional cardiology, to its service mix. During fiscal 2006, this hospital completed major expansions of the emergency room and the radiology suite in separate projects.

West Valley Hospital

This project at West Valley Hospital, a facility first opened in September 2003, commenced in the first quarter of fiscal 2006 and was completed in the fourth quarter of fiscal 2007. This expansion project significantly expanded the number of medical/surgical beds, the number of ICU beds and emergency room capacity. In addition, the project provides the facility with the ability to offer a wider range of clinical services.

North Central Baptist Hospital

North Central Baptist Hospital is located in an area of San Antonio that we believe has relatively high population growth and favorable demographics. Several areas of the facility, the emergency room, surgery capacity, telemetry, obstetrics, and critical care beds, were previously at functional capacity. We commenced this expansion project during the fourth quarter of fiscal 2004 and it was completed in the second quarter of fiscal 2007. This project consisted of:

- expanding obstetrics;
- adding medical/surgical and critical care beds;
- expanding emergency room capacity, including a separate pediatric and adult emergency room; and
- adding new clinical services, including high risk prenatal services, invasive cardiology, pediatric neurosurgery and other subspecialties along with appropriate operating room expansions.

Northeast Baptist Hospital

This project at Northeast Baptist Hospital improved the layout of the facility and added capacity. The project added medical/surgical beds, ICU beds, emergency room positions, obstetrics, one operating room and a new cardiology center. Construction began on this project late in the fourth quarter of fiscal 2004 and was completed in the second quarter of fiscal 2007. This expansion project resulted in more private room capacity and helped reduce and eliminate certain capacity issues in the emergency room, obstetrics and the ICU.

St. Luke's Baptist Hospital

The project at St. Luke's Baptist Hospital consisted of relocating and expanding the intensive care (ICU) and telemetry units. The new telemetry unit consists of a central monitoring area capable of monitoring both a number of dedicated telemetry beds as well as remote beds throughout the facility. The new expanded ICU added capacity and is equipped with the latest intensive care capabilities. This project added 27 licensed beds and was completed during the fourth quarter of our fiscal year 2007.

Hospital Operations

Our hospitals typically provide the full range of services commonly available in acute care hospitals, such as internal medicine, general surgery, cardiology, oncology, neurosurgery, orthopedics, obstetrics, diagnostic and emergency services, as well as select tertiary services such as open-heart surgery and level II and III neonatal intensive care. Our hospitals also generally provide outpatient and ancillary healthcare services such as outpatient surgery, laboratory, radiology, respiratory therapy and physical therapy. We also provide outpatient services at our imaging centers and ambulatory surgery centers. Certain of our hospitals have a limited number of psychiatric, skilled nursing and rehabilitation beds.

Our senior management team has extensive experience in operating multi-facility hospital networks and focuses on strategic planning for our facilities. A hospital's local management team is generally comprised of a chief executive officer, chief financial officer and chief nursing officer. Local management teams, in consultation with our corporate staff, develop annual operating plans setting forth revenue growth strategies through the expansion of offered services and the recruitment of physicians in each community, as well as plans to improve operating efficiencies and reduce costs. We believe that the ability of each local management team to identify and meet the

needs of our patients, medical staffs and the community as a whole is critical to the success of our hospitals. We base the compensation for each local management team in part on its ability to achieve the goals set forth in the annual operating plan.

Boards of trustees at each hospital, consisting of local community leaders, members of the medical staff and the hospital administrator, advise the local management teams. Members of each board of trustees are identified and recommended by our local management teams and serve three-year staggered terms. The boards of trustees establish policies concerning medical, professional and ethical practices, monitor these practices and ensure that they conform to our high standards. We maintain company-wide compliance and quality assurance programs and use patient care evaluations and other assessment methods to support and monitor quality of care standards and to meet accreditation and regulatory requirements.

We believe that the most important factors affecting the utilization of a hospital are the quality and market position of the hospital and the number, quality and specialties of physicians and medical staff caring for patients at the facility. Overall, we believe that the attractiveness of a hospital to patients, physicians and payers depends on its breadth of services, level of technology and emphasis on quality of care and convenience for patients and physicians. Other factors that affect utilization include local demographics and population growth, local economic conditions and managed care market penetration.

The following table sets forth certain operating statistics from continuing operations for the periods indicated. Acute care hospital operations are subject to fluctuations due to seasonal cycles of illness and weather, including increased patient utilization during the cold weather months and decreases during holiday periods.

	Year Ended June 30,				
	2003	2004	2005	2006	2007
Number of hospitals at end of period (a)	11	12	15	15	15
Number of licensed beds at end of period (b)	3,066	3,133	3,907	3,937	4,143
Discharges (c)	93,144	126,356	147,798	162,446	166,873
Adjusted discharges - hospitals (d)	137,409	186,464	231,322	261,422	265,448
Average length of stay (days) (e)	4.1	4.1	4.2	4.3	4.3
Average daily census (f)	1,049	1,420	1,708	1,921	1,978
Occupancy rate (g)	45.9%	45.5%	48.5%	49.2%	48.4%
Member lives (h)	130,700	142,200	146,700	146,200	145,600

(a) The number of hospitals at the end of each period represents hospitals included in continuing operations.

(b) Licensed beds are those beds for which a facility has been granted approval to operate from the applicable state licensing agency.

(c) Represents the total number of patients discharged (in the facility for a period in excess of 23 hours) from our hospitals and is used by management and certain investors as a general measure of inpatient volumes.

(d) Adjusted discharges-hospitals is used by management and certain investors as a general measure of combined inpatient and outpatient volumes and is computed by multiplying discharges by the sum of gross hospital inpatient and outpatient revenues and then dividing the result by gross hospital inpatient revenues. This computation enables management to assess hospital volumes by a combined measure of inpatient and outpatient volumes.

(e) Average length of stay represents the average number of days admitted patients stay in our hospitals.

(f) Average daily census represents the average number of patients in our hospitals each day during our ownership.

(g) Occupancy rate represents the percentage of hospital licensed beds occupied by patients. Both average daily census and occupancy rate provide measures of utilization of inpatient rooms.

(h) Member lives represents the total number of enrollees in our Arizona prepaid managed health plans and our Chicago capitated health plan as of the end of the respective period.

The healthcare industry has experienced a general shift during the past few years from inpatient services to outpatient services as Medicare, Medicaid and managed care payers have sought to reduce costs by shifting lower-acuity cases to an outpatient setting. Advances in medical equipment technology and pharmacology have supported the shift to outpatient utilization, which has resulted in an increase in the acuity of inpatient admissions. However, we expect inpatient admissions to recover over the long-term as the baby boomer population reaches ages where inpatient admissions become more prevalent. We have responded to the shift to outpatient services through our ambulatory surgery centers in Orange County, California, our interests in diagnostic imaging centers in San Antonio, Texas, our outpatient diagnostic imaging centers in metropolitan Phoenix, Arizona and our network of primary care and occupational medicine centers in metropolitan Chicago, Illinois, along with continued expansion of emergency and outpatient services at our acute hospitals. We have the resources in place or are in the process of procuring the resources, including quality physicians and nursing staff and technologically advanced equipment, to support our comprehensive service offerings to capture inpatient volumes from the baby boomers and have focused on core services including cardiology, neurology, oncology and orthopedics. We have also opened sub-acute units such as rehabilitation and psychiatric services, where appropriate, to meet the needs of our patients while increasing volumes and increasing care management efficiencies.

Phoenix Health Plan, Abrazo Advantage Health Plan and MacNeal Health Providers

Phoenix Health Plan ("PHP") is a prepaid Medicaid managed health plan that serves Maricopa, Pinal and Gila counties in the Phoenix, Arizona area. We acquired PHP in May 2001. We are able to enroll eligible patients in our hospitals into PHP or other local Medicaid managed health plans who otherwise would not be able to pay for their hospital expenses. In addition, we believe that we will increase the availability of medically necessary services to such patients at our hospitals. We believe the volume of patients generated through our health plans will help attract quality physicians to our hospitals.

For the year ended June 30, 2007, we derived approximately $301.9 million of our total revenues from PHP. PHP had approximately 98,300 enrollees as of June 30, 2007, and derives substantially all of its revenues through a contract with the Arizona Health Care Cost Containment System ("AHCCCS"), which is Arizona's state Medicaid program. The contract requires PHP to arrange for healthcare services for enrolled Medicaid patients in exchange for fixed periodic payments and supplemental payments from AHCCCS. PHP subcontracts with physicians, hospitals and other healthcare providers to provide services to its enrollees. These services are provided regardless of the actual costs incurred to provide these services. We receive reinsurance and other supplemental payments from AHCCCS to cover certain costs of healthcare services that exceed certain thresholds.

As part of its contract with AHCCCS, PHP is required to maintain a performance guarantee in the amount of $19.0 million. Vanguard maintains this performance guarantee on behalf of PHP in the form of surety bonds totaling $19.0 million with independent third party insurers that expire on October 1, 2007. We were also required to arrange for $2.9 million in letters of credit to collateralize our $19.0 million in surety bonds with the third party insurers. The amount of the performance guaranty that AHCCCS requires is based upon the membership in the health plan and the related capitation amounts paid to us. We currently do not expect a material increase in the amount of the performance guarantee during the next fiscal year.

Our current contract with AHCCCS commenced on October 1, 2003. In September 2007, AHCCCS executed its final one-year renewal option that effectively extends the contract through September 30, 2008.

Effective January 1, 2006, our subsidiary Abrazo Advantage Health Plan ("AAHP") became a Medicare Advantage Prescription Drug Special Needs Plan provider under a contract with the Centers for Medicare & Medicaid Services ("CMS"). This allows AAHP to offer Medicare and Part D drug benefit coverage for dual-eligible members (those that are eligible for Medicare and Medicaid). PHP has historically served this type of member through the AHCCCS Medicaid program. As of June 30, 2007, approximately 3,400 members were enrolled in AAHP, most of whom were previously enrolled in PHP. For the year ended June 30, 2007, we derived approximately $43.0 million of our total revenues from AAHP.

The operations of MacNeal Health Providers ("MHP") are somewhat integrated with our MacNeal Hospital in Berwyn, Illinois. For the year ended June 30, 2007, we derived approximately $56.5 million of our total revenues from MHP. Substantially all of the revenues of MHP arose from its contracts with health maintenance organizations

from whom it took assignment of capitated member lives. As of June 30, 2007, MHP had contracts in effect covering approximately 43,900 capitated member lives. Such capitation is limited to physician services and outpatient ancillary services and does not cover inpatient hospital services. We try to utilize MacNeal Hospital and its medical staff as much as possible for the physician and outpatient ancillary services that are required by such capitation arrangements. Revenues of MHP could decrease significantly if the health maintenance organizations in the metropolitan Chicago area move away from assigning capitated-member lives to health plans like MHP and enter into direct fee-for-service arrangements with healthcare providers.

Sources of Revenues

We receive payment for patient services from:

- the federal government, primarily under the Medicare program;
- state Medicaid programs; and
- health maintenance organizations, preferred provider organizations, other private insurers and individual patients.

The table below presents the approximate percentage of net patient revenues we received from the following sources for the periods indicated:

	Year ended June 30,		
Payer Source	**2005**	**2006**	**2007**
Medicare	30%	28%	26%
Medicaid	7	7	9
Managed care plans (1)	47	52	52
Self-pay	11	9	10
Commercial	5	4	3
Total	100%	100%	100%

(1) Includes revenues under managed Medicare, managed Medicaid and other governmental managed plans in addition to commercial managed care plans.

Most of our hospitals offer discounts from established charges to private managed care plans if they are large group purchasers of healthcare services. These discount programs limit our ability to increase charges in response to increasing costs. Patients generally are not responsible for any difference between established hospital charges and amounts reimbursed for such services under Medicare, Medicaid, some private insurance plans, health maintenance organizations or preferred provider organizations, but are generally responsible for exclusions, deductibles and co-insurance features of their coverages. Due to rising healthcare costs, many payers have increased the number of excluded services and the levels of deductibles and co-insurance resulting in a higher portion of the contracted rate due from the individual patients. Collecting amounts due from individual patients is typically more difficult than collecting from governmental or private managed care plans.

Competition

The hospital industry is highly competitive. We currently face competition from established, not-for-profit healthcare companies, investor-owned hospital companies, large tertiary care centers, specialty hospitals and outpatient service providers. In the future, we expect to encounter increased competition from companies, like ours, that consolidate hospitals and healthcare companies in specific geographic markets. Continued consolidation in the healthcare industry will be a leading factor contributing to increased competition in our current markets and markets we may enter in the future. Due to the shift to outpatient care and more stringent payer-imposed pre-authorization requirements during the past few years, most hospitals have significant unused capacity resulting in increased

competition for patients. Many of our competitors are larger than us and have more financial resources available than we do. Other not-for-profit competitors have endowment and charitable contribution resources available to them and can purchase equipment and other assets on a tax-free basis.

One of the most important factors in the competitive position of a hospital is its location, including its geographic coverage and access to patients. A location convenient to a large population of potential patients or a wide geographic coverage area through hospital networks can make a hospital significantly more competitive. Another important factor is the scope and quality of services a hospital offers, whether at a single facility or a network of facilities, compared to the services offered by its competitors. A hospital or network of hospitals that offers a broad range of services and has a strong local market presence is more likely to obtain favorable managed care contracts. We intend to evaluate changing circumstances in the geographic areas in which we operate on an ongoing basis to ensure that we offer the services and have the access to patients necessary to compete in these managed care markets and, as appropriate, to form our own, or join with others to form, local hospital networks.

A hospital's competitive position also depends in large measure on the quality and scope of the practices of physicians associated with the hospital. Physicians refer patients to a hospital primarily on the basis of the quality and scope of services provided by the hospital, the quality of the medical staff and employees affiliated with the hospital, the hospital's location and the quality and age of the hospital's equipment and physical plant. Although physicians may terminate their affiliation with our hospitals, we seek to retain physicians of varied specialties on our medical staffs and to recruit other qualified physicians by maintaining and improving our level of care and providing quality facilities, equipment, employees and services for physicians and their patients.

Another major factor in the competitive position of a hospital is the ability of its management to obtain contracts with managed care plans and other group payers. The importance of obtaining managed care contracts has increased in recent years and is expected to continue to increase as private and government payers and others increasingly turn to managed care organizations to help control rising healthcare costs. Our markets have experienced significant managed care penetration. The revenues and operating results of our hospitals are significantly affected by our hospitals' ability to negotiate favorable contracts with managed care plans. Health maintenance organizations and preferred provider organizations use managed care contracts to encourage patients to use certain hospitals in exchange for discounts from the hospitals' established charges. Traditional health insurers and large employers also are interested in containing costs through similar contracts with hospitals.

The hospital industry and our hospitals continue to have significant unused capacity. Inpatient utilization, average lengths of stay and average occupancy rates have historically been negatively affected by payer-required pre-admission authorization, utilization review and payer pressure to maximize outpatient and alternative healthcare delivery services for less acutely ill patients. Admissions constraints, payer pressures and increased competition are expected to continue. We endeavor to meet these challenges by expanding many of our facilities to include outpatient centers, offering discounts to private payer groups, upgrading facilities and equipment and offering new or expanded programs and services.

A number of other factors affect our competitive position, including:

- our reputation;
- the amounts we charge for our services;
- parking availability or access to public transportation; and
- the restrictions of state Certificate of Need laws.

Employees and Medical Staff

As of June 30, 2007, we had approximately 18,000 employees, including approximately 2,000 part-time employees. Approximately 1,600 of our full-time employees at our three Massachusetts hospitals are unionized. Overall, we consider our employee relations to be good. While some of our non-unionized hospitals experience union organizing activity from time to time, we do not expect these efforts to materially affect our future operations. Our hospitals, like most hospitals, have experienced labor costs rising faster than the general inflation rate.

In the industry as a whole, and in our markets, there is currently a shortage of nurses and other medical support personnel. To address the nursing shortage, we have implemented comprehensive recruiting and retention plans for nurses. As part of this plan, we have expanded our nursing schools in San Antonio and Phoenix to attract new students and to provide options for current nurses to advance their careers. We also increased our involvement with other colleges, participated in more job fairs and recruited nurses from abroad. Our recruiting and retention plan also focuses on mentoring, flexible work hours, performance leadership training, quality of care and patient safety and competitive pay and benefits. We anticipate that demand for nurses will continue to exceed supply especially as the baby boomer population reaches the ages where inpatient stays become more frequent. However, we expect our initiatives to help stabilize our nursing resources over time.

Our hospitals grant staff privileges to licensed physicians who may serve on the medical staffs of multiple hospitals, including hospitals not owned by us. A physician who is not an employee can terminate his or her affiliation with our hospital at any time. Although we employ a limited number of physicians, a physician does not have to be an employee of ours to be a member of the medical staff of one of our hospitals. Any licensed physician may apply to be admitted to the medical staff of any of our hospitals, but admission to the staff must be approved by each hospital's medical staff and board of trustees in accordance with established credentialing criteria.

Compliance Program

We voluntarily maintain a company-wide compliance program designed to ensure that we maintain high standards of ethics and conduct in the operation of our business and implement policies and procedures so that all our employees act in compliance with all applicable laws, regulations and company policies. The organizational structure of our compliance program includes oversight by our board of directors and a high-level corporate management compliance committee. The board of directors and compliance committee are responsible for ensuring that the compliance program meets its stated goals and remains up-to-date to address the current regulatory environment and other issues affecting the healthcare industry. Our Senior Vice President of Compliance and Ethics reports jointly to our Chairman and Chief Executive Officer and to our board of directors, serves as Chief Compliance Officer and is charged with direct responsibility for the day-to-day management of our compliance program. Other features of our compliance program include Regional Compliance Officers who report to our Chief Compliance Officer in all four of our operating regions, initial and periodic ethics and compliance training and effectiveness reviews, a toll-free hotline for employees to report, without fear of retaliation, any suspected legal or ethical violations, annual "fraud and abuse" audits to examine all of our payments to physicians and other referral sources and annual "coding audits" to make sure our hospitals bill the proper service codes in respect of obtaining payment from the Medicare and Medicaid programs.

A recent focus of our compliance program is the interpretation and implementation of the standards set forth by the Health Insurance Portability and Accountability Act ("HIPAA") for privacy and security. To facilitate reporting of potential HIPAA compliance concerns by patients, family or employees, we established a second toll-free hotline dedicated to HIPAA and other privacy matters and placed it in service in April 2003. Corporate HIPAA compliance staff monitors all reports to the privacy hotline and each phone call is responded to appropriately. Ongoing HIPAA compliance also includes self-monitoring of HIPAA policy and procedure implementation by each of our healthcare facilities and corporate compliance oversight.

Our Information Systems

We believe that our information systems must cost-effectively meet the needs of our hospital management, medical staff and nurses in the following areas of our business operations:

- patient accounting, including billing and collection of revenues;
- accounting, financial reporting and payroll;
- coding and compliance;
- laboratory, radiology and pharmacy systems;

- medical records and document storage;
- materials and asset management; and
- negotiating, pricing and administering our managed care contracts.
- quality indicators

Although we map the information systems from each of our hospitals to one centralized database, we do not automatically standardize our information systems among all of our hospitals. We carefully review existing systems at the hospitals we acquire and, if a particular information system is unable to cost-effectively meet the operational needs of the hospital, we will convert or upgrade the information system at that hospital to one of several standardized information systems that can cost-effectively meet these needs.

Insurance

As is typical in the healthcare industry, we are subject to claims and legal actions by patients and others in the ordinary course of business. For claims incurred on or after June 1, 2002 through May 31, 2006, our wholly owned captive subsidiary insured our professional and general liability risks at a $10.0 million retention level. For professional and general liability claims incurred on or after June 1, 2006, we self-insure the first $9.0 million of each claim, and the captive subsidiary insures the next $1.0 million. We maintain excess coverage from independent third-party carriers for individual claims exceeding $10.0 million per occurrence up to $75.0 million, but limited to total annual payments of $65.0 million in the aggregate. The captive insurance subsidiary funds its portion of claims costs from proceeds of premium payments received from us.

The malpractice insurance environment remains volatile. However, some states, including Illinois and Texas, have in recent years passed tort reform legislation to place limits on non-economic damages. Absent significant additional legislation to curb the size of malpractice judgments in the other states, we expect insurance costs to remain volatile for the foreseeable future.

Reimbursement

Medicare Overview

Medicare is a federal program that provides hospital and medical insurance benefits to persons age 65 and over, some disabled persons and persons with end-stage renal disease. All of our hospitals are certified as providers of Medicare services. Under the Medicare program, acute care hospitals receive reimbursement under a prospective payment system for inpatient and outpatient hospital services.

Under the inpatient prospective payment system, a hospital receives a fixed payment based on the patient's assigned diagnosis related group ("DRG"). The DRG classifies categories of illnesses according to the estimated intensity of hospital resources necessary to furnish care for each principal diagnosis. The DRG rates for acute care hospitals are based upon a statistically normal distribution of severity. When treatments for patients fall well outside the normal distribution, providers may receive additional payments known as outlier payments. The DRG payments do not consider a specific hospital's actual costs but are adjusted for geographic area wage differentials. Inpatient capital costs for acute care hospitals are reimbursed on a prospective system based on DRG weights multiplied by geographically adjusted federal weights. In the Medicare Modernization Act, Congress equalized the DRG payment rate for urban and rural hospitals at the large urban rate for all hospitals for discharges on or after April 1, 2003.

Pursuant to regulation, the DRG rates are supposed to be adjusted each federal fiscal year for inflation, but such adjustment has often been affected by new federal legislation. The index used to adjust the DRG rates, known as the "market basket index," gives consideration to the inflation experienced by hospitals and entities outside of the healthcare industry in purchasing goods and services. However, often federal legislation has lowered the annual percentage increase to the DRG rates below the annual amount indicated by the "market basket index" for the year. Thus, under legislation adopted in 2000, the DRG rate increased in the amount of the market basket minus 0.55% for federal fiscal year 2002, the market basket minus 0.55% for federal fiscal year 2003, but the full market basket

for federal fiscal year 2004. However, subsequent federal legislation provided for DRG rate increases for federal fiscal years 2005, 2006 and 2007 at the full market basket, but only if the facility submitted data for 10 patient care quality indicators to the Secretary of Health and Human Services in federal fiscal years 2005 and 2006 and 21 patient care quality indicators in federal fiscal year 2007. We currently have the ability to monitor our compliance with the quality indicators and have submitted or intend to submit the quality data required to receive the full market basket pricing updates during federal fiscal years 2005, 2006 and 2007. Those hospitals not submitting data on the quality indicators received an increase equal to the market basket rate minus 0.40% in federal fiscal years 2005 and 2006 and minus 2% in federal fiscal year 2007. Consistent with federal law, CMS issued final rules in August 2004, 2005 and 2006 that increased the hospital DRG payment rates by the full market basket of 3.30% for federal fiscal year 2005, the full market basket of 3.70% for federal fiscal year 2006 and the full market basket of 3.40% for federal fiscal year 2007 for those hospitals submitting data on the required 10 or 21 quality indicators.

In August 2007 CMS issued a final rule that increases the hospital inpatient DRG payment rates by the full market basket update of 3.3% for federal fiscal year 2008. However, in this final rule CMS also significantly restructured the inpatient prospective payment system to better account for patient severity, enacted a "behavioral monetary offset" to compensate for projected coding adjustments by hospitals which CMS expects to increase Medicare payments and expanded the number of quality measures that hospitals must report to qualify for the full market basket update in federal fiscal years 2008 and 2009. In an effort to ensure that payments reflect variations in patient acuity and reduce incentives to "cherry pick" profitable patients, the final rule creates 745 new severity-adjusted DRGs to replace the current system of 538 DRGs - a change that is expected to redistribute payments among hospitals but is not expected by CMS to change aggregate Medicare expenditures. However, in response to public comments objecting to the proposed one-year implementation timeline, CMS decided to phase in the new system over two years. Moreover, to account for anticipated coding adjustments by hospitals in the transition into the revised system which CMS expects to increase aggregate Medicare payments without a "real" increase in patient severity, CMS has imposed a 1.2% cut to its federal fiscal year 2008 inpatient payments and has proposed 1.8% reductions for both federal fiscal year 2009 and 2010. Also, the final rule requires that beginning October 1, 2007, hospitals will need to commence reporting whether any of eight conditions are present on admission and beginning in federal fiscal year 2009, cases involving these conditions will not be paid at higher rates unless the conditions were present on admission. Finally, the rule adds several additional quality measures to be reported by hospitals bringing to 27 the number that facilities must report in federal fiscal year 2008, and 28 in federal fiscal year 2009, in order to qualify for the full market basket update in federal fiscal years 2008 and 2009 rather than a 2% reduction to such update amount for failure to report all of such quality measures. We currently intend to submit the additional quality data required to receive the full 3.3% market basket update available in federal fiscal year 2008.

In addition to DRG inpatient payments, in certain high-cost situations CMS makes additional payments to acute care hospitals, commonly referred to as "outlier payments", for those DRG cases where the cost of the case exceeds the total DRG payments plus a fixed threshold amount. Historically, the Medicare program has set aside 5.1% of Medicare inpatient payments to pay for outlier cases. During federal fiscal years 2001, 2002 and 2003, the CMS payments for outlier cases far exceeded the 5.1% set aside. As a result CMS increased the threshold amount from $16,350 at the end of federal fiscal year 2001, to $21,025 for 2002 and to $33,560 for 2003. Additionally, on June 9, 2003, CMS published a final rule substantially modifying the methodology for determining Medicare outlier payments in order to ensure that only the highest cost cases are entitled to receive additional payments under the inpatient prospective payment system. For discharges occurring on or after October 1, 2003, outlier payments are based on either a provider's most recent tentatively settled cost report or the most recent settled cost report, whichever is from the latest cost reporting period. Previously, outlier payments had been based on the most recent settled cost report, resulting in excessive outlier payments for some hospitals. The final rule requires, in most cases, the use of hospital-specific cost to charge ratios instead of a statewide ratio. Further, outlier payments may be adjusted retroactively to recoup any past outlier overpayments plus interest or to return any underpayments plus interest. We believe that these 2003 changes to the outlier payment methodology have not and will not have a material adverse effect on our business, financial position or results of operations. Indeed, we believe that as a result of these 2003 changes to the outlier payment methodology, CMS reduced the outlier threshold amounts to $31,000 for federal fiscal year 2004; to $25,800 for federal fiscal year 2005; to $23,600 for federal fiscal year 2006; but increased the threshold to $24,485 in federal fiscal year 2007 and again decreased the threshold in federal fiscal year 2008 to $22,650. Decreasing the outlier threshold amounts has and will increase both the number of our cases that qualify for outlier payments and the amount of payments for qualifying outlier cases, compared to the "peak" year of federal fiscal year 2003 when the threshold amount was $33,560. The most recent cost reports filed for each of our

facilities as of June 30, 2005, 2006 and 2007 reflected outlier payments of $4.7 million, $5.9 million and $5.8 million for those respective cost report periods. These amounts represent 1.9%, 1.8% and 1.8% of our Medicare inpatient DRG reimbursements during those cost report years.

In August 2005 CMS made certain DRG changes for federal fiscal year 2006 that decreased our reimbursement during our 2006 and 2007 fiscal years and will decrease our reimbursement in future years. The most significant change that decreased our Medicare reimbursement was that CMS greatly expanded the number of DRGs that are subject to CMS' post-acute care transfer policy. This policy reduces payment to acute care hospitals when the patient is transferred after a short stay to a post-acute care setting that provides most of the patient's care. The purpose of this policy is to protect Medicare from paying for the same care twice: once as part of a hospital's payment for the DRG, and then as a separate payment to the post-acute facility. In federal fiscal year 2006, CMS proposed to increase the DRGs subject to the post-acute transfer policy from 30 to 231. As a result of public comments, CMS reduced the number of DRGs subject to the policy to 182 from the original proposal of 231. However, CMS expanded the list to 192 DRGs in federal fiscal year 2007. The impact of these changes was not material to us during fiscal 2006 and 2007.

Outpatient services traditionally were paid at the lower of established charges or on a reasonable cost basis. However, on August 1, 2000, CMS began reimbursing hospital outpatient services and certain Medicare Part B services furnished to hospital inpatients who have no Part A coverage on a prospective payment system basis. CMS will continue to use existing fee schedules to pay for physical, occupational and speech therapies, durable medical equipment, clinical diagnostic laboratory services and nonimplantable orthotics and prosthetics. Freestanding surgery centers are also reimbursed on a fee schedule.

All services paid under the prospective payment system for hospital outpatient services are classified into groups called ambulatory payment classifications ("APCs"). Services in each APC are similar clinically and in terms of the resources they require. A payment rate is established for each APC. Depending on the services provided, a hospital may be paid for more than one APC for a patient visit. The APC payment rates were updated for calendar years 2005 and 2006 by the full market baskets of 3.30% and 3.70%, respectively. However, as a result of the expiration of additional payments for drugs that were being paid in calendar year 2005, for calendar year 2006 there was an effective 2.25% reduction to the market basket of 3.70%, resulting in a net market basket of 1.45%. For calendar year 2007, federal legislation provides for a full market basket update. In November 2006, CMS published a final rule to update outpatient prospective payment system payments for calendar year 2007 by 3.4%, which is the full market basket. However, after taking into account other factors that affect the level of payments, CMS estimated in its final rule that hospitals will receive an overall average increase of 3.0 percent in Medicare payments for outpatient department services in calendar 2007 due to other outpatient reimbursement changes which CMS made in its final rule. In addition, the final rule for calendar year 2007 announced a new initiative for the first time to tie payment rate increases to the reporting of quality measures beginning in 2009. In the approach adopted in the 2007 rule, hospitals that report quality measures for purposes of the update in the inpatient prospective payment system would receive a full update on outpatient payments as well. Those hospitals required to report quality measures for inpatient services in order to receive the full inpatient update (such as our hospitals), but fail to do so, would receive the outpatient rate update minus 2.0 percentage points. On July 16, 2007, CMS issued a proposed rule with a 3.3% inflation update to the calendar year 2008 hospital outpatient payment rates. Following up on the new quality initiatives adopted in the final rule for calendar year 2007, the proposed rule would require hospitals to report data on ten specific quality measures in order to receive the full outpatient payment update factor for calendar year 2009 and reiterated that the annual update factor for calendar year 2009 and forward would be reduced by 2.0 percentage points for hospitals that do not report these ten quality measures. In addition, in the proposed rule CMS is seeking public comment on a number of other quality measures that CMS is considering using in 2009 and future years.

Hospitals that treat a disproportionately large number of low-income patients (Medicare and Medicaid patients eligible to receive supplemental Social Security income) currently receive additional payments from the federal government in the form of disproportionate share payments. CMS has recommended changes to the present formula used to calculate these payments. One recommended change would give greater weight to the amount of uncompensated care provided by a hospital than it would to the number of low-income patients treated. The Medicare Modernization Act increased disproportionate share payments effective April 1, 2004 for rural hospitals and some urban hospitals. During fiscal year 2007 all of our hospitals qualified for disproportionate share payments.

These Medicare disproportionate share payments as a percentage of patient service revenues were 0.9% for the fiscal year ended June 30, 2007.

Rehabilitation Units

Inpatient rehabilitation hospitals and designated units were fully transitioned from a reasonable cost reimbursement system to a prospective payment system for cost reporting periods beginning on or after October 1, 2002. Under this prospective payment system, patients are classified into case mix groups based upon impairment, age, comorbidities and functional capability. Inpatient rehabilitation facilities and units are paid a predetermined amount per discharge that reflects the patient's case mix group and is adjusted for area wage levels, low-income patients, rural areas and high-cost outliers. For federal fiscal years 2006 and 2007, CMS updated the payment rate for inpatient rehabilitation facilities and units by the full market basket rates of 3.6% and 3.3%, respectively. CMS announced in July 2007 that the update for federal fiscal year 2008 will be the full market basket rate of 3.2%. As of June 30, 2007 we operated three inpatient rehabilitation units within our acute care hospitals.

Skilled Nursing Units

Medicare historically reimbursed skilled nursing units within hospitals on the basis of actual costs, subject to limits. CMS has established a prospective payment system for Medicare skilled nursing units, under which units are paid a federal per diem rate for virtually all covered services. The effect of the new payment system generally has been to significantly reduce reimbursement for skilled nursing services, which has led many hospitals to close such units. We will monitor closely and evaluate the few remaining skilled nursing units in our hospitals and related facilities to determine whether it is feasible to continue to offer such services under the new reimbursement system. As of June 30, 2007, we operated two skilled nursing units within our acute care hospitals.

Psychiatric Units

On November 15, 2004 CMS published a final regulation to implement a new Medicare prospective payment system for inpatient psychiatric hospitals and units. The new system replaced a cost-based payment system with a per diem prospective payment system for reporting periods beginning on or after January 1, 2005. The new system is a per diem prospective payment system with adjustments to account for certain patient and facility characteristics. The final rule included several provisions to ease the transition to the new payment system. For example, CMS is phasing in the new system over a three-year period so that full payment under the new system would not begin until the fourth year. Additionally, CMS has included in the final rule a stop-loss provision, an "outlier" policy authorizing additional payments for extraordinarily costly cases and an adjustment to the base payment if the facility maintains a full-service emergency department which all of our units qualified for. In May 2007, CMS published its final rule for the annual increase to the federal component of the psychiatric prospective payment system per diem rate. This increase includes the effects of market basket updates resulting in a 3.2% increase in total payments for the psychiatric rate year of July 1, 2007 to June 30, 2008.

At the current time we continue to believe that the new psychiatric payment system will not materially negatively impact our Medicare reimbursement in respect of our psychiatric units. As of June 30, 2007, we operated seven psychiatric units within our acute care hospitals.

Home Health

On October 1, 2000, a prospective payment system became effective for home health services. The Benefits Improvement and Protection Act of 2000 delayed a 15.0% payment reduction for home health services, originally expected to take effect upon implementation of the prospective payment system, until October 1, 2002. The 15.0% payment reduction was adopted on October 1, 2002 and was included in the prospective payment system rates established for 2003. The Medicare Modernization Act established a Home Health prospective payment system update of 100% of the home health market basket through the first quarter of calendar 2004, 100% of the home health market basket minus 0.8% through calendar year 2006 and 100% of the home health market basket for 2007 and thereafter. As of June 30, 2007, we operated two entities providing home health services.

Contractor Reform

CMS has a significant initiative underway that could affect the administration of the Medicare program and impact how hospitals bill and receive payment for covered Medicare services. In accordance with the Medicare Modernization Act, CMS has begun implementation of contractor reform whereby CMS will competitively bid the Medicare fiscal intermediary and Medicare carrier functions to Medicare Administrative Contractors ("MACs"). CMS began selecting MACs in 2006 and plans to have all MACs selected by 2008. Hospital companies will have the option to work with the selected MAC in the jurisdiction where a given hospital is located or to use the MAC in the jurisdiction where the hospital company's home office is located. These changes could impact claim processing functions and our resulting cash flows. We are unable, at the current time, to predict the impact that these changes could have, if any, to cash flows.

Medicaid

Medicaid is a federal-state program, administered by the states, which provides hospital and medical benefits to qualifying individuals who are unable to afford healthcare. Most state Medicaid payments are made under a prospective payment system or under programs that negotiate payment levels with individual hospitals. Medicaid reimbursement is often less than a hospital's cost of services. The federal government and each state government currently jointly fund Medicaid in each state.

The federal government and many states are currently considering altering the level of Medicaid funding (including upper payment limits) or program eligibility that could adversely affect future levels of Medicaid reimbursement received by our hospitals. As permitted by law, certain states in which we operate have adopted broad-based provider taxes to fund their Medicaid programs.

Since states must operate with balanced budgets and since the Medicaid program is often the state's largest program, states can be expected to adopt or consider adopting legislation designed to reduce their Medicaid expenditures. DRA 2005, signed into law on February 8, 2006, includes Medicaid cuts of approximately $4.8 billion over five years. In addition, proposed regulatory changes, if implemented, would reduce federal Medicaid funding by an additional $12.2 billion over five years. On January 18, 2007, CMS published a proposed rule entitled "Medicaid Program: Cost Limits for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership". The proposed rule, if finalized, could significantly impact state Medicaid programs. It is uncertain if such rule will be finalized. States have also adopted, or are considering, legislation designed to reduce coverage and program eligibility, enroll Medicaid recipients in managed care programs and/or impose additional taxes on hospitals to help finance or expand the states' Medicaid systems. Future legislation or other changes in the administration or interpretation of government health programs could have a material adverse effect on our financial position and results of operations.

Annual Cost Reports

All hospitals participating in the Medicare and Medicaid programs are required to meet specific 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. Moreover, annual cost reports required under the Medicare and Medicaid programs are subject to routine audits, which may result in adjustments to the amounts ultimately determined to be due to us under these reimbursement programs. The audit process takes several years to reach the final determination of allowable amounts under the programs. Providers also have the right of appeal, and it is common to contest issues raised in audits of prior years' reports.

Many prior year cost reports of our facilities are still open. If any of our facilities are found to have been in violation of federal or state laws relating to preparing and filing of Medicare or Medicaid cost reports, whether prior to or after our ownership of these facilities, we and our facilities could be subject to substantial monetary fines, civil and criminal penalties and exclusion from participation in the Medicare and Medicaid programs. If an allegation is lodged against one of our facilities for a violation occurring during the time period before we acquired the facility, we may have indemnification rights against the seller of the facility to us. In each of our acquisitions, we have negotiated customary indemnification and hold harmless provisions for any damages we may incur in these areas.

Managed Care and Other Private Insurers

Managed care providers, including health maintenance organizations, preferred provider organizations, other private insurance companies and employers, are organizations that provide insurance coverage and a network of healthcare providers to members for a fixed monthly premium. To attract additional volume, most of our hospitals offer discounts from established charges or prospective payment systems to these large group purchasers of healthcare services. These discount programs often limit our ability to increase charges in response to increasing costs. However, as part of our business strategy, we have been able to renegotiate payment rates on many of our managed care contracts to improve our operating margin. While we generally received annual average payment rate increases of 4 to 12 percent from non-governmental managed care payers during fiscal year 2007, there can be no assurance that we will continue to receive increases in the future and that patient volumes from these payers will not be adversely affected by rate negotiations. While the majority of our admissions and revenues are generated from patients covered by managed care plans, the percentage may decrease in the future due to increased Medicare utilization associated with the aging U.S. population. We experienced a slight increase in managed care utilization of inpatient days as a percentage of total inpatient days during the year ended June 30, 2007 compared to the year ended June 30, 2006.

Self-Pay Patients

Self-pay patients are patients who do not qualify for government programs payments, such as Medicare and Medicaid, and who do not have some form of private insurance, and are, therefore, responsible for their own medical bills. We also include in our self-pay accounts those unpaid co-insurance and deductible amounts for which payment has been received from the primary payer. A significant portion of our self-pay patients are admitted through our hospitals' emergency departments and often require high-acuity treatment. High-acuity treatment is more costly to provide and, therefore, results in higher billings, which are the least collectible of all accounts. We believe self-pay patient volumes and revenues have been higher in the last two years than previous periods due to a combination of broad economic factors, including reductions in state Medicaid budgets, increasing numbers of individuals and employers who choose not to purchase insurance and an increased burden of co-payments and deductibles to be made by patients instead of insurers.

Self-pay accounts pose significant collectibility problems. At June 30, 2006 and 2007, approximately 11.2% and 13.2%, respectively, of our net accounts receivable are due from self-pay patients. The majority of our provision for doubtful accounts relates to self-pay patients. We are taking multiple actions in an effort to mitigate the effect on us of the high number of uninsured patients and the related economic impact. These initiatives include conducting detailed reviews of intake procedures in hospitals facing the greatest pressures and enhancing and updating intake best practices for all of our hospitals. We developed hospital-specific reports detailing collection rates by type of patient to help the hospital management teams better identify areas of vulnerability and opportunities for improvement. Also, we completely redesigned our self-pay collection workflows, enhanced technology and improved staff training in an effort to increase collections.

We do not pursue collection of amounts due from uninsured patients that qualify for charity care under our guidelines (currently those uninsured patients whose incomes are equal to or less than 200% of the current federal poverty guidelines set forth by the Department of Health and Human Services). We exclude charity care accounts from revenues when we determine that the account meets our charity care guidelines. We provide expanded discounts from billed charges and alternative payment structures for uninsured patients who do not qualify for charity care but meet certain other minimum income guidelines, primarily those uninsured patients with incomes between 200% and 500% of the federal poverty guidelines. During the fiscal years ended June 30, 2006 and 2007, we deducted $71.1 million and $86.1 million of charity care from gross charges, respectively.

Government Regulation and Other Factors

Overview

All participants in the healthcare industry are required to comply with extensive government regulation at the federal, state and local levels. In addition, these laws, rules and regulations are extremely complex and the healthcare industry has had the benefit of little or no regulatory or judicial interpretation of many of them. Although

we believe we are in compliance in all material respects with such laws, rules and regulations, if a determination is made that we were in material violation of such laws, rules or regulations, our business, financial condition or results of operations could be materially adversely affected. 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 their ability to participate in the Medicare and Medicaid programs.

Licensing, Certification and Accreditation

Healthcare facility construction and operation is subject to federal, state and local regulations relating to the adequacy of medical care, equipment, personnel, operating policies and procedures, fire prevention, rate-setting and compliance with building codes and environmental protection laws. Our facilities also are subject to periodic inspection by governmental and other authorities to assure continued compliance with the various standards necessary for licensing and accreditation. We believe that all of our operating healthcare facilities are properly licensed under appropriate state healthcare laws.

All of our operating hospitals are certified under the Medicare program and are accredited by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"), the effect of which is to permit the facilities to participate in the Medicare and Medicaid programs. If any facility loses its accreditation by JCAHO, or otherwise loses its certification under the Medicare program, then the facility will be unable to receive reimbursement from the Medicare and Medicaid programs. We intend to conduct our operations in compliance with current applicable federal, state, local and independent review body regulations and standards. The requirements for licensure, certification and accreditation are subject to change and, in order to remain qualified, we may need to make changes in our facilities, equipment, personnel and services.

Certificates of Need

In some states, the construction of new facilities, acquisition of existing facilities or addition of new beds or services may be subject to review by state regulatory agencies under a Certificate of Need program. Illinois and Massachusetts are the only states in which we currently operate that require approval under a Certificate of Need program. These laws generally require appropriate state agency determination of public need and approval prior to the addition of beds or services or other capital expenditures. Failure to obtain necessary state approval can result in the inability to expand facilities, add services, acquire a facility or change ownership. Further, violation of such laws may result in the imposition of civil sanctions or the revocation of a facility's license.

Utilization Review

Federal law contains numerous provisions designed to ensure that services rendered by hospitals to Medicare and Medicaid patients meet professionally recognized standards and are medically necessary and that claims for reimbursement are properly filed. These provisions include a requirement that a sampling of admissions of Medicare and Medicaid patients be reviewed by quality improvement organizations that analyze the appropriateness of Medicare and Medicaid patient admissions and discharges, quality of care provided, validity of diagnosis related group classifications and appropriateness of cases of extraordinary length of stay or cost. Quality improvement organizations may deny payment for services provided, assess fines and recommend to the Department of Health and Human Services that a provider not in substantial compliance with the standards of the quality improvement organization be excluded from participation in the Medicare program. Most non-governmental managed care organizations also require utilization review.

Federal and State Fraud and Abuse Provisions

Participation in any federal healthcare program, such as the Medicare and Medicaid programs, is regulated heavily by statute and regulation. If a hospital provider fails to substantially comply with the numerous conditions of participation in the Medicare or Medicaid program or performs specific prohibited acts, the hospital's participation in the Medicare program may be terminated or civil or criminal penalties may be imposed upon it under provisions of the Social Security Act and other statutes.

Among these statutes is a section of the Social Security Act known as the federal Anti-Kickback Statute. This law prohibits providers and others from soliciting, receiving, offering or paying, directly or indirectly, any remuneration with the intent of generating referrals or orders for services or items covered by a federal healthcare program. Violation of this statute is a felony, including criminal penalties of imprisonment or criminal fines up to $25,000 for each violation, civil money penalties up to $50,000 per violation, damages up to three times the total amount of the improper payment to the referral source and exclusion from participation in Medicare, Medicaid or other federal healthcare programs.

The Office of the Inspector General of the Department of Health and Human Services (the "OIG") has published final safe harbor regulations that outline categories of activities that are deemed protected from prosecution under the Anti-Kickback Statute. Currently there are safe barbors for various activities, including the following: investment interests, space rental, equipment rental, practitioner recruitment, personal services and management contracts, sale of practice, referral services, warranties, discounts, employees, group purchasing organizations, waiver of beneficiary coinsurance and deductible amounts, managed care arrangements, obstetrical malpractice insurance subsidies, investments in group practices, ambulatory surgery centers and referral agreements for specialty services.

The fact that conduct or a business arrangement does not fall within a safe harbor does not automatically render the conduct or business arrangement illegal under the Anti-Kickback Statute. The conduct or business arrangement, however, does increase the risk of scrutiny by government enforcement authorities. We may be less willing than some of our competitors to take actions or enter into business arrangements that do not clearly satisfy the safe harbors. As a result, this unwillingness may put us at a competitive disadvantage.

The OIG, among other regulatory agencies, is responsible for identifying and eliminating fraud, abuse and waste. The OIG carries out this mission through a nationwide program of audits, investigations and inspections. In order to provide guidance to healthcare providers, the OIG has from time to time issued "fraud alerts" that, although they do not have the force of law, identify features of a transaction that may indicate that the transaction could violate the Anti-Kickback Statute or other federal healthcare laws. The OIG has identified several incentive arrangements as potential violations, including:

- 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;
- guarantees that 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 or a physician's continuing education courses;
- coverage on the hospital's group health insurance plans at an inappropriately low cost to the physician;
- rental of space in physician offices, at other than fair market value terms, by persons or entities to which physicians refer;
- 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

- "gain sharing," the practice of giving physicians a share of any reduction in a hospital's costs for patient care attributable in part to the physician's efforts.

Also, the OIG has encouraged persons having information about hospitals who offer the above types of incentives to physicians to report such information to the OIG.

The OIG also issues "Special Advisory Bulletins" as a means of providing guidance to healthcare providers. These bulletins, along with other "fraud alerts", have focused on certain arrangements between physicians and providers that could be subject to heightened scrutiny by government enforcement authorities, including, "suspect" joint ventures where physicians may become investors with the provider in a newly formed joint venture entity where the investors refer their patients to this new entity, and are paid by the entity in the form of "profit distributions." These subject joint ventures may be intended not so much to raise investment capital legitimately to start a business, but to lock up a stream of referrals from the physician investors and to compensate them indirectly for these referrals. Because physician investors can benefit financially from their referrals, unnecessary procedures and tests may be ordered or performed, resulting in unnecessary Medicare expenditures.

Similarly, in a Special Advisory Bulletin issued in April 2003, the OIG focused on "questionable" contractual arrangements where a healthcare provider in one line of business (the "Owner") expands into a related healthcare business by contracting with an existing provider of a related item or service (the "Manager/Supplier") to provide the new item or service to the Owner's existing patient population, including federal healthcare program patients (so called "suspect Contractual Joint Ventures"). The Manager/Supplier not only manages the new line of business, but may also supply it with inventory, employees, space, billing, and other services. In other words, the Owner contracts out substantially the entire operation of the related line of business to the Manager/Supplier – otherwise a potential competitor – receiving in return the profits of the business as remuneration for its federal program referrals. The Bulletin lists the following features of these "questionable" contractual relationships. First, the Owner expands into a related line of business, which is dependent on referrals from, or other business generated by, the Owner's existing business. Second, the Owner neither operates the new business itself nor commits substantial financial, capital or human resources to the venture. Instead, it contracts out substantially all the operations of the new business. The Manager/Supplier typically agrees to provide not only management services, but also a range of other services, such as the inventory necessary to run the business, office and healthcare personnel, billing support, and space. Third, the Manager/Supplier is an established provider of the same services as the Owner's new line of business. In other words, absent the contractual arrangement, the Manager/Supplier would be a competitor of the new line of business, providing items and services in its own right, billing insurers and patients in its own name, and collecting reimbursement. Fourth, the Owner and the Manager/Supplier share in the economic benefit of the Owner's new business. The Manager/Supplier takes its share in the form of payments under the various contracts with the Owner; the Owner receives its share in the form of the residual profit from the new business. Fifth, aggregate payments to the Manager/Supplier typically vary with the value or volume of business generated for the new business by the Owner. We monitor carefully our contracts with other healthcare providers and attempt to not allow our facilities to enter into these suspect Contractual Joint Ventures.

In addition to issuing fraud alerts and Special Advisory Bulletins, the OIG from time to time issues compliance program guidance for certain types of healthcare providers. In January 2005, the OIG published a Supplemental Compliance Guidance for Hospitals, supplementing its 1998 guidance for the hospital industry. In the supplemental guidance, the OIG identifies a number of risk areas under federal fraud and abuse statutes and regulations. These areas of risk include compensation arrangements with physicians, recruitment arrangements with physicians and joint venture relationships with physicians.

We have a variety of financial relationships with physicians who refer patients to our hospitals. As of June 30, 2007, physicians owned interests in two of our free-standing surgery centers and five of our diagnostic imaging centers. We may sell ownership interests in certain other of our facilities to physicians and other qualified investors in the future. We also have contracts with physicians providing for a variety of financial arrangements, including employment contracts, leases and professional service agreements. We have provided financial incentives to recruit physicians to relocate to communities served by our hospitals, including income and collection guarantees and reimbursement of relocation costs, and will continue to provide recruitment packages in the future. Although we have established policies and procedures to ensure that our arrangements with physicians comply with current law and available interpretations, we cannot assure you that regulatory authorities that enforce these laws will not

determine that some of these arrangements violate the Anti-Kickback Statute or other applicable laws. An adverse determination could subject us to liabilities under the Social Security Act, including criminal penalties, civil monetary penalties and exclusion from participation in Medicare, Medicaid or other federal health care programs, any of which could have a material adverse effect in our business, financial condition or results of operations.

The Social Security Act also imposes criminal and civil penalties for submitting false claims to Medicare and Medicaid. False claims include, but are not limited to, billing for services not rendered, misrepresenting actual services rendered in order to obtain higher reimbursement and cost report fraud. Like the Anti-Kickback Statute, these provisions are very broad. Further, the Social Security Act contains civil penalties for conduct including improper coding and billing for unnecessary goods and services. Careful and accurate preparation and submission of claims for reimbursement must be performed in order to avoid liability.

The Health Insurance Portability and Accountability Act of 1996 broadened the scope of the fraud and abuse laws by adding several criminal provisions for healthcare fraud offenses that apply to all health benefit programs. This act also created new enforcement mechanisms to combat fraud and abuse, including the Medicaid Integrity Program and an incentive program under which individuals can receive up to $1,000 for providing information on Medicare fraud and abuse that leads to the recovery of at least $100 of Medicare funds. In addition, federal enforcement officials now have the ability to exclude from Medicare and Medicaid any investors, officers and managing employees associated with business entities that have committed healthcare fraud. Additionally, this act establishes a violation for the payment of inducements to Medicare or Medicaid beneficiaries in order to influence those beneficiaries to order or receive services from a particular provider or practitioner.

The Social Security Act also includes a provision commonly known as the "Stark Law." This law prohibits physicians from referring Medicare and (to an extent) Medicaid patients to entities with which they or any of their immediate family members have a financial relationship for the provision of certain designated health services that are reimbursable by Medicare or Medicaid, including inpatient and outpatient hospital services. The law also prohibits the entity from billing the Medicare program for any items or services that stem from a prohibited referral. Sanctions for violating the Stark Law include civil money penalties up to $15,000 per item or service improperly billed and exclusion from the federal healthcare programs. The statute also provides for a penalty of up to $100,000 for a circumvention scheme. There are a number of exceptions to the self-referral prohibition, including an exception for a physician's ownership interest in an entire hospital as opposed to an ownership interest in a hospital department. There are also exceptions for many of the customary financial arrangements between physicians and providers, including employment contracts, leases, professional services agreements, non-cash gifts having an annual value of no more than $329 in calendar 2007 and recruitment agreements.

During 2002 and 2004 CMS issued two phases of interim final regulations implementing the Stark Law, which became effective on January 4, 2002 and July 26, 2004, respectively, and which created several additional exceptions. On July 2, 2007, CMS released a number of proposed and potentially far-reaching changes to the Stark Law regulations as part of its annual physician fee schedule update. These proposed Stark Law revisions would, among other things, prohibit certain "per click" leases and percentage compensation arrangements in hospital and physician arrangements, eliminate many "under arrangements" joint ventures and curtail use of the in-office ancillary services exception by physicians. It appears that the July 2007 proposed changes result from CMS's frustration with what it perceives as a growing number of arrangements that permit physicians to profit from their referrals of ancillary services, while side-stepping or working around existing Stark Law restrictions. CMS accepted comments on these proposed regulations until August 31, 2007, and commentators are predicting final regulations on these subject matters by December 31, 2007.

On August 27, 2007, CMS released the final rule that constitutes the third phase ("Phase III") of the rulemaking process relating to the Stark Law. The Phase III regulations will be effective December 4, 2007. While the Phase III regulations did not create any new exceptions to the Stark Law, it contains many technical changes and nuanced details as well as many significant and substantive changes that will require all hospitals to revisit and possibly restructure many of their physician arrangements before the current terms of such arrangements expire. While these three phases of regulations help clarify the requirements of the exceptions to the Stark Law, it is still unclear how the government will enforce them in practice.

Evolving interpretations of current, or the adoption of new, federal or state laws or regulations could affect many of the arrangements entered into by each of our hospitals. In addition, law enforcement authorities, including the OIG, the courts and Congress are increasing scrutiny of arrangements between healthcare providers and potential referral sources to ensure that the arrangements are not designed as a mechanism to improperly pay for patient referrals and or other business.

Investigators also have demonstrated a willingness to look behind the formalities of a business transaction to determine the underlying purpose of payments between healthcare providers and potential referral sources.

Many of the states in which we operate also have adopted laws that prohibit payments to physicians in exchange for referrals similar to the federal Anti-Kickback Statute or that otherwise prohibit fraud and abuse activities. Many states also have passed self-referral legislation, similar to the Stark Law, prohibiting the referral of patients to entities with which the physician has a financial relationship. Often these state laws are broad in scope and they may apply regardless of the source of payment for care. These statutes typically provide criminal and civil penalties, as well as loss of licensure. Little precedent exists for the interpretation or enforcement of these state laws.

Our operations could be adversely affected by the failure of our arrangements to comply with the Anti-Kickback Statute, the Stark Law, billing laws and regulations, current state laws or other legislation or regulations in these areas adopted in the future. We are unable to predict whether other legislation or regulations at the federal or state level in any of these areas will be adopted, what form such legislation or regulations may take or how they may impact our operations. We are continuing to enter into new financial arrangements with physicians and other providers in a manner structured to comply in all material respects with these laws. We cannot assure you, however, that governmental officials responsible for enforcing these laws will not assert that we are in violation of them or that such statutes or regulations ultimately will be interpreted by the courts in a manner consistent with our interpretation.

The Federal False Claims Act and Similar Laws

Another trend affecting the healthcare industry today is the increased use of the federal False Claims Act, and, in particular, actions being brought by individuals on the government's behalf under the False Claims Act's "*qui tam*" or whistleblower provisions. Whistleblower provisions allow private individuals to bring actions on behalf of the government alleging that the defendant has defrauded the federal government. If the government intervenes in the action and prevails, the party filing the initial complaint may share in any settlement or judgment. If the government does not intervene in the action, the whistleblower plaintiff may pursue the action independently, and may receive a larger share of any settlement or judgment. When a private party brings a *qui tam* action under the False Claims Act, the defendant generally will not be made aware of the lawsuit until the government makes a determination whether it will intervene.

When a defendant is determined by a court of law to be liable under the False Claims Act, the defendant must pay three times the actual damages sustained by the government, plus mandatory civil penalties of between $5,500 to $11,000 for each separate false claim. Settlements entered into prior to litigation usually involve a less severe calculation of damages. There are many potential bases for liability under the False Claims Act. Although liability often arises when an entity knowingly submits a false claim for reimbursement to the federal government, the False Claims Act defines the term "knowingly" broadly. Thus, simple negligence will not give rise to liability under the False Claims Act, but submitting a claim with reckless disregard to its truth or falsity can constitute "knowingly" submitting a false claim and result in liability. In some cases, whistleblowers or the federal government have taken the position that providers who allegedly have violated other statutes, such as the Anti-Kickback Statute or the Stark Law, have thereby submitted false claims under the False Claims Act.

A number of states, including states in which we operate, have adopted their own false claims provisions as well as their own whistleblower provisions whereby a private party may file a civil lawsuit in state court. From time to time, companies in the healthcare industry, including ours, may be subject to actions under the False Claims Act or similar state laws.

Provisions in the Deficit Reduction Act of 2005 ("DRA") that went into effect on January 1, 2007 give states significant financial incentives to enact false claims laws modeled on the federal False Claims Act.

Additionally, the DRA requires every entity that receives annual payments of at least $5 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 health care providers. We have complied with the written policy requirements.

Corporate Practice of Medicine and Fee Splitting

The states in which we operate have laws that prohibit unlicensed persons or business entities, including corporations, from employing physicians or laws that prohibit certain 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 that may violate these restrictions. These statutes vary from state to state, are often vague and seldom have been interpreted by the courts or regulatory agencies. Although we exercise care to structure our arrangements with healthcare providers to comply with the relevant state law, and believe these arrangements comply with applicable laws in all material respects, we cannot assure you that governmental officials responsible for enforcing these laws will not assert that we, or transactions in which we are involved, are in violation of such laws, or that such laws ultimately will be interpreted by the courts in a manner consistent with our interpretations.

The Health Insurance Portability and Accountability Act of 1996

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires the use of uniform electronic data transmission standards for healthcare claims and payment transactions submitted or received electronically. These provisions are intended to encourage electronic commerce in the healthcare industry. On August 17, 2000, the Department of Health and Human Services published final regulations establishing electronic data transmission standards that all healthcare providers must use when submitting or receiving certain healthcare transactions electronically. Compliance with these standards became mandatory on October 16, 2003. However, the Department of Health and Human Services agreed to accept noncompliant Medicare claims until October 1, 2005 to assist providers that were not yet able to process compliant transactions. Thus, commencing on October 1, 2005, fee-for-service Medicare claims that did not meet the standards required by HIPAA were returned to the filer for resubmission as compliant claims and non-compliant claims were not processed by Medicare. As of October 1, 2005, all of our facilities were filing compliant Medicare claims and continue doing so as of the date of this report.

HIPAA also requires the Department of Health and Human Services to adopt standards to protect the security and privacy of health-related information. The Department of Health and Human Services released final regulations containing privacy standards in December 2000 and published revisions to the final regulations in August 2002. Compliance with these regulations became mandatory on April 14, 2003. The privacy regulations extensively regulate the use and disclosure of individually identifiable health-related information. The privacy regulations also provide patients with significant new rights related to understanding and controlling how their health information is used or disclosed. The Department of Health and Human Services released final security regulations on February 20, 2003. The security regulations became mandatory on April 20, 2005 and require healthcare providers to implement administrative, physical and technical practices to protect the security of individually identifiable health information that is electronically maintained or transmitted.

Violations of HIPAA could result in civil penalties of up to $25,000 per type of violation in each calendar year and criminal penalties of up to $250,000 per violation. In addition, our facilities will continue to remain subject to any privacy-related federal or state laws that are more restrictive than the privacy regulations issued under HIPAA. These laws vary by jurisdiction and could impose additional penalties.

Compliance with these standards has and will continue to require significant commitment and action by us. We have appointed members of our management team to direct our compliance with these standards. Implementation has and will continue to require us to engage in extensive preparation and make significant expenditures. At this time we have appointed a corporate privacy officer and a privacy officer at each of our facilities, prepared privacy policies, trained our workforce on these policies and entered into business associate agreements with the appropriate vendors. However, failure by us or third parties on which we rely, including payers, to resolve HIPAA-related implementation or operational issues could have a material adverse effect on our results of

operations and our ability to provide healthcare services. Consequently, we can give you no assurance that issues related to the full implementation of, or our operations under, HIPAA will not have a material adverse effect on our financial condition or future results of operations.

Conversion Legislation

Many states have enacted laws affecting the conversion or sale of not-for-profit hospitals. These laws generally include provisions relating to attorney general approval, advance notification and community involvement. In addition, attorneys general in states without specific conversion legislation may exercise authority over these transactions based upon existing law. In many states, there has been an increased interest in the oversight of not-for-profit conversions. The adoption of conversion legislation and the increased review of not-for-profit hospital conversions may increase the cost and difficulty or prevent the completion of transactions with or acquisitions of not-for-profit organizations in various states.

The Emergency Medical Treatment and Active Labor Act

The Federal Emergency Medical Treatment and Active Labor Act ("EMTALA") was adopted by Congress in response to reports of a widespread hospital emergency room practice of "patient dumping." At the time of the enactment, patient dumping was considered to have occurred when a hospital capable of providing the needed care sent a patient to another facility or simply turned the patient away based on such patient's inability to pay for his or her care. The law imposes requirements upon physicians, hospitals and other facilities that provide emergency medical services. Such requirements pertain to what care must be provided to anyone who comes to such facilities seeking care before they may be transferred to another facility or otherwise denied care. The government broadly interprets the law to cover situations in which patients do not actually present to a hospital's emergency department, but present to a hospital-based clinic that treats emergency medical conditions on an urgent basis or are transported in a hospital-owned ambulance, subject to certain exceptions. EMTALA does not generally apply to patients admitted for inpatient services. Sanctions for violations of this statute include termination of a hospital's Medicare provider agreement, exclusion of a physician from participation in Medicare and Medicaid programs and civil monetary penalties. In addition, the law creates private civil remedies that enable an individual who suffers personal harm as a direct result of a violation of the law, and a medical facility that suffers a financial loss as a direct result of another participating hospital's violation of the law, to sue the offending hospital for damages and equitable relief. Although we believe that our practices are in material compliance with the law, we cannot assure you that governmental officials responsible for enforcing the law will not assert from time to time that our facilities are in violation of this statute.

Patient Safety and Quality Improvement Act of 2005

On July 29, 2005, the President signed the Patient Safety and Quality Improvement Act of 2005, which has the goal of reducing medical errors and increasing patient safety. This legislation establishes a confidential reporting structure in which providers can voluntarily report "Patient Safety Work Product" ("PSWP") to "Patient Safety Organizations" ("PSOs"). Under the system, PSWP is made privileged, confidential and legally protected from disclosure. PSWP does not include medical, discharge or billing records or any other original patient or provider records but does include information gathered specifically in connection with the reporting of medical errors and improving patient safety. This legislation does not preempt state or federal mandatory disclosure laws concerning information that does not constitute PSWP. PSOs will be certified by the Secretary of the DHHS for three-year periods after the Secretary develops applicable certification criteria. PSOs will analyze PSWP, provide feedback to providers and may report non-identifiable PSWP to a database. In addition, PSOs are expected to generate patient safety improvement strategies. We will monitor the progress of these voluntary reporting programs and we anticipate that we will participate in some form when the details are available.

Antitrust Laws

The federal government and most states have enacted antitrust laws that prohibit certain types of conduct deemed to be anti-competitive. These laws prohibit price fixing, agreements to fix wages, concerted refusal to deal, market monopolization, price discrimination, tying arrangements, acquisitions of competitors and other practices that have, or may have, an adverse effect on competition. Violations of federal or state antitrust laws can result in

various sanctions, including criminal and civil penalties. Antitrust enforcement in the healthcare industry is currently a priority of the Federal Trade Commission. We believe we are in compliance with such federal and state laws, but there can be no assurance that a review of our practices by courts or regulatory authorities will not result in a determination that could adversely affect our operations.

Healthcare Reform

The healthcare industry, as one of the largest industries in the United States, continues to attract much legislative interest and public attention. Changes in Medicare, Medicaid and other programs, hospital cost-containment initiatives by public and private payers, proposals to limit payments and healthcare spending and industry-wide competitive factors are highly significant to the healthcare industry. In addition, a framework of extremely complex federal and state laws, rules and regulations governs the healthcare industry and, for many provisions, there is little history of regulatory or judicial interpretation on which to rely.

Both the federal government and many states have enacted or are considering enacting measures designed to reduce their Medicaid expenditures and change private healthcare insurance. Most states, including the states in which we operate, have applied for and been granted federal waivers from current Medicaid regulations to allow them to serve some or all of their Medicaid participants through managed care providers. We are unable to predict the future course of federal, state or local healthcare legislation. Further changes in the law or regulatory framework that reduce our revenues or increase our costs could have a material adverse effect on our business, financial condition or results of operations.

Healthcare Industry Investigations

Significant media and public attention has focused in recent years on the hospital industry. In recent years, increased attention has been paid to hospitals with high Medicare outlier payments and to recruitment arrangements with physicians. Further, there are numerous ongoing federal and state investigations regarding multiple issues. These investigations have targeted hospital companies as well as their executives and managers. Like other hospital companies, we have substantial Medicare, Medicaid and other governmental billings and we engage in various arrangements with physicians, which could result in scrutiny of our operations. We continue to monitor these and all other aspects of our business and have developed a compliance program to assist us in gaining comfort that our business practices are consistent with both legal principles and current industry standards. However, because the law in this area is complex and constantly evolving, we cannot assure you that government investigations will not result in interpretations that are inconsistent with industry practices, including ours. In public statements surrounding current investigations, governmental authorities have taken positions on a number of issues, including some for which little official interpretation previously has been available, that appear to be inconsistent with practices that have been common within the industry and that previously have not been challenged in this manner. In some instances, government investigations that have in the past been conducted under the civil provisions of federal law may now be conducted as criminal investigations.

Many current healthcare investigations are national initiatives in which federal agencies target an entire segment of the healthcare industry. One example is the federal government's initiative regarding hospital providers' improper requests for separate payments for services rendered to a patient on an outpatient basis within three days prior to the patient's admission to the hospital, where reimbursement for such services is included as part of the reimbursement for services furnished during an inpatient stay. In particular, the government has targeted all hospital providers to ensure conformity with this reimbursement rule. The federal government also has undertaken a national investigative initiative targeting the billing of claims for inpatient services related to bacterial pneumonia, as the government has found that many hospital providers have attempted to bill for pneumonia cases under more complex and higher reimbursed diagnosis related groups codes. Further, the federal government continues to investigate Medicare overpayments to prospective payment hospitals that incorrectly report transfers of patients to other prospective payment system hospitals as discharges. We are aware that prior to our acquisition of them, several of our hospitals were contacted in relation to certain government investigations relating to their operations. Although we take the position that, under the terms of the acquisition agreements, the prior owners of these hospitals retained any liability resulting from these government investigations, we cannot assure you that the prior owners' resolution of these matters or failure to resolve these matters, in the event that any resolution was deemed necessary, will not have a material adverse effect on our operations. Further, under the federal False Claims Act, private parties have

the right to bring *"qui tam"* whistleblower lawsuits against companies that submit false claims for payments to the government. Some states have adopted similar state whistleblower and false claims provisions.

In addition to national enforcement initiatives, federal and state investigations commonly relate to a wide variety of routine healthcare operations such as: cost reporting and billing practices; financial arrangements with referral sources; physician recruitment activities; physician joint ventures; and hospital charges and collection practices for self-pay patients. We engage in many of these routine healthcare operations and other activities that could be the subject of governmental investigations or inquiries from time to time. For example, we have significant Medicare and Medicaid billings, we have numerous financial arrangements with physicians who are referral sources to our hospitals and we have joint venture arrangements involving physician investors.

While we are not currently aware of any material investigation of us under federal or state health care laws or regulations, it is possible that governmental entities may conduct investigations at facilities operated by us and that such investigations could result in significant penalties to us, as well as adverse publicity. It is also possible that our executives and managers, many of whom have worked at other healthcare companies that are or may become the subject of federal and state investigations and private litigation, could be included in governmental investigations or named as defendants in private litigation. The positions taken by authorities in any future investigations of us, our executives or managers or other healthcare providers and the liabilities or penalties that may be imposed could have a material adverse effect on our business, financial condition and results of operations.

Health Plan Regulatory Matters

Our health plans are subject to state and federal laws and regulations. CMS has the right to audit our health plans to determine the plans' compliance with such standards. In addition, AHCCCS has the right to audit PHP to determine PHP's compliance with such standards. Also, PHP is required to file periodic reports with AHCCCS, meet certain financial viability standards, provide its enrollees with certain mandated benefits and meet certain quality assurance and improvement requirements. Our health plans also have to comply with the standardized formats for electronic transmissions and privacy and security standards set forth in the Administrative Simplifications Provisions of HIPAA. Our health plans have implemented the necessary policies and procedures to comply with the final federal regulations on these matters and were in compliance with them by their deadlines.

The Anti-Kickback Statute has been interpreted to prohibit the payment, solicitation, offering or receipt of any form of remuneration in return for the referral of federal health program patients or any item or service that is reimbursed, in whole or in part, by any federal healthcare program. Similar statutes have been adopted in Illinois and Arizona that apply regardless of the source of reimbursement. The Department of Health and Human Services has adopted safe harbor regulations specifying certain relationships and activities that are deemed not to violate the Anti-Kickback Statute which specifically relate to managed care including:

- waivers by health maintenance organizations of Medicare and Medicaid beneficiaries' obligations to pay cost-sharing amounts or to provide other incentives in order to attract Medicare and Medicaid enrollees;
- certain discounts offered to prepaid health plans by contracting providers;
- certain price reductions offered to eligible managed care organizations; and
- certain price reductions offered by contractors with substantial financial risk to managed care organizations.

We believe that the incentives offered by our health plans to their enrollees and the discounts they receive contracting with healthcare providers satisfy the requirements of the safe harbor regulations. However, the failure to satisfy each criterion of the applicable safe harbor does not mean that the arrangement constitutes a violation of the law; rather, the safe harbor regulations provide that an arrangement which does not fit within a safe harbor must be analyzed on the basis of its specific facts and circumstances. We believe that our health plans' arrangements comply in all material respects with the federal Anti-Kickback Statute and similar state statutes.

Environmental Matters

We are subject to various federal, state and local laws and regulations relating to environmental protection. Our hospitals are not highly regulated under environmental laws because we do not engage in any industrial

activities at those locations. The principal environmental requirements and concerns applicable to our operations relate to:

- the proper handling and disposal of hazardous and low level medical radioactive waste;
- ownership or historical use of underground and above-ground storage tanks;
- management of impacts from leaks of hydraulic fluid or oil associated with elevators, chiller units or incinerators;
- appropriate management of asbestos-containing materials present or likely to be present at some locations; and
- the potential acquisition of, or maintenance of air emission permits for, boilers or other equipment.

We do not expect our compliance with environmental laws and regulations to have a material effect on us. We may also be subject to requirements related to the remediation of substances that have been released into the environment at properties owned or operated by us or at properties where substances were sent for off-site treatment or disposal. These remediation requirements may be imposed without regard to fault and whether or not we owned or operated the property at the time that the relevant releases or discharges occurred. Liability for environmental remediation can be substantial.

Item 1A. Risk Factors.

If any of the following events discussed in the following risks were to occur, our business, results of operations, financial condition, cash flows or prospects could be materially adversely affected. Additional risks and uncertainties not presently known, or currently deemed immaterial by us, may also constrain our business and operations.

Risks Relating to our Capital Structure

Our high level of debt and significant leverage may adversely affect our operations and our ability to grow and otherwise execute our business strategy.

We have a substantial amount of debt. As of June 30, 2007, we had $1,528.7 million of outstanding debt, excluding letters of credit and guarantees. This represented 73.2% of our total capitalization as of June 30, 2007. The amount of our outstanding indebtedness is large compared to the net book value of our assets, and we have significant repayment obligations under our outstanding indebtedness.

Our substantial indebtedness could:

- limit our ability to obtain additional financing to fund future capital expenditures, working capital, acquisitions or other needs;
- increase our vulnerability to general adverse economic, market and industry conditions and limit our flexibility in planning for, or reacting to, these conditions;
- make us vulnerable to increases in interest rates since $781.9 million of our borrowings under our senior credit facilities as of August 31, 2007 are, and additional borrowings may be, at variable interest rates;
- our flexibility to adjust to changing market conditions and ability to withstand competitive pressures could be limited, and we may be more vulnerable to a downturn in general economic or industry conditions or be unable to carry out capital spending that is necessary or important to our growth strategy and our efforts to improve operating margins;
- limit our ability to use operating cash in other areas of our business because we must use a substantial portion of these funds to make principal and interest payments; and
- limit our ability to compete with others who are not as highly-leveraged.

Our ability to make scheduled payments of principal and interest or to satisfy our other debt obligations, to refinance our indebtedness or to fund capital expenditures will depend on our future operating performance. Prevailing economic conditions (including interest rates) and financial, business and other factors, many of which are beyond our control, will also affect our ability to meet these needs. We may not be able to generate sufficient cash flows from operations or realize anticipated revenue growth or operating improvements, or obtain future borrowings in an amount sufficient to enable us to pay our debt, or to fund our other liquidity needs. We may need to refinance all or a portion of our debt on or before maturity. We may not be able to refinance any of our debt when needed on commercially reasonable terms or at all.

Despite our current significant leverage, we may still be able to incur substantially more debt. This could further exacerbate the risks that we and our subsidiaries face.

We and our subsidiaries may be able to incur substantial additional indebtedness in the future. The terms of the indentures and the senior credit facilities do not fully prohibit us or our subsidiaries from doing so. Our revolving credit facility provides commitments of up to $250.0 million (not giving effect to any outstanding letters of credit, which would reduce the amount available under our revolving credit facility), of which $221.5 million was available for future borrowings as of September 15, 2007. In addition, upon the occurrence of certain events, we may request an incremental term loan facility or facilities be added to our current senior credit facilities in an amount not to exceed $300.0 million in the aggregate, subject to receipt of commitments by existing lenders or other financing institutions and to the satisfaction of certain other conditions. We may in the future borrow all available amounts under the revolving credit facility, under the incremental term loan facility and in addition, we may borrow substantial additional indebtedness in the future under new debt agreements. If new debt is added to our current debt levels, the related risks that we and our subsidiaries now face could intensify.

Operating and financial restrictions in our debt agreements limit our operational and financial flexibility.

The senior credit facilities and the indentures under which $575.0 million aggregate principal amount of our 9.0% senior subordinated notes due 2014 and $216.0 million aggregate principal amount of our 11.25% senior discount notes due 2015 were issued (collectively, the "Public Notes") contain a number of significant covenants that, among other things, restrict our ability to:

- incur additional indebtedness or issue preferred stock;
- pay dividends on or make other distributions or repurchase our capital stock or make other restricted payments;
- make investments;
- enter into certain transactions with affiliates;
- limit dividends or other payments by restricted subsidiaries to our restricted subsidiaries;
- create liens on *pari passu* or subordinated indebtedness without securing the Public Notes;
- designate our subsidiaries as unrestricted subsidiaries; and
- sell certain assets or merge with or into other companies or otherwise dispose of all or substantially all of our assets.

In addition, under the senior credit facilities, we are required to satisfy and maintain specified financial ratios and tests. Events beyond our control may affect our ability to comply with those provisions and we may not be able to meet those ratios and tests. The breach of any of these covenants would result in a default under the senior credit facilities and the lenders could elect to declare all amounts borrowed under the senior credit facilities, together with accrued interest, to be due and payable and could proceed against the collateral securing that indebtedness. Borrowings under the senior credit facilities are senior in right of payment to the Public Notes. If any of our

indebtedness were to be accelerated, our assets may not be sufficient to repay in full that indebtedness and the Public Notes.

Our capital expenditure and acquisition strategy requires substantial capital resources. The building of new hospitals and the operations of our existing hospitals and newly acquired hospitals require ongoing capital expenditures for construction, renovation, expansion and the addition of medical equipment and technology. More specifically, we may in the future be contractually obligated to make significant capital expenditures relating to the facilities we acquire. Also, construction costs to build new hospitals are substantial. Our debt agreements may restrict our ability to incur additional indebtedness to fund these expenditures.

A breach of any of the restrictions or covenants in our debt agreements could cause a cross-default under other debt agreements. A significant portion of our indebtedness then may become immediately due and payable. We are not certain whether we would have, or be able to obtain, sufficient funds to make these accelerated payments. If any senior debt is accelerated, our assets may not be sufficient to repay in full such indebtedness and our other indebtedness.

We may not be able to generate sufficient cash to service all of our indebtedness and 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 certain financial, business and other factors beyond our control. We may not be able to 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. In addition, the indentures governing the Public Notes allow us to make significant dividend payments, investments and other restricted payments. The making of these payments could decrease available cash and adversely affect our ability to make principal and interest payments on our indebtedness.

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, seek additional capital or seek to restructure or refinance our indebtedness. These alternative measures may not be successful and may not permit us to meet our scheduled debt service obligations. In the absence of such operating results and resources, we could face substantial liquidity problems and might be required to sell material assets or operations to attempt to meet our debt service and other obligations. The senior credit facilities and the indentures restrict our ability to use the proceeds from asset sales. We may not be able to consummate those asset sales to raise capital or sell assets at prices that we believe are fair and proceeds that we do receive may not be adequate to meet any debt service obligations then due.

An increase in interest rates would increase the cost of servicing our debt and could reduce our profitability.

The substantial borrowings under our Senior Credit Facilities bear interest at variable rates. As a result, an increase in interest rates, whether because of an increase in market interest rates or an increase in our own cost of borrowing, would increase the cost of servicing our debt and could materially reduce our profitability. The impact of such an increase would be more significant than it would be for some other companies because of our substantial debt. For a discussion of how we manage our exposure to changes in interest rates through the use of interest rate swap agreements on certain portions of our outstanding debt, see "Item 7A. – Quantitave and Qualitative Disclosure About Market Risks."

We are controlled by a small number of stockholders and they may have conflicts of interest with us in the future.

We are controlled by our principal equity sponsors, and they have the ability to control our policies and operations. The interests of our principal equity sponsors may not in all cases be aligned with our interests. For example, our principal equity sponsors could cause us to make acquisitions, divestitures and other transactions that, in their judgment, could enhance their equity investment in us, even though such transactions might reduce cash flows or capital reserves available to fund our debt service obligations. Additionally, our controlling shareholders are in the business of making investments in companies and may from time to time acquire and hold interests in

businesses that compete directly or indirectly with us. Accordingly, our principal equity sponsors may also pursue acquisitions that may be complementary to our business, and as a result, those acquisition opportunities may not be available to us. So long as our principal equity sponsors continue to own a significant amount of our equity interests, even if such amount is less than 50%, they will continue to be able to strongly influence or effectively control our decisions.

Risks Related to our Business

If we are unable to enter into favorable contracts with managed care plans, our operating revenues may be reduced.

Our ability to negotiate favorable contracts with health maintenance organizations, insurers offering preferred provider arrangements and other managed care plans significantly affects the revenues and operating results of our hospitals. Revenues derived from health maintenance organizations, insurers offering preferred provider arrangements and other managed care plans, including Medicare and Medicaid managed care plans, accounted for approximately 52% of our net patient revenues for the year ended June 30, 2007. Managed care organizations offering prepaid and discounted medical services packages represent an increasing portion of our admissions, a general trend in the industry which has limited hospital revenue growth nationwide and a trend that may continue if the Medicare Modernization Act increases enrollment in Medicare managed care plans. In addition, private payers are increasingly attempting to control healthcare costs through direct contracting with hospitals to provide services on a discounted basis, increased utilization review, including the use of hospitalists, and greater enrollment in managed care programs such as health maintenance organizations and preferred provider organizations. Additionally, the trend towards consolidation among private managed care payers tends to increase their bargaining prices over fee structures. In most cases, we negotiate our managed care contracts annually as they come up for renewal at various times during the year. Our future success will depend, in part, on our ability to renew existing managed care contracts and enter into new managed care contracts on terms favorable to us. Other healthcare companies, including some with greater financial resources, greater geographic coverage or a wider range of services, may compete with us for these opportunities. If we are unable to contain costs through increased operational efficiencies or to obtain higher reimbursements and payments from managed care payers, our results of operations and cash flows will be materially adversely affected.

Our revenues may decline if federal or state programs reduce our Medicare or Medicaid payments or managed care companies reduce our reimbursements.

Approximately 35% of our net patient revenues for the year ended June 30, 2007 came from Medicare and Medicaid programs, excluding Medicare and Medicaid managed plans. In recent years, federal and state governments have made significant changes in the Medicare and Medicaid programs. Some of those changes adversely affect the reimbursement we receive for certain services. In addition, due to budget deficits in many states, significant decreases in state funding for Medicaid programs have occurred or are being proposed.

On August 1, 2006, CMS announced a final rule that refines the DRG payment system by both transitioning to using estimated hospital costs rather than list charges to set payment rates and to more accurately account for the severity of a patient's illness. CMS announced that it is considering additional changes effective in federal fiscal year 2008. We cannot predict the impact that any such changes, if finalized, would have on our revenues. Future realignments in the DRG system could also reduce the margins we receive for certain specialties, including cardiology and orthopedics. In fact, the greater popularity of specialty hospitals in recent years has caused CMS to focus on payment levels for such specialties. Any such change in the payments received for specialty services could have an adverse effect on our revenues and could require us to modify our strategy. Other Medicare payment changes may also affect our revenues. See Item 1. "Business — Reimbursement." DRG rates are updated and DRG weights are recalibrated each federal fiscal year. The index used to update the market basket gives consideration to the inflation experienced by hospitals and entities outside the health care industry in purchasing goods and services. Congressional legislation provides for DRG increases using the full market basket if data for certain patient care quality indicators is submitted quarterly to CMS, and using the market basket minus two percentage points if such data is not submitted. While we will endeavor to comply with all data submission requirements, our submissions may not be deemed timely or sufficient to entitle us to the full market basket adjustment for all of our hospitals.

Since states must operate with balanced budgets and since the Medicaid program is often a state's largest program, a number of states have adopted, or are considering adopting, legislation designed to reduce their Medicaid expenditures. The Deficit Reduction Act of 2005, signed into law in February 2006, includes Medicaid cuts of approximately $4.8 billion over five years. In addition, proposed regulatory changes, if implemented, would reduce federal Medicaid funding by an additional $12.2 billion over five years. On January 18, 2007, CMS published a proposed rule entitled "Medicaid Program: Cost Limits for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership." The proposed rule, if finalized, could significantly impact state Medicaid programs. It is uncertain if the rule will be finalized. States have also adopted, or are considering adopting, legislation designed to reduce coverage and program eligibility, enroll Medicaid recipients in managed care programs and/or impose additional taxes on hospitals to help finance or expand the states' Medicaid systems. Future legislation or other changes in the administration or interpretation of government health programs could have a material adverse effect on our financial position and results of operations.

In addition, insurance and managed care companies and other third parties from whom we receive payment for our services increasingly attempt to control healthcare costs by requiring that hospitals discount their fees 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.

In recent years, both the Medicare Program and several large managed care companies have changed our reimbursement to link some of their payments, especially their annual increases in payments, to performance of quality of care measures. We expect this trend to "pay-for-performance" to increase in the future. If we are unable to meet these performance measures, our results of operations and cash flow will be materially adversely affected.

We conduct business in a heavily regulated industry, and changes in regulations or violations of regulations may result in increased costs or sanctions that could reduce our revenues and profitability.

The healthcare industry is subject to extensive federal, state and local laws and regulations relating to licensing, the conduct of operations, the ownership of facilities, the addition of facilities and services, financial arrangements with physicians and other referral sources, confidentiality, maintenance and security issues associated with medical records, billing for services and prices for services. If a determination were made that we were in material violation of such laws or regulations, our operations and financial results could be materially adversely affected.

In many instances, the industry does not have the benefit of significant regulatory or judicial interpretations of these laws and regulations. This is particularly true in the case of Medicare and Medicaid statute codified under section 1128B(b) of the Social Security Act and known as the "Anti-Kickback Statute." This law prohibits providers and other person or entities from soliciting, receiving, offering or paying, directly or indirectly, any remuneration with the intent to generate referrals of orders for services or items reimbursable under Medicare, Medicaid and other federal healthcare programs. As authorized by Congress, the United States Department of Health and Human Services has issued regulations which describe some of the conduct and business relationships immune from prosecution under the Anti-Kickback Statute. The fact that a given business arrangement does not fall within one of these "safe harbor" provisions does not render the arrangement illegal, but business arrangements of healthcare service providers that fail to satisfy the applicable safe harbor criteria risk increased scrutiny by enforcement authorities.

Some of the financial arrangements that our facilities maintain with physicians do not meet all of the requirements for safe harbor protection. The regulatory authorities that enforce the Anti-Kickback Statute may in the future determine that one or more of these arrangements violate the Anti-Kickback Statute or other federal or state laws. A determination that a facility has violated the Anti-Kickback Statute or other federal laws could subject us to liability under the Social Security Act, including criminal and civil penalties, as well as exclusion of the facility from participation in government programs such as Medicare and Medicaid or other federal healthcare programs.

In addition, the portion of the Social Security Act commonly known as the "Stark Law" prohibits physicians from referring Medicare and (to an extent) Medicaid patients to providers of certain "designated health services" if the physician or a member of his or her immediate family has an ownership or investment interest in, or compensation arrangement with, that provider. In addition, the provider in such arrangements is prohibited from

billing for all of the designated health services referred by the physician. Many of the services furnished by our facilities are "designated health services" for Stark Law purposes. There are multiple exceptions to the Stark Law, among others, for physicians maintaining an ownership interest in an entire hospital or having a compensation relationship with the facility as a result of employment agreements, leases, physician recruitment and certain other arrangements. However, each of these exceptions applies only if detailed conditions are met. These conditions were the subject of regulations which became effective in July 2004, and little precedent exists for their interpretation or enforcement. An arrangement subject to the Stark Law must qualify for an exception in order for the services to be lawfully referred by the physician and billed by the provider.

All of the states in which we operate have adopted or have considered adopting similar anti-kickback and physician self-referral legislation, some of which extends beyond the scope of the federal law to prohibit the payment or receipt of remuneration for the referral of patients and physician self-referrals, regardless of the source of payment for the care. Little precedent exists for the interpretation or enforcement of these laws. Both federal and state government agencies have announced heightened and coordinated civil and criminal enforcement efforts.

Government officials responsible for enforcing healthcare laws could assert that one or more of our facilities, or any of the transactions in which we are involved, are in violation of the Anti-Kickback Statute or the Stark Law and related state law exceptions. It is also possible that the courts could ultimately interpret these laws in a manner that is different from our interpretations. Moreover, other healthcare companies, alleged to have violated these laws, have paid significant sums to settle such allegations and entered into "corporate integrity agreements" because of concern that the government might exercise its authority to exclude those providers from governmental payment programs (Medicare, Medicaid, TRICARE). A determination that one or more of our facilities has violated these laws, or the public announcement that we are being investigated for possible violations of these laws, could have a material adverse effect on our business, financial condition, results of operations or prospects, and our business reputation could suffer significantly.

Illinois and Massachusetts require governmental determinations of need ("Certificates of Need") prior to the purchase of major medical equipment or the construction, expansion, closure, sale or change of control of healthcare facilities. We believe our facilities have obtained appropriate certificates wherever applicable. However, if a determination were made that we were in material violation of such laws, our operations and financial results could be materially adversely affected. The governmental determinations, embodied in Certificates of Need, can also affect our facilities' ability to add bed capacity or important services. We cannot predict whether we will be able to obtain required Certificates of Need in the future. A failure to obtain any required Certificates of Need may impair our ability to operate the affected facility profitably.

The laws, rules and regulations described above are complex and subject to interpretation. If we are in violation of any of these laws, rules or regulations, or if further changes in the regulatory framework occur, our results of operations could be significantly harmed. For a more detailed discussion of the laws, rules and regulations described above, see "Business – Government Regulation and Other Factors."

Providers in the healthcare industry have been the subject of federal and state investigations, whistleblower lawsuits and class action litigation, and we may become subject to investigations, whistleblower lawsuits or class action litigation in the future.

Both federal and state government agencies have heightened and coordinated civil and criminal enforcement efforts as part of numerous ongoing investigations of hospital companies, as well as their executives and managers. These investigations relate to a wide variety of topics, including:

- cost reporting and billing practices;
- laboratory and home healthcare services;
- physician ownership of, and joint ventures with, hospitals;
- physician recruitment activities; and
- other financial arrangements with referral sources

In addition, the federal False Claims Act permits private parties to bring *qui tam*, or whistleblower, lawsuits against companies. Whistleblower provisions allow private individuals to bring actions on behalf of the government

alleging that the defendant has defrauded the federal government. Because *qui tam* lawsuits are filed under seal, we could be named in one or more such lawsuits of which we are not aware. Defendants determined to be liable under the False Claims Act may be required to pay three times the actual damages sustained by the government, plus mandatory civil penalties of between $5,500 and $11,000 for each separate false claim. Typically, each fraudulent bill submitted by a provider is considered a separate false claim, and thus the penalties under false claims may be substantial. Liability arises when an entity knowingly submits a false claim for reimbursement to the federal government. In some cases, whistleblowers or the federal government have taken the position that providers who allegedly have violated other statutes and have submitted claims to a governmental payer during the time period they allegedly violated these other statutes, have thereby submitted false claims under the False Claims Act. Some states have adopted similar whistleblower and false claims provisions.

The Office of the Inspector General of the Department of Health and Human Services and the Department of Justice have, from time to time, established national enforcement initiatives that focus on specific billing practices or other suspected areas of abuse. Initiatives include a focus on hospital billing for outpatient charges associated with inpatient services, as well as hospital laboratory billing practices. As a result of these regulations and initiatives, some of our activities could become the subject of governmental investigations or inquiries. For example, we have significant Medicare and Medicaid billings, we provide some durable medical equipment and home healthcare services, and we have joint venture arrangements involving physician investors. We also have a variety of other financial arrangements with physicians and other potential referral sources including recruitment arrangements and leases. In addition, our executives and managers, many of whom have worked at other healthcare companies that are or may become the subject of federal and state investigations and private litigation, could be included in governmental investigations or named as defendants in private litigation. We are aware that several of our hospitals or their related healthcare operations were and may still be under investigation in connection with activities conducted prior to our acquisition of them. Under the terms of our various acquisition agreements, the prior owners of our hospitals are responsible for any liabilities arising from pre-closing violations. The prior owners' resolution of these matters or failure to resolve these matters, in the event that any resolution was deemed necessary, may have a material adverse effect on our business, financial condition or results of operations. Any investigations of us, our executives, managers, facilities or operations could result in significant liabilities or penalties to us, as well as adverse publicity.

We maintain a voluntary compliance program to address health regulatory and other compliance requirements. This program includes initial and periodic ethics and compliance training and effectiveness reviews, a toll-free hotline for employees to report, without fear of retaliation, any suspected legal or ethical violations, annual "fraud and abuse" audits to look at all of our financial relationships with physicians and other referral sources and annual "coding audits" to make sure our hospitals bill the proper service codes in respect of obtaining payment from the Medicare and Medicaid programs.

As an element of our corporate compliance program and our internal compliance audits, from time to time we make voluntary disclosures and repayments to the Medicare and Medicaid programs and/or to the federal and/or state regulators for these programs in the ordinary course of business. At the current time, we know of no active investigations by any of these programs or regulators in respect of our disclosures or repayments, except as set forth below. All of these voluntary actions on our part could lead to an investigation by the regulators to determine whether any of our facilities have violated the Stark Law, the Anti-Kickback Statute, the False Claims Act or similar state law. Either an investigation or initiation of administrative or judicial actions could result in a public announcement of possible violations of the Stark Law, the Anti-Kickback Statute or the False Claims Act or similar state law. Such determination or announcements could have a material adverse effect on our business, financial condition, results of operations or prospects, and our business reputation could suffer significantly.

Additionally, several hospital companies have recently been named defendants in class action litigation alleging, among other things, that their charge structures are fraudulent and, under state law, unfair or deceptive practices, insofar as those hospitals charge insurers lower rates than those charged to uninsured patients. We cannot assure you that we will not be named as a defendant in litigation of this type. Furthermore, the outcome of these suits may affect the industry standard for charity care policies and any response we take may have a material adverse effect on our financial results.

In June 2006 we and two other hospital systems operating in San Antonio, Texas had a putative class action lawsuit brought against all of us alleging that we and the other defendants has conspired with each other and with other unidentified San Antonio area hospitals to depress the compensation levels of registered nurses employed at the competing hospitals within the San Antonio area by engaging in certain activities that violated the federal antitrust laws. See "Item 3- Legal Proceedings" for further discussion of this litigation. On the same day that this litigation was brought against us and two other hospital systems in San Antonio, substantially similar litigation was brought against multiple hospitals in three other cities.

Competition from other hospitals or healthcare providers (especially specialty hospitals) may reduce our patient volumes and profitability.

The healthcare business is highly competitive and competition among hospitals and other healthcare providers for patients has intensified in recent years. Generally, other hospitals in the local communities served by most of our hospitals provide services similar to those offered by our hospitals. In addition, we believe the number of freestanding specialty hospitals and surgery and diagnostic centers in the geographic areas in which we operate has increased significantly in recent years. As a result, most of our hospitals operate in an increasingly competitive environment. Some of the hospitals that compete with our hospitals are owned by governmental agencies or not-for-profit corporations supported by endowments and charitable contributions and can finance capital expenditures and operations on a tax-exempt basis. Increasingly, we are facing competition from physician-owned specialty hospitals and freestanding surgery centers that compete for market share in high margin services and for quality physicians and personnel. If our competitors are better able to attract patients, recruit physicians, expand services or obtain favorable managed contracts at their facilities, we may experience a decline in patient volumes.

In 2005, CMS began making public performance data related to ten quality measures that hospitals submit in connection with their Medicare reimbursement. In February 2006, federal legislation was enacted expanding the number of quality measures that must be reported to 21, beginning with discharges occurring in the third quarter of 2006. If any of our hospitals achieve poor results (or results that are lower than our competitors) on these 21 quality measures, patient volumes could decline. In addition, this legislation requires that CMS expand the number of quality measures in future years. In August 2007, CMS announced a final rule that expanded to 27 and 28 the number of quality measures that must be reported during federal fiscal years 2008 and 2009, respectively, in order to qualify for the full market basket update in those years. The additional quality measures and future trends toward clinical transparency may have an unanticipated impact on our competitive position and patient volumes.

Federal legislation passed in 2003 provided for an 18-month moratorium on the establishment of new specialty hospitals which expired on June 8, 2005. However, HHS suspended processing new provider enrollment applications for specialty hospitals until January 2006, creating, in effect, a new moratorium on specialty hospitals. Other legislation enacted in 2006 directed HHS to extend this enrollment suspension until the earlier of six months from the enactment of the legislation or the release of a report regarding physician owned specialty hospitals by HHS. On August 8, 2006, HHS issued its final report, in which it announced that it would resume processing and certifying provider enrollment applications. As a result of the moratorium being rescinded, we face additional competition from an increased number of specialty hospitals, including hospitals owned by physicians currently on staff at our hospitals. In addition, HHS announced that it will require all hospitals to disclose any physician ownership and certain financial arrangements with physicians. HHS has not yet finalized when it will begin collecting this data, the specific data that hospitals will be required to submit or which hospitals will be required to provide information although it issued for public comments a proposed Disclosure of Financial Relationship Report in May 2007 and said it would begin collecting information from an initial group of 500 hospitals soon after the public comment period on the Report expired on July 17, 2007.

PHP also faces competition within the Arizona market that it serves. As in the case of our hospitals, some of our competitors in this market are owned by governmental agencies or not-for-profit corporations that have greater financial resources than we do. Other competitors have larger membership bases, are more established and have greater geographic coverage areas that give them an advantage in competing for a limited pool of eligible health plan members. The revenues we derive from PHP could significantly decrease if new plans operating under AHCCCS enter the market or other existing AHCCCS plans increase their number of enrollees. Moreover, a failure to attract future enrollees may negatively impact our ability to maintain our profitability in this market.

We may be subject to liabilities from claims brought against our facilities.

We operate in a highly regulated and litigious industry. As a result, various lawsuits, claims and legal and regulatory proceedings have been instituted or asserted against us, including those outside of the ordinary course of business like class actions and those in the ordinary course of business like malpractice lawsuits. Some of these actions may involve large claims as well as significant defense costs. (See "Item 3, "Legal Proceedings.")

We maintain professional and general liability insurance in amounts we believe are sufficient to cover claims arising out of the operations of our facilities. Some of the claims could exceed the scope of the coverage in effect or coverage of particular claims or damages could be denied.

The relatively high cost of professional liability insurance and, in some cases, the lack of availability of such insurance coverage, for physicians with privileges at our hospitals increases our risk of vicarious liability in cases where both our hospital and the uninsured or underinsured physician are named as co-defendants. As a result, we are subject to greater self-insured risk and may be required to fund claims out of our operating cash flows to a greater extent than during fiscal year 2007. We cannot assure you that we will be able to continue to obtain insurance coverage in the future or that such insurance coverage, if it is available, will be available on acceptable terms.

While we cannot predict the likelihood of future claims or inquiries, we expect that new matters may be initiated against us from time to time. Moreover, the results of current claims, lawsuits and investigations cannot be predicted, and it is possible that the ultimate resolution of these matters, individually or in the aggregate, may have a material adverse effect on our business (both in the near and long term), financial position, results of operations or cash flows.

Our hospitals face a growth in uncompensated care as the result of the inability of uninsured patients to pay for healthcare services and difficulties in collecting patient portions of insured accounts.

Like others in the hospital industry, we have experienced an increase in uncompensated care. Our combined provision for doubtful accounts and charity care deductions as a percentage of patient service revenues increased from 10.8% during fiscal 2005, to 11.2% during fiscal 2006 and to 12.0% during fiscal 2007. Our self pay discharges as a percentage of total discharges increased from 3.1% during fiscal 2005 to 3.2% during fiscal 2006 to 3.7% during fiscal 2007. Our hospitals remain at risk for increases in uncompensated care as a result of price increases, the continuing trend of increases in co-payment and deductible portions of managed care accounts and increases in uninsured patients as a result of potential state Medicaid funding cuts or general economic weakness. Although we continue to seek ways of improving point of service collection efforts and implementing appropriate payment plans with our patients, if we continue to experience growth in self-pay volumes and revenues, our results of operations could be materially adversely affected. Further, our ability to improve collections for self-pay patients may be limited by regulatory and investigatory initiatives, including private lawsuits directed at hospital charges and collection practices for uninsured and underinsured patients.

Our performance depends on our ability to recruit and retain quality physicians.

Physicians generally direct the majority of hospital admissions. Thus, the success of our hospitals depends in part on the following factors:

- the number and quality of the physicians on the medical staffs of our hospitals;
- the admitting practices of those physicians; and
- the maintenance of good relations with those physicians.

We generally do not employ physicians. Most physicians at our hospitals also have admitting privileges at other hospitals. If facilities are not staffed with adequate support personnel or technologically advanced equipment that meets the needs of patients, physicians may be discouraged from referring patients to our facilities, which could adversely affect our profitability.

We may be unable to achieve our acquisition and growth strategies and we may have difficulty acquiring not-for-profit hospitals due to regulatory scrutiny.

An important element of our business strategy is expansion by acquiring hospitals in our existing and in new urban and suburban markets and by entering into partnerships or affiliations with other healthcare service providers. The competition to acquire hospitals is significant, including competition from healthcare companies with greater financial resources than ours, and we may not be able to make suitable acquisitions on favorable terms. We may have difficulty obtaining financing, if necessary, for such acquisitions on satisfactory terms. We sometimes agree not to sell an acquired hospital for some period of time (currently no longer than 10 years) after closing and/or grant the seller a right of first refusal to purchase the hospital if we agree to sell it to a third party. In addition, we may not be able to effectively integrate any acquired facilities with our operations. Even if we continue to acquire additional facilities and/or enter into partnerships or affiliations with other healthcare service providers, federal and state regulatory agencies may constrain our ability to grow.

Additionally, many states, including some where we have hospitals and others where we may in the future attempt to 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 focus primarily on the appropriate valuation of the assets divested and the use of the sale proceeds by the not-for-profit seller. These review and approval processes can add time to the consummation of an acquisition of a not-for profit hospital, and future actions on the state level could seriously delay or even prevent future acquisitions of not-for-profit hospitals. Furthermore, as a condition to approving an acquisition, the attorney general of the state in which the hospital is located may require us to maintain specific services, such as emergency departments, or to continue to provide specific levels of charity care, which may affect our decision to acquire or the terms upon which we acquire one of these hospitals.

Difficulties with integrating our acquisitions may disrupt our ongoing operations.

We may not be able to profitably or effectively integrate the operations of, or otherwise achieve the intended benefits from, any acquisitions we make or partnerships or affiliations we may form. The process of integrating acquired hospitals may require a disproportionate amount of management's time and attention, potentially distracting management from its day-to-day responsibilities. This process may be even more difficult in the case of hospitals we may acquire out of bankruptcy or otherwise in financial distress. In addition, poor integration of acquired facilities could cause interruptions to our business activities, including those of the acquired facilities. As a result, we may incur significant costs related to acquiring or integrating these facilities and may not realize the anticipated benefits.

Moreover, acquired businesses may have unknown or contingent liabilities, including liabilities for failure to comply with healthcare laws and regulations. We could in the future become liable for past activities of acquired businesses and these liabilities could be material.

Our hospitals face competition for staffing, which may increase our labor costs and reduce profitability.

We compete with other healthcare providers in recruiting and retaining qualified management and staff personnel responsible for the day-to-day operations of each of our hospitals, including nurses and other non-physician healthcare professionals. In the healthcare industry generally, including in our markets, the scarcity of nurses and other medical support personnel has become a significant operating issue. This shortage may require us to increase wages and benefits to recruit and retain nurses and other medical support personnel or to hire more expensive temporary personnel. We have raised on several occasions in the past, and expect to raise in the future, wages for our nurses and other medical support personnel. We also depend on the available labor pool of semi-skilled and unskilled employees in each of the markets in which we operate. In addition, to the extent that a significant additional portion of our employee base unionizes, or attempts to unionize, our labor costs could increase materially. If our labor costs increase, we may not be able to raise rates to offset these increased costs. Because approximately 87% of our net patient revenues for the year ended June 30, 2007, consisted of payments based on fixed or negotiated rates, our ability to pass along increased labor costs is constrained. Our failure to recruit and

retain qualified management, nurses and other medical support personnel, or to control our labor costs, could have a material adverse effect on our profitability.

The cost of our malpractice insurance and the malpractice insurance of physicians who practice at our facilities remains volatile. Successful malpractice or tort claims asserted against us, our physicians or our employees could materially adversely affect our financial condition and profitability.

In recent years, physicians, hospitals and other healthcare providers have become subject to an increasing number of legal actions alleging malpractice, product liability or related legal theories. Many of these actions involve large monetary claims and significant defense costs. Hospitals and physicians have typically maintained a special type of insurance (commonly called malpractice or professional liability insurance) to protect against the costs of these types of legal actions. Due to unfavorable pricing and availability trends, we created a captive insurance subsidiary on June 1, 2002, to assume a substantial portion of the professional and general liability risks of our facilities. For claims incurred during the period June 1, 2002 to May 31, 2006, we maintain all of our professional and general liability insurance through this captive insurance subsidiary in respect of losses up to $10.0 million per occurrence. For claims incurred subsequent to May 31, 2006, we self-insure the first $9.0 million per occurrence, and our captive subsidiary insures the next $1.0 million per occurrence. We have also purchased an umbrella excess policy for professional and general liability insurance for the period June 1, 2007 to May 31, 2008 with unrelated commercial carriers. This policy covers losses in excess of $10.0 million per occurrence up to $75.0 million, but is limited to total annual payments of $65.0 million in the aggregate. While premium prices have declined during the past several years, the total cost of professional and general liability insurance remains sensitive to the volume and severity of cases reported. There is no guarantee that excess insurance coverage will continue to be available in the future at a cost allowing us to maintain adequate levels of such insurance. Moreover, due to the increased retention limits insured by us and our captive subsidiary, if actual payments of claims materially exceed our projected estimates of malpractice claims, our financial condition could be materially adversely affected.

In addition, physicians' professional liability insurance costs in certain markets have dramatically increased to the point where some physicians are either choosing to retire early or leave those markets. If physician professional liability insurance costs continue to escalate in markets in which we operate, some physicians may choose not to practice at our facilities, which could reduce our patient volumes and revenues. Our hospitals may also incur a greater percentage of the amounts paid to claimants if physicians are unable to obtain adequate malpractice coverage.

We are subject to uncertainties regarding healthcare reform that could materially and adversely affect our business.

In recent years, an increasing number of legislative initiatives have been introduced or proposed in Congress and in state legislatures that would result in major changes in the healthcare system, either nationally or at the state level. Among the proposals that have been introduced are price controls on hospitals, insurance market reforms to increase the availability of group health insurance to small businesses, requirements that all businesses offer health insurance coverage to their employees and the creation of a government health insurance plan or plans that would cover all citizens and increase payments by beneficiaries. Increased regulations, mandated benefits and more oversight, audits and investigations and changes in laws allowing access to federal and state courts to challenge healthcare decisions may increase our administrative, litigation and healthcare costs. We cannot predict whether any of the above proposals or any other proposals will be adopted, and if adopted, we cannot assure you that the implementation of these reforms will not have a material adverse effect on our business, financial position or results of operations.

Our facilities are concentrated in a small number of regions. If any one of the regions in which we operate experiences a regulatory change, economic downturn or other material change, our overall business results may suffer.

Among our operations as of June 30, 2007, five hospitals and various related healthcare businesses were located in San Antonio, Texas; five hospitals and related healthcare businesses were located in metropolitan Phoenix, Arizona; two hospitals and related healthcare businesses were located in metropolitan Chicago, Illinois;

and three hospitals and related healthcare businesses were located in Massachusetts. For the year ended June 30, 2007, our total revenues were generated as follows:

	Year Ended June 30, 2007
San Antonio	31.2 %
Massachusetts	19.8
Metropolitan Phoenix, excluding Phoenix Health Plan and Abrazo Advantage Health Plan	19.5
Metropolitan Chicago (1)	15.6
Phoenix Health Plan and Abrazo Advantage Health Plan	13.4
Other	0.5
	100.0 %

(1) Includes MacNeal Health Providers.

Any material change in the current demographic, economic, competitive or regulatory conditions in any of these regions could adversely affect our overall business results because of the significance of our operations in each of these regions to our overall operating performance. Moreover, due to the concentration of our revenues in only four regions, our business is less diversified and, accordingly, is subject to greater regional risk than that of some of our larger competitors.

If we are unable to control our healthcare costs at Phoenix Health Plan and Abrazo Advantage Health Plan, if the health plans should lose their governmental contracts or if budgetary cuts reduce the scope of Medicaid or dual-eligibility coverage, our profitability may be adversely affected.

For the year ended June 30, 2007, PHP generated approximately 11.7% of our total revenues. PHP derives substantially all of its revenues through a contract with AHCCCS. AHCCCS pays capitated rates to PHP, and PHP subcontracts with physicians, hospitals and other healthcare providers to provide services to its enrollees. If we fail to effectively manage our healthcare costs, these costs may exceed the payments we receive. Many factors can cause actual healthcare costs to exceed the capitated rates paid by AHCCCS, including:

- our ability to contract with cost-effective healthcare providers;
- the increased cost of individual healthcare services;
- the type and number of individual healthcare services delivered; and
- the occurrence of catastrophes, epidemics or other unforeseen occurrences

Our current contract with AHCCCS expires September 30, 2008 and is terminable without cause on 90 days' written notice from AHCCCS or for cause upon written notice from AHCCCS if we fail to comply with any term or condition of the contract or fail to take corrective action as required to comply with the terms of the contract. AHCCCS may also terminate the contract with PHP in the event of unavailability of state or federal funding. We plan to rebid for a new contract with AHCCCS in calendar 2008. We or our predecessors have had a contract with AHCCCS since October 1983. As other health plans attempt to enter the Arizona market, we may face increased competition. If we are unable to successfully rebid or compete for our contract with AHCCCS, or if our contract is terminated, our profitability would be adversely affected by the loss of these revenues and cash flows. Also, should the scope of the Medicaid program be reduced as a result of state budgetary cuts or other political factors, our results of operations could be adversely affected.

For the year ended June 30, 2007, AAHP generated 1.7% of our total revenues. AAHP began providing healthcare coverage to Medicare and Medicaid dual-eligible enrollees on January 1, 2006. Most of AAHP's members were formerly enrolled in PHP. AAHP's contract with CMS went into effect on January 1, 2006, for a term of one year, with a provision for successive one year renewals, and has currently been renewed through December 31, 2007. If we fail to effectively manage AAHP's healthcare costs, these costs may exceed the payments we receive.

We are dependent on our senior management team and local management personnel, and the loss of the services of one or more of our senior management team or key local management personnel could have a material adverse effect on our business.

The success of our business is largely dependent upon the services and management experience of our senior management team, which includes Charles N. Martin, Jr., our Chairman and Chief Executive Officer; Kent H. Wallace, our President and Chief Operating Officer; Joseph D. Moore, our Executive Vice President, Chief Financial Officer and Treasurer; and Keith B. Pitts, our Vice Chairman. In addition, we depend on our ability to attract and retain local managers at our hospitals and related facilities, on the ability of our senior officers and key employees to manage growth successfully and on our ability to attract and retain skilled employees. We do not maintain key man life insurance policies on any of our officers. If we were to lose any of our senior management team or members of our local management teams, or if we are unable to attract other necessary personnel in the future, it could have a material adverse effect on our business, financial condition and results of operations. If we were to lose the services of one or more members of our senior management team or a significant portion of our hospital management staff at one or more of our hospitals, we would likely experience a significant disruption in our operations and failure of the affected hospitals to adhere to their respective business plans.

Changes in legislation may significantly reduce government healthcare spending and our revenues.

Governmental healthcare programs, principally Medicare and Medicaid, accounted for 35% of our net patient revenues (excluding managed Medicare and Medicaid programs) for both of the years ended June 30, 2006 and 2007. In recent years, legislative changes have resulted in limitations on and, in some cases, reductions in levels of, payments to healthcare providers for certain services under many of these government programs. Further, legislative changes have altered the method of payment for various services under the Medicare and Medicaid programs. We believe that hospital operating margins across the country, including ours, have been and may continue to be under pressure because of limited pricing flexibility and growth in operating expenses in excess of the increase in prospective payments under the Medicare program. DRA 2005 passed in February 2006 reduces federal funding for Medicare and Medicaid by approximately $11 billion over the next five years. In addition, a number of states are experiencing budget problems and have adopted or are considering legislation designed to reduce their Medicaid expenditures and to provide universal coverage and additional care, including enrolling Medicaid recipients in managed care programs and imposing additional taxes on hospitals to help finance or expand states' Medicaid systems.

Controls designed to reduce inpatient services may reduce our revenues.

Controls imposed by Medicare and commercial third-party payers designed to reduce admissions and lengths of stay, commonly referred to as "utilization review," have affected and are expected to continue to affect our facilities. Utilization review entails the review of the admission and course of treatment of a patient by managed care plans. Inpatient utilization, average lengths of stay and occupancy rates continue to be negatively affected by payer-required preadmission authorization and utilization review and by payer pressures to maximize outpatient and alternative healthcare delivery services for less acutely ill patients. Efforts to impose more stringent cost controls are expected to continue. Although we are unable to predict the effect these changes will have on our operations, significant limits on the scope of services reimbursed and on reimbursement rates and fees could have a material, adverse effect on our business, financial position and results of operations.

If we fail to continually enhance our hospitals with the most recent technological advances in diagnostic and surgical equipment, our ability to maintain and expand our markets will be adversely affected.

Technological advances with respect to computed axial tomography (CT), magnetic resonance imaging (MRI) and positron emission tomography (PET) equipment, as well as other equipment used in our facilities, are continually evolving. In an effort to compete with other healthcare providers, we must constantly evaluate our equipment needs and upgrade equipment as a result of technological improvements. Such equipment costs typically range from $1.0 million to $3.0 million, exclusive of construction or build-out costs.

Our hospitals face competition for staffing especially as a result of the national shortage of nurses and the increased imposition on us of nurse-staffing ratios, which has in the past and may in the future increase our labor costs and materially reduce our profitability.

We compete with other healthcare providers in recruiting and retaining qualified management and staff personnel responsible for the day-to-day operations of each of our hospitals, including most significantly nurses and other non-physician healthcare professionals. In the healthcare industry generally, including in our markets, the national shortage of nurses and other medical support personnel has become a significant operating issue. This shortage has caused us in the past and may require us in the future to increase wages and benefits to recruit and retain nurses and other medical support personnel or to hire more expensive temporary personnel. We have voluntarily raised on several occasions in the past, and expect to raise in the future, wages for our nurses and other medical support personnel. In addition, union-mandated or state-mandated nurse-staffing ratios significantly affect not only labor costs, but may also cause us to limit patient admissions with a corresponding adverse effect on revenues if we are unable to hire the appropriate number of nurses to meet the required ratios. While we do not currently operate in any states with mandated nurse-staffing ratios, the states in which we operate could adopt mandatory nurse-staffing ratios at any time. In those instances where our nurses are unionized, it is our experience that new union contracts often impose significant new additional staffing ratios by contract on our hospitals. This was the case with the increased staffing ratios imposed on us in our recently negotiated new union contract with our nurses at Saint Vincent Hospital in Worcester, Massachusetts (which contract obtained union member ratification on or about February 16, 2007 by a vote of 349 to 6). In addition, to the extent that a significant additional portion of our employee base unionizes, or attempts to unionize, our labor costs could increase materially, especially if the newly unionized employees are nurses. If our labor costs continue to increase, we may not be able to raise our payer reimbursement levels to offset these increased costs, including the significantly increased costs that we will incur for wage increases and nurse-staffing ratios under our new union contract with our nurses at Saint Vincent Hospital. Because substantially all of our net patient revenues consist of payments based on fixed or negotiated rates, our ability to pass along increased labor costs is materially constrained. Our failure to recruit and retain qualified management, nurses and other medical support personnel, or to control our labor costs, could have a material adverse effect on our profitability.

Compliance with section 404 of the Sarbanes-Oxley Act may negatively impact our results of operations and failure to comply may subject us to regulatory scrutiny and a loss of investors' confidence in our internal control over financial reporting.

Section 404 of the Sarbanes-Oxley Act of 2002 requires us to perform an evaluation of our internal control over financial reporting and file management's attestation with our annual report beginning with fiscal 2008 and requires our auditors to opine on our internal control over financial reporting beginning with fiscal 2009. Compliance with these requirements, and any changes in our internal control over financial reporting in response to our internal evaluations, may be expensive and time-consuming and may negatively impact our results of operations. In addition, we cannot assure you that we will be able to meet the required deadlines for compliance with Section 404. Any failure on our part to meet the required compliance deadlines may subject us to regulatory scrutiny and a loss of public confidence in our internal control over financial reporting.

A failure of our information systems would adversely affect our ability to properly manage our operations.

We rely on our advanced information systems and our ability to successfully use these systems in our operations. These systems are essential to the following areas of our business operations, among others:

- patient accounting, including billing and collection of patient service revenues;
- financial, accounting, reporting and payroll;
- coding and compliance;
- laboratory, radiology and pharmacy systems;

- negotiating, pricing and administering managed care contracts; and
- monitoring quality of care.

If we are unable to use these systems effectively, we may experience delays in collection of patient service revenues and may not be able to properly manage our operations or oversee the compliance with laws or regulations.

Difficulties with current construction projects or new construction projects such as additional hospitals or major expansion projects may involve significant capital expenditures that could have an adverse impact on our liquidity.

We recently completed four major expansion projects at our hospitals and are still in the process of completing portions of two others. The total budgeted cost to construct these projects is currently estimated to be approximately $337.0 million. We have spent approximately $296.1 million of this budgeted amount as of June 30, 2007. Thus, we currently expect to incur approximately an additional $40.9 million in capital expenditures through fiscal 2009 related to completion of the construction of these projects. In addition, we may decide to construct an additional hospital or hospitals in the future or construct additional major expansion projects. Our ability to complete construction of the remainder of these current construction projects on budget and on schedule or to construct new hospitals or new expansion projects on budget and on schedule would depend on a number of factors, including, but not limited to:

- our ability to control construction costs;
- the failure of general contractors or subcontractors to perform under their contracts;
- adverse weather conditions;
- shortages of labor or materials;
- our ability to obtain necessary licensing and other required governmental authorizations; and
- other unforeseen problems and delays.

As a result of these and other factors, we cannot assure you that we will not experience increased construction costs on our construction projects or that we will be able to construct our current or any future construction projects as originally planned. In addition, our current and any future major construction projects has and would involve a significant commitment of capital with no revenues associated with the projects during construction, which also could have in the future an adverse impact on our liquidity.

If the costs for construction materials and labor continue to rise, such increased costs could have an adverse impact on the return on investment relating to our expansion projects.

The cost of construction materials and labor has significantly increased over the past year as a result of global and domestic events. We have experienced significant increases in the cost of steel due to the demand in China for such materials and an increase in the cost of lumber due to multiple catastrophic hurricanes in the United States. As we continue to invest in modern technologies, emergency rooms and operating room expansions, we expend large sums of cash generated from operating activities. We evaluate the financial viability of such projects based on whether the projected cash flow return on investment exceeds our cost of capital. Such returns may not be achieved if the cost of construction continues to rise significantly or anticipated volumes do not materialize.

State efforts to regulate the construction or expansion of hospitals could impair our ability to operate and expand our operations.

Some states require healthcare providers to obtain prior approval, known as certificates of need, for:

- the purchase, construction or expansion of healthcare facilities;
- capital expenditures exceeding a prescribed amount; or
- changes in services or bed capacity.

In giving approval, these states consider the need for additional or expanded healthcare facilities or services. Illinois and Massachusetts are the only states in which we currently own hospitals that have certificate of need laws. The failure to obtain any required certificate of need could impair our ability to operate or expand operations in these states.

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

Blackstone acquired our predecessor company during fiscal 2005. We recorded a significant portion of the purchase price as goodwill. At June 30, 2007, we had approximately $689.2 million of goodwill recorded on our books. We expect to recover the carrying value of this goodwill through our future cash flows. On an ongoing basis, we evaluate, based on the fair value of our reporting units, whether the carrying value of our goodwill is impaired. During fiscal 2007, we recorded a $123.8 million ($110.5 million, net of tax benefit) impairment charge to goodwill to reduce the carrying values of our Chicago hospitals to their fair values. If the carrying value of our goodwill is further impaired, we may incur an additional material non-cash charge to earnings.

Additional Risk Factors

See the additional risks related to our business in "Item 7 – Management's Discussion and Analysis of Financial Conditions and Results of Operations – General Trends" which are incorporated by reference in this Item 1A as if fully set forth herein.

Available Information

We currently voluntarily file certain reports with the Securities and Exchange Commission ("SEC"), including annual reports on Form 10-K and quarterly reports on Form 10-Q. The public may read and copy any materials we file with the SEC at the SEC's Public Reference Room at 100 F Street, N.E., Washington, DC 20549. The public may obtain information on the operation of the Public Reference Room by calling the SEC at 1-800-SEC-0330. We are an electronic filer and the SEC maintains an Internet site at http://www.sec.gov that contains the reports and other information we file electronically. Our Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q, Current Reports on Form 8-K and amendments to those reports are also available free of charge on our internet website at www.vanguardhealth.com under "Investor Relations-SEC Filings-SEC Filings on the Edgar Database" as soon as reasonably practicable after such reports are electronically filed with or furnished to the SEC. Please note that our website address is provided as an inactive textual reference only. Also, the information provided on our website is not part of this report, and is therefore not incorporated by reference unless such information is specifically referenced elsewhere in this report.

Item 1B. Unresolved Staff Comments.

Not applicable.

Item 2. Properties.

A listing of our owned acute hospitals is included in Item 1 of this report under the caption "Business-Our Facilities". We also own or lease space for outpatient service facilities complementary to our hospitals and own and

operate a limited number of medical office buildings (some of which are joint ventures) associated with our hospitals that are occupied primarily by physicians who practice at our hospitals. The most significant of these complementary outpatient healthcare facilities are two surgery centers in Orange County, California, five diagnostic imaging centers in metropolitan Phoenix, Arizona and a 50% interest in seven diagnostic imaging centers in San Antonio, Texas. Most of these outpatient facilities are in leased facilities, and the diagnostic imaging centers in San Antonio are owned and operated in joint ventures where we have minority partners.

As of June 30, 2007, we leased approximately 40,500 square feet of office space at 20 Burton Hills Boulevard, Nashville, Tennessee, for our corporate headquarters.

Our headquarters, hospitals and other facilities are suitable for their respective uses and are, in general, adequate for our present needs. Our obligations under our senior credit facilities are secured by a pledge of substantially all of our assets, including first priority mortgages on each of our hospitals. Also, our properties are subject to various federal, state and local statutes and ordinances regulating their operation. Management does not believe that compliance with such statutes and ordinances will materially affect our financial position or results from operations.

Item 3. Legal Proceedings.

We operate in a highly regulated and litigious industry. As a result, various lawsuits, claims and legal and regulatory proceedings have been instituted or asserted against us. While we cannot predict the likelihood of future claims or inquiries, we expect that new matters may be initiated against us from time to time. The results of claims, lawsuits and investigations cannot be predicted, and it is possible that the ultimate resolution of these matters, individually or in the aggregate, may have a material adverse effect on our business (both in the near and long term), financial position, results of operations or cash flows. We recognize that, where appropriate, our interests may be best served by resolving certain matters without litigation. If non-litigated resolution is not possible or appropriate with respect to a particular matter, we will continue to defend ourselves vigorously.

Currently pending and recently settled legal proceedings and investigations that are not in the ordinary course of business are set forth below. Where specific amounts are sought in any pending legal proceeding, those amounts are disclosed. For all other matters, where the possible loss or range of loss is reasonably estimable, an estimate is provided. Where no estimate is provided, the possible amount of loss is not reasonably estimable at this time. We record reserves for claims and lawsuits when they are probable and reasonably estimable. For matters where the likelihood or extent of a loss is not probable or cannot be reasonably estimated, we have not recognized in our consolidated financial statements all potential liabilities that may result. We undertake no obligation to update the following disclosures for any new developments.

Sherman Act Antitrust Class Action Litigation – Maderazo, et al v. VHS San Antonio Partners, L.P. d/b/a Baptist Health Systems, et al, Case No. 5:06cv00535 (United States District Court, Western District of Texas, San Antonio Division, filed June 20, 2006 and amended August 29, 2006)

On June 20, 2006, a federal antitrust class action suit was filed in San Antonio, Texas against our Baptist Health System subsidiary in San Antonio, Texas and two other large hospital systems in San Antonio. In the complaint, plaintiffs allege that the three hospital system defendants conspired with each other and with other unidentified San Antonio area hospitals to depress the compensation levels of registered nurses employed at the conspiring hospitals within the San Antonio area by engaging in certain activities that violated the federal antitrust laws. The complaint alleges two separate claims. The first count asserts that the defendant hospitals violated Section 1 of the federal Sherman Act, which prohibits agreements that unreasonably restrain competition, by conspiring to depress nurses' compensation. The second count alleges that the defendant hospital systems also violated Section 1 of the Sherman Act by participating in wage, salary and benefits surveys for the purpose, and having the effect, of depressing registered nurses' compensation or limiting competition for nurses based on their compensation. The class on whose behalf the plaintiffs filed the complaint is alleged to comprise all registered nurses employed by the defendant hospitals since June 20, 2002. The suit seeks unspecified damages, trebling of this damage amount pursuant to federal law, interest, costs and attorneys fees. Currently, the parties are producing documents relating to our efforts to defeat class certification in this suit. We believe that the allegations contained within this putative class action suit are without merit, and we intend to vigorously defend against the litigation.

On the same date that this suit was filed against us in federal district court in San Antonio, the same attorneys filed three other substantially similar putative class action lawsuits in federal district courts in Chicago, Illinois, Albany, New York and Memphis, Tennessee against some of the hospitals in those cities (none of such hospitals being owned by us). The attorneys representing the plaintiffs in all four of these cases said in June 2006 that they may file similar complaints in other jurisdictions and in December 2006 they brought a substantially similar class action lawsuit against various hospitals in the Detroit, Michigan metropolitan area. Since representatives of the Service Employees International Union joined plaintiffs' attorneys in announcing the filing of all four complaints on June 20, 2006, and as has been reported in the media, we believe that SEIU's involvement in these actions appears to be part of a corporate campaign to attempt to organize nurses in these cities, including San Antonio. The nurses in our hospitals in San Antonio are currently not members of any union.

Medicare Secondary Payor Act Litigation - Brockovich, on behalf of the United States of America v. Vanguard Health Systems, Inc., et al. Case No. SACV06-547 JVS(MLGx) (United States District Court, Central District of California, Southern Division, filed June 9, 2006)

In June 2006, Plaintiff Erin Brockovich, purportedly on behalf of the United States of America, filed a civil complaint in United States District Court in California claiming our violation of the Medicare Secondary Payer Act. In the complaint plaintiff alleged that we have inappropriately received and retained reimbursement from Medicare for treatment given to certain unidentified patients of our facilities whose injuries were caused by us as a result of unidentified and unadjudicated incidents of medical malpractice. Also, in June 2006 this same plaintiff filed identical lawsuits against more than 20 other companies that own hospitals and convalescent homes in California. In the case against us, plaintiff is seeking damages of twice the amount that defendants were allegedly obligated to pay or reimburse Medicare in connection with the treatment in question under the Medicare Secondary Payor Act, plus interest, together with plaintiff's costs and fees, including attorneys' fees. On July 25, 2006, we filed with the court a motion to dismiss this litigation (1) for failure to state a claim in so far as plaintiff has no standing to bring this action since she alleges no injury to herself as a result of our alleged acts and (2) for failure to state a cause of action since no court has ever held that claims may be brought under the Medicare Secondary Payer Act based upon unadjudicated and unidentified tort claims. On October 24, 2006, the United States District Court granted our July 25, 2006 motion to dismiss this litigation on the grounds that plaintiff Erin Brockovich lacked constitutional standing to bring this action. The District Court dismissed the litigation with prejudice because the deficiencies could not be cured by amendment of plaintiff's compliant. On November 17, 2006, plaintiff appealed the District Court's order dismissing this litigation to the United States Court of Appeals for the Ninth Circuit. We believe the allegations contained in this suit are without merit, and we intend to vigorously defend against the litigation.

Claims in the ordinary course of business.

We are also subject to claims and lawsuits arising in the ordinary course of business, including potential claims related to care and treatment provided at our hospitals and outpatient services facilities. Although the results of these claims and lawsuits cannot be predicted with certainty, we believe that the ultimate resolution of these ordinary course claims and lawsuits will not have a material adverse effect on our business, financial condition or results of operations.

Item 4. Submission of Matters to a Vote of Security Holders.

No matters were submitted to a vote of stockholders during the fourth quarter ended June 30, 2007.

PART II

Item 5. Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities.

There is no established public trading market for our common stock. At September 1, 2007, there were five holders of record of our common stock. These holders are VHS Holdings LLC and four investment funds affiliated with Blackstone.

The Company has not declared or paid any dividends on its common stock in its two most recent fiscal years. We intend to retain all current and foreseeable future earnings to support operations and finance expansion. Our senior secured credit facility and the indentures governing our long-term indebtedness restrict our ability to pay cash dividends on our common stock. For information in respect of securities authorized under our equity compensation plans, see "Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters – Equity Compensation Plan Information."

Information regarding our equity compensation plans is set forth in this report under "Item 12 – Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters – Equity Compensation Plan Information", which information is incorporated herein by reference.

Item 6. Selected Financial Data.

The following table sets forth our selected historical financial and operating data for, or as of the end of, each of the five years ended June 30, 2007 (including the predecessor and successor periods). The selected historical financial data as of and for the predecessor years ended June 30, 2003 and 2004, the combined predecessor and successor year ended June 30, 2005 and the years ended June 30, 2006 and 2007 were derived from our audited consolidated financial statements that have been audited by Ernst & Young LLP, an independent registered public accounting firm. Comparability of the selected historical financial and operating data has been impacted by the timing of acquisitions completed during fiscal 2003 and 2005. Dispositions completed during fiscal 2006 and 2007 have been excluded from all periods presented. See "Executive Overview" included in "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations." This table should be read in conjunction with the consolidated financial statements and notes thereto.

	Predecessor		Combined Basis			Predecessor	Successor
	Year Ended June 30,		Year Ended June 30,	Year ended June 30,	Year ended June 30,	July 1, 2004 through September 22,	September 23, 2004 through June 30,
	2003	2004	2005	2006	2007	2004	2005
	(Dollars in millions, except Operating Data)						
Statement of Operations Data:							
Total revenues	$ 1,150.0	$ 1,583.1	$ 2,037.3	$ 2,418.6	$ 2,580.7	$ 397.9	$ 1,639.4
Costs and expenses:							
Salaries and benefits (includes stock compensation of $0, $0.1, $97.4, $1.7, $1.2, $96.7 and $0.7, respectively)	480.3	633.5	909.2	991.4	1,067.9	248.2	661.0
Supplies	174.4	253.2	336.8	394.1	421.8	63.7	273.1
Medical claims expense	160.8	211.8	237.2	270.3	297.0	55.0	182.2
Provision for doubtful accounts	61.0	104.7	133.0	156.8	175.2	27.8	105.2
Other operating expenses	172.6	222.0	288.8	353.0	375.0	57.3	231.5
Depreciation and amortization	41.7	58.8	75.7	100.3	118.6	16.0	59.7
Interest, net	34.2	41.4	82.3	103.8	123.8	9.0	73.3
Debt extinguishment costs	—	4.9	62.2	0.1	—	62.2	—
Minority interests	0.7	(2.5)	(0.3)	2.6	2.6	(0.5)	0.2
Merger expenses	—	—	23.3	—	—	23.1	0.2
Impairment loss	—	—	—	—	123.8	—	—
Other expenses	(1.7)	(2.3)	3.6	6.5	0.2	0.4	3.2
Subtotal	1,124.0	1,525.5	2,151.8	2,378.9	2,705.9	562.2	1,589.6
Income (loss) from continuing operations before income taxes	26.0	57.6	(114.5)	39.7	(125.2)	(164.3)	49.8
Income tax expense (benefit)	10.2	21.9	(34.7)	16.2	(11.6)	(52.2)	17.5
Income (loss) from continuing operations	15.8	35.7	(79.8)	23.5	(113.6)	(112.1)	32.3
Income (loss) from discontinued operations, net of taxes	1.1	4.4	1.7	(10.6)	(19.1)	1.4	0.3
Net income (loss)	16.9	40.1	(78.1)	12.9	(132.7)	(110.7)	32.6
Preferred dividends	(2.8)	(4.0)	(1.0)	—	—	(1.0)	—
Net income (loss) attributable to common stockholders	$ 14.1	$ 36.1	$ (79.1)	$ 12.9	$ (132.7)	$ (111.7)	$ 32.6
Balance Sheet Data:							
Assets	$ 1,226.9	$ 1,427.8	$ 2,471.7	$ 2,650.5	$ 2,531.4		$ 2,471.7
Long-term debt, including current portion	479.4	623.5	1,357.1	1,519.2	1,528.7		1,357.1
Payable-in-Kind Preferred Stock	57.0	61.0	—	—	—		—
Working capital	37.1	162.7	77.7	193.0	156.4		77.7
Other Financial Data:							
Capital expenditures	$ 87.6	$ 136.1	$ 224.2	$ 275.5	$ 164.3	$ 27.1	$ 197.1
Cash provided by operating activities	117.7	109.0	201.8	149.3	123.3	78.8	123.0
Cash used in investing activities	(344.0)	(225.1)	(324.3)	(245.4)	(118.5)	(50.0)	(274.3)
Cash provided by (used in) financing activities	198.1	139.0	151.6	140.5	(8.3)	(20.0)	171.6
Operating Data-continuing operations: (unaudited)							
Number of hospitals at end of period	11	12	15	15	15		
Number of licensed beds at end of period (a)	3,066	3,133	3,907	3,937	4,143		
Discharges (b)	93,144	126,356	147,798	162,446	166,873		
Adjusted discharges - hospitals (c)	137,409	186,464	231,322	261,422	265,448		

	Predecessor		Combined Basis			Predecessor	Successor
	Year Ended June 30,		Year Ended June 30,	Year ended June 30,	Year ended June 30,	July 1, 2004 through September 22,	September 23, 2004 through June 30,
	2003	2004	2005	2006	2007	2004	2005
Net revenue per adjusted discharge – hospitals (d)	$ 6,305	$ 6,455	$ 6,859	$ 7,332	$ 7,798		
Patient days (e)	382,923	519,589	623,333	701,307	721,832		
Adjusted patient days – hospitals (f)	564,899	766,760	975,593	1,128,603	1,148,233		
Average length of stay (days) (g)	4.1	4.1	4.2	4.3	4.3		
Outpatient surgeries (h)	43,536	54,180	67,944	76,437	76,606		
Emergency room visits (i)	326,200	430,794	504,172	554,250	572,946		
Occupancy rate (j)	45.9%	45.5%	48.5%	49.2%	48.4%		
Average daily census (k)	1,049	1,420	1,708	1,921	1,978		
Member lives (l)	130,700	142,200	146,700	146,200	145,600		
Medical claims expense percentage (m)	73.5%	72.1%	71.1%	72.1%	74.0%		

(a) Licensed beds are those beds for which a facility has been granted approval to operate from the applicable state licensing agency.

(b) Discharges represent the total number of patients discharged (in the facility for a period in excess of 23 hours) from our hospitals and is used by management and certain investors as a general measure of inpatient volumes.

(c) Adjusted discharges-hospitals is used by management and certain investors as a general measure of combined inpatient and outpatient volumes. Adjusted discharges-hospitals is computed by multiplying discharges by the sum of gross hospital inpatient and outpatient revenues and then dividing the result by gross hospital inpatient revenues. This computation enables management to assess hospital volumes by a combined measure of inpatient and outpatient utilization.

(d) Net revenue per adjusted discharge-hospitals is calculated by dividing hospital net patient revenues by adjusted discharges-hospitals and measures the average net payment expected to be received for a patient's stay in the hospital.

(e) Patient days represent the number of days (calculated as overnight stays) our beds were occupied by patients during the periods.

(f) Adjusted patient days-hospitals is calculated by multiplying patient days by the sum of gross hospital inpatient and outpatient revenues and then dividing the result by gross hospital inpatient revenues. This computation is an indicator of combined inpatient and outpatient volumes.

(g) Average length of stay represents the average number of days an admitted patient stays in our hospitals.

(h) Outpatient surgeries represent the number of surgeries performed at hospitals or ambulatory surgery centers on an outpatient basis (patient overnight stays not necessary).

(i) Emergency room visits represent the number of patient visits to a hospital or freestanding emergency room where treatment is received, regardless of whether an overnight stay is subsequently required.

(j) Occupancy rate represents the percentage of hospital licensed beds occupied by patients. Occupancy rate provides a measure of the utilization of inpatient rooms.

(k) Average daily census represents the average number of patients in our hospitals each day during our ownership.

(l) Member lives represent the total number of enrollees in PHP, AAHP and MHP as of the end of the respective period.

(m) Medical claims expense percentage is calculated by dividing medical claims expense by premium revenues.

Item 7. Management's Discussion and Analysis of Financial Conditions and Results of Operations.

The following discussion and analysis of our financial condition and results of operations covers periods both prior to and subsequent to the Merger (as discussed below). Accordingly, the discussion and analysis of certain historical periods do not reflect the significant impact of the Merger. We have presented the information for the year ended June 30, 2005 on a predecessor period and successor period combined basis to facilitate meaningful comparisons of those operating results to the years ended June 30, 2006 and June 30, 2007. You should read the following discussion together with our historical financial statements and related notes included elsewhere herein and the information set forth under "Item 6. Selected Financial Data."

The discussion contains forward-looking statements that involve risks and uncertainties. For additional information regarding some of the risks and uncertainties that affect our business and the industry in which we operate, please read "Item 1A. - Risk Factors" included elsewhere herein. Our actual results may differ materially from those estimated or projected in any of these forward-looking statements.

Executive Overview

As of June 30, 2007, we owned and operated 15 hospitals with a total of 4,143 licensed beds, and related outpatient service facilities complementary to the hospitals in San Antonio, Texas, metropolitan Phoenix, Arizona, metropolitan Chicago, Illinois, and Massachusetts, and two surgery centers in Orange County, California. We acquired our three Massachusetts hospitals on December 31, 2004 from subsidiaries of Tenet Healthcare Corporation for $87.7 million cash. We funded the acquisition and subsequent working capital buildup and capital expenditure projects at the Massachusetts hospitals primarily by borrowing a total of $150.0 million of delayed draw term loans during fiscal 2005. On March 8, 2006, we sold our medical office buildings in California to a third-party buyer for approximately $28.7 million. On October 1, 2006, we sold our three California hospitals with combined 491 licensed beds to subsidiaries of Prime Healthcare, Inc. for a base purchase price of $44.0 million, prior to adjustments for working capital items included in the sale and transaction expenses. The operating results of the California hospitals and medical office buildings are classified as discontinued operations in our consolidated statements of operations for all periods presented. In June 2007, we ceased providing acute care services at Phoenix Memorial Hospital ("PMH") and began leasing certain floors of the building to various third party healthcare providers. As a result, the acute care operating results of PMH are also classified as discontinued operations in our consolidated statements of operations for all periods presented.

As of June 30, 2007, we also owned three health plans as set forth in the following table.

Health Plan	Location	June 30, 2007 Membership
Phoenix Health Plan ("PHP") – managed Medicaid	Arizona	98,300
Abrazo Advantage Health Plan ("AAHP") – managed Medicare and Dual Eligible	Arizona	3,400
MacNeal Health Providers ("MHP") – capitated outpatient and physician services	Illinois	43,900
		145,600

Our objective is to provide high-quality, cost-effective healthcare services through an integrated delivery platform serving the needs of the communities in which we operate. We focus our business development efforts and operations on hospital and other related healthcare facilities where we see an opportunity to improve operating performance and profitability and increase market share.

Merger Transaction

On September 23, 2004, The Blackstone Group and certain of its affiliates (collectively "Blackstone") purchased approximately 66% of our equity interests (the "Merger"). Certain investment funds affiliated with Morgan Stanley Capital Partners (collectively "MSCP") and certain of our senior members of management and other shareholders (collectively the "Rollover Management Investors") purchased the remaining 34% of our equity

interests. The transaction was treated as a leveraged buyout purchase for accounting purposes. In connection with the Merger, we repaid $299.0 million of our outstanding $300.0 million 9.75% senior subordinated notes (we repaid the remaining $1.0 million in October 2005), our outstanding $17.6 million 8.18% subordinated notes and the $300.0 million Term B loans outstanding under our 2004 senior secured credit facility. We financed the Merger by issuing $575.0 million of 9.0% senior subordinated notes (the "9.0% Notes"), by issuing 11.25% senior discount notes (the "11.25% Notes") having an aggregate principal amount at maturity of $216.0 million, by borrowing $475.0 million of initial Term B loans under new senior secured credit facilities (the "merger credit facilities") and with equity proceeds totaling approximately $749.0 million (valued at approximately $635.7 million for accounting purposes). Certain members of senior management also purchased $5.7 million of the equity incentive units in VHS Holdings LLC. The merger credit facilities include a $250.0 million revolving credit facility, of which $31.6 million of capacity was utilized for letters of credit (with no outstanding borrowings) as of June 30, 2007. The merger credit facilities also included $325.0 million in delayed draw term loan facilities, which were drawn at various times during fiscal 2005 and 2006.

Operating Environment

The operating environment for hospital management companies is undergoing a significant change that presents both challenges and opportunities for us. In order to remain competitive in the markets we serve, we must adapt our operating strategies to not only accommodate changing environmental factors but to make them operating advantages for us relative to our peers. These factors will require changing our previous business model that focused primarily on service expansion to improve revenues and economies of scale to reduce expenses. These strategies remain important but will now become subsets of a corporate strategy focused on quality of care. As consumers become more involved in their healthcare decisions, perceived quality of care will become an even greater factor in determining where physicians choose to practice and where patients choose to receive care. The following paragraphs discuss some of the new challenges that we currently face and that we expect to become more prominent during the foreseeable future. We believe that if we implement a corporate strategy focused on quality of care, then we can meet each of these challenges and become a provider of choice in the communities we serve.

Pay for Performance Reimbursement

Many payers, including Medicare and several large managed care organizations, currently require providers to report certain quality measures in order to receive the full amount of payment increases that were awarded automatically in the past. For federal fiscal year 2008, Medicare expanded the number of quality measures to be reported to 27 from 21 during 2007 and 10 during 2006. These measures include risk-adjusted outcomes measures such as 30-day mortality measures for patients who suffered a heart attack, heart failure or pneumonia; additional measures related to patients who undergo surgical procedures such as hospital-acquired infections data; and several patient satisfaction indicators. Many large managed care organizations have developed quality measurement criteria that are similar to or even more stringent than the Medicare requirements. We have invested and will continue to invest significant capital to upgrade our clinical information systems to enable us to report these quality measures.

While current payer guidelines are based upon the reporting of quality measures, we believe it is only a matter of time until the quality measures themselves determine reimbursement rates for hospital services. For example, on April 13, 2007, CMS proposed reforms in the hospital inpatient prospective payment system that would implement a provision of the Deficit Reduction Act of 2005 ("DRA") that takes the first steps toward preventing Medicare from giving hospitals higher payment for the additional costs of treating a patient that acquires a condition (including an infection) during a hospital stay. The DRA required CMS to select at least two conditions that are (1) high cost, high volume or both; (2) assigned to a higher paying DRG when present as a secondary diagnosis; and (3) are reasonably preventable through application of evidence-based guidelines. These rules were adopted in August 2007. Under the rules, beginning in federal fiscal year 2009 (which commences October 1, 2008) cases with these conditions would not be paid at a higher DRG unless they were present on admission. The rules identify eight conditions, including three serious preventable events (sometimes called "never events") that meet the statutory criteria. Thus, our ability to demonstrate quality of care in our hospitals could significantly impact our future operating results.

Physician Integration

Our ability to attract skilled physicians to our hospitals is critical to our success. We have significant physician recruitment goals in place with primary emphasis on family practice and internal medicine, hospitalists, obstetrics and gynecology, cardiology, neurology and orthopedics. Similar to previous strategies, physician employment and relocation incentives remain important. However, the perceived quality of care at our hospitals will become even more important to physicians. Similar to hospital reimbursement, plans are being developed to transform physician reimbursement to a pay for performance basis. In a hospital setting, many of the quality measures that apply to nursing care also apply to physician care. This interdependence aligns the quality of care focus of physicians and hospitals in order that both can receive equitable compensation for services provided.

We also face the risk of heightened physician reimbursement pressures that could cause physicians to seek to increase revenues by competing with hospitals for inpatient business. Additional competition from physician-owned specialty hospitals could adversely impact our future operating results. Again, we expect to mitigate this risk by achieving a competitive advantage with our quality of care initiatives that new specialty hospitals might not be equipped to implement. These pressures may also result in our employing more physicians or pursuing additional opportunities to partner with physicians to provide healthcare services to the communities we serve.

Nursing Salaries Pressures

In order to demonstrate high quality services, we must hire and retain nurses who share our ideals and beliefs and who have access to the training necessary to implement our quality of care initiatives. Given the nationwide nursing shortage and the particular limited nursing availability in the Phoenix area, we expect continued pressure on nursing salaries and benefits. These pressures include higher than normal base wage increases, flexible working hours and other benefits and higher nurse to patient ratios necessary to improve quality of care. Quality of care initiatives also require additional nurse training programs that increase salaries and benefits costs. We will incur significant training costs as nurses learn to utilize our new information technology tools that allow us to monitor and report quality performance indicators. Becoming the employer of choice for nurses requires upfront human resource investments that could negatively affect operating results in the short-term. We may also be limited in our ability to adjust staffing levels in periods of lower than expected volumes. However, reducing turnover and improving the skill sets of our nurses will reduce our reliance on contract labor and result in improved quality of care and increased revenues in the long-term.

We expect to supplement our base of trained nursing professionals by expanding our comprehensive nurse recruiting and retention program. This program includes the following key components, among others:

- Nursing schools in San Antonio and Phoenix
- Foreign nurse recruiting initiatives
- Tuition reimbursement and internal training to promote career advancement opportunities, including specialization qualifications
- Extern programs and campus events to network with students
- Preceptor and other mentoring programs
- Expansion of orientation programs and employee involvement initiatives
- Performance leadership training for managers and directors
- Flexible work hours for nurses
- Employee safety initiatives
- Competitive pay and benefits and nursing recognition programs

We operate the Baptist Health System School of Health Professions ("SHP") in San Antonio, which offers eight different programs with the greatest enrollment in the professional nursing program. The SHP trains approximately 450 students each year, the majority of which have historically chosen permanent employment with us. SHP experienced an enrollment growth of over 30% for fall 2006 compared to fall 2005 and expects enrollment to increase slightly in fall 2007. Plans are underway to transition SHP's current diploma program to a degree granting program that will be more attractive to potential students. SHP enrollment includes approximately 80 students in our metropolitan Phoenix market that are trained using state of the art distance learning technology maximizing utilization of SHP instructors. Students are provided with company-funded scholarships that cover

tuition, books and fees in return for a commitment to work at one of our hospitals for a defined period of time. Should we be unsuccessful in our attempts to maintain adequate nursing staff for our present and future needs, our future operating results could be materially adversely impacted.

Competition for Outpatient Services

With advances in medical technologies and pharmaceuticals, many services once provided in an inpatient setting are now available in an outpatient setting. The redirection of services to outpatient settings is also influenced by pressures from payers to reduce costs and by patients who seek convenience. Our hospitals and many other acute hospitals have struggled to retain or grow outpatient business resulting from this inpatient to outpatient shift. Competition for outpatient services has increased significantly with the proliferation of surgery centers, outpatient imaging centers and outpatient laboratories that are often viewed as more convenient to physicians and patients. While we remain at risk for further migration of outpatient services to non-hospital settings or to other hospitals, we expect to mitigate these risks with our quality of care initiatives, physician integration strategies and capital projects to improve the design of and access to outpatient service areas in our hospitals.

Implementation of our Quality Initiatives

The previous paragraphs discuss the industry trends that are integral to our future success and how quality of care is the most important component in achieving success in those areas. While we are in the early stages of implementing our expanded quality of care initiatives, we believe that the following programs currently in place represent key building blocks to a successful strategy.

- Monthly review of the 21 quality indicators prescribed by CMS for federal fiscal year 2007 with plans to expand to 27 during our fiscal 2008
- Rapid response teams in place at all of our hospitals to provide more timely and efficient care
- Hourly nursing rounds in place at most of our hospitals
- Engagement of an external group to conduct unannounced mock JCAHO surveys
- Alignment of hospital management incentive compensation with quality performance indicators
- Additional staffing to collect and report quality information and to facilitate action plans to address areas for improvement
- Common information system in place at all hospitals to report quality indicators
- Common information system at departmental level to achieve efficiencies in delivering care and to feed data to the common reporting system (partially implemented, with all modules to be operational by the end of fiscal 2009)

Revenue/Volume Trends

Our revenues depend upon inpatient occupancy levels, outpatient procedures performed at our facilities, the ancillary services and therapy programs ordered by physicians and provided to patients and our ability to successfully negotiate appropriate payment rates for these services with third party payers. During the year ended June 30, 2007, we experienced a 2.7% increase in discharges from continuing operations and a 1.5% increase in hospital adjusted discharges from continuing operations compared to the prior year. The following table provides details of discharges from continuing operations by payer for the years ended June 30, 2005, 2006 and 2007.

	Year ended June 30,					
	2005		2006		2007	
Medicare	45,383	30.7%	47,352	29.2%	46,452	27.8%
Medicaid	17,634	11.9%	20,514	12.6%	22,518	13.5%
Managed care	78,767	53.3%	87,910	54.1%	90,399	54.2%
Self pay	4,519	3.1%	5,169	3.2%	6,181	3.7%
Other	1,495	1.0%	1,501	0.9%	1,323	0.8%
Total	147,798	100.0%	162,446	100.0%	166,873	100.0%

We attribute the modest growth in discharges from continuing operations during 2007 to stagnant demand for inpatient healthcare services. Additionally, decreases in certain subacute services as a result of regulatory changes and reduced demand for elective procedures as a result of changes in patient insurance coverage continue to weaken inpatient and outpatient volumes. We expect our volumes to improve more significantly over the long-term as a result of quality initiatives, service expansion initiatives and our market-driven management strategies. We also expect that as we fully implement our significant expansion projects, patient volumes will improve at those facilities where growth was previously constrained by physical plant limitations and patient throughput inefficiencies. However, the success of our growth initiatives is dependent upon maintaining the community's confidence in our services and staying ahead of the competition in the markets we serve. Continued weakened demand for hospital healthcare services could negate these growth initiatives in the short-term.

The majority of our patient service revenues are based on negotiated, per diem or pre-determined payment structures. Our facilities' gross charges typically do not reflect what the facilities are actually paid. In addition to volume factors described above, patient mix, acuity factors and pricing trends affect our patient service revenues. Net patient revenues per adjusted hospital discharge from continuing operations increased 6.4% from $7,332 during the year ended June 30, 2006 to $7,798 during the year ended June 30, 2007. This increase reflects improved reimbursement for services provided under negotiated managed care contracts and improved Medicare reimbursements.

During the year ended June 30, 2007, we recorded $11.6 million of revenues for payments received in April 2007 under the Bexar County, Texas upper payment limit ("UPL") Medicaid payment program that relate to services provided during fiscal years 2005 and 2006. The UPL payment also positively impacted loss from continuing operations before income taxes by $5.9 million during the year ended June 30, 2007 related to services provided in fiscal years 2005 and 2006. The UPL revenues attributable to prior fiscal years represented 0.6% of the 6.4% period over period increase in net patient revenues per adjusted hospital discharge.

Increases in levels of charity care and negotiated self-pay discounts also impact net patient revenues per adjusted hospital discharge by decreasing revenues and decreasing the provision for doubtful accounts. We cannot assure you that future reimbursement rates, even if improved, will sufficiently cover potential increases in the cost of providing healthcare services to our patients.

We recognize premium revenues from our three health plans, PHP, AAHP and MHP. AAHP commenced operations on January 1, 2006 primarily to provide healthcare services (including Medicare Part D) to those individuals eligible for both Medicare and Medicaid benefits based on age and income levels. As of June 30, 2007, approximately 3,400 members were enrolled in this program, most of whom were previously enrolled in PHP. PHP's membership increased to approximately 98,300 at June 30, 2007 compared to approximately 96,700 at June 30, 2006. Premium revenues from these three plans increased by $26.4 million or 7.0% during the year ended June 30, 2007 compared to the prior year. This increase resulted primarily from the increased per member per month reimbursement from owning AAHP during the full twelve months of fiscal 2007. PHP also experienced period over period increased per member per month reimbursement as a result of a rate increase that went into effect on October 1, 2006. We do not anticipate a significant increase in membership for our health plan reporting segment during our

fiscal year ending June 30, 2008 but could realize significant membership increases during future fiscal years. In September 2007, the Arizona Health Care Cost Containment System ("AHCCCS") exercised its final one-year renewal option under its contract with PHP that commenced on October 1, 2003, which extended the current contract through September 30, 2008. The Centers for Medicare and Medicaid Services ("CMS") renewed its contract with AAHP for a one-year period effective January 1, 2007. Should the PHP contract terminate, our future operating results and cash flows could be materially reduced.

General Trends

The following paragraphs discuss recent trends that we believe are significant factors in our current and/or future operating results and cash flows. While these trends may involve certain factors that are outside of our control, the extent to which these trends affect us and our ability to manage the impact of these trends play vital roles in our current and future success. In many cases, we are unable to predict what impact these trends, if any, will have on us.

Accounts Receivable Collection Risks Leading to Increased Bad Debts

Similar to others in the hospital industry, the collectibility of our accounts receivable has deteriorated primarily due to an increase in self-pay receivables. The following table provides a summary of our accounts receivable by age since discharge date and payer class as of each respective period presented (in millions).

June 30, 2005	0-90 days	91-180 days	Over 180 days	Total
Medicare	$ 95.9	$ 5.5	$ 2.3	$ 103.7
Medicaid	43.1	12.1	7.3	62.5
Managed Care	204.1	21.2	10.1	235.4
Self Pay[1]	53.8	45.4	10.0	109.2
Other	17.8	6.0	1.8	25.6
Total[2]	$ 414.7	$ 90.2	$ 31.5	$ 536.4

June 30, 2006	0-90 days	91-180 days	Over 180 days	Total
Medicare	$ 93.7	$ 5.4	$ 3.5	$ 102.6
Medicaid	40.6	11.6	7.2	59.4
Managed Care	208.6	24.0	11.9	244.5
Self Pay[1]	58.8	51.7	11.9	122.4
Other	14.7	5.3	2.3	22.3
Total[2]	$ 416.4	$ 98.0	$ 36.8	$ 551.2

June 30, 2007	0-90 days	91-180 days	Over 180 days	Total
Medicare	$ 81.1	$ 3.2	$ 2.9	$ 87.2
Medicaid	40.4	10.7	5.5	56.6
Managed Care	205.1	21.7	15.3	242.1
Self Pay[1]	64.8	58.5	15.2	138.5
Other	9.6	3.2	2.3	15.1
Total[2]	$ 401.0	$ 97.3	$ 41.2	$ 539.5

(1) Includes uninsured patients and those patient co-insurance and deductible amounts for which payment has been received from the primary payer. If primary payment has not been received for an account, the patient co-insurance and deductible amounts remain classified in the primary payer category.

(2) The total accounts receivable balances reflected on these tables differ from the net accounts receivable balances as stated on the consolidated balance sheets for those respective periods because the balance sheet accounts receivable amounts are reduced by manual contractual allowances for unbilled patient accounts, certain billed patient accounts and for cash payments received but not posted to patient accounts, whereas those deductions are not reflected on the aging reports. The table below provides a reconciliation of these amounts.

	June 30, 2006	June 30, 2007
	(In millions)	
Accounts receivable per aging report	$ 551.2	$ 539.5
Less: Allowance for doubtful accounts	(103.5)	(113.2)
Less: Manual contractual allowances for unbilled patient accounts	(118.4)	(97.8)
Less: Manual contractual allowances for certain billed patient accounts	(22.5)	(26.3)
Less: Unposted cash receipts and other	(12.7)	(14.9)
Net accounts receivable reflected on the consolidated balance sheets	$ 294.1	$ 287.3

Our combined allowance for doubtful accounts and allowance for charity care on a consolidated basis covered 93.4% and 91.4% of self-pay accounts receivable as of June 30, 2006 and 2007, respectively. Our combined allowance for doubtful accounts and allowance for charity care from continuing operations covered 93.2% and 87.5% of self-pay accounts receivable from continuing operations as of June 30, 2006 and June 30, 2007, respectively.

The increase in self-pay accounts receivable has led to increased write-offs and older accounts receivable outstanding, resulting in the need for an increased allowance for doubtful accounts and charity care. The increase in self-pay accounts receivable results from a combination of factors including price increases, increased patient volumes, higher levels of patient deductibles and co-insurance under managed care programs and the increased difficulties of uninsured patients who do not qualify for charity care programs to pay for escalating healthcare costs. We have implemented policies and procedures designed to expedite upfront cash collections and promote repayment plans from our patients. Our upfront cash collections from continuing operations increased 14.4% during the year ended June 30, 2007 compared to the prior year. However, we believe bad debts will remain sensitive to changes in payer mix, pricing and general economic conditions for the hospital industry during the foreseeable future.

Expansion of Charity Care and Self-Pay Discount Programs

We do not pursue collection of amounts due from uninsured patients that qualify for charity care under our guidelines (currently those uninsured patients whose incomes are equal to or less than 200% of the current federal poverty guidelines set forth by the Department of Health and Human Services). We exclude charity care accounts from revenues when we determine that the account meets our charity care guidelines. We deducted $51.0 million, $71.1 million, and $86.1 million of charity care from total revenues during the years ended June 30, 2005, 2006 and 2007, respectively. During fiscal 2006, we began tracking healthcare services provided to undocumented aliens that qualify for border funding reimbursement and recording those costs as charity care deductions. Until December 2006, border funding payments received were recorded as a decrease to charity deductions when received. In December 2006, we began recording a receivable representing estimated future border funding receipts based upon our historical ratio of payments received to claims filed. As of June 30, 2007, this receivable balance was $2.1 million. Since the program's inception in May 2005 through June 30, 2007, we have collected $2.9 million in border funding payments. We continually update the estimated receivable as new payment data is received. Revenue deductions for services provided to border funding patients, net of payments received and accrued, accounted for $10.5 million and $19.4 million of our charity care deductions during the years ended June 30, 2006 and 2007.

Medicaid Funding Cuts

Many states, including certain states in which we operate, have periodically reported budget deficits as a result of increased costs and lower than expected tax collections. Health and human service programs, including Medicaid and similar programs, represent a significant component of state spending. To address these budgetary concerns, certain states have decreased funding for these programs and other states may make similar funding cuts. These cuts may include tightened participant eligibility standards, reduction of benefits, enrollment caps or payment reductions. Additionally, pressure exists at the federal level to reduce Medicaid matching funds provided to states as evidenced by a budget resolution set forth by Congress in April 2005 calling for $10.0 billion in cuts to federal funding of the Medicaid program over a five-year period. We are unable to assess the financial impact on our business of enacted or proposed state or federal funding cuts at this time.

Volatility of Professional Liability Costs

We maintained professional and general liability insurance coverage through a wholly owned captive insurance subsidiary for individual claims incurred through May 31, 2006 up to $10.0 million. For claims incurred subsequent to May 31, 2006, we self-insure the first $9.0 million per occurrence, and the captive subsidiary insures the next $1.0 million per occurrence. We maintain excess insurance coverage with independent third party carriers on a claims-made basis for individual claims exceeding $10.0 million up to $75.0 million, but limited to total annual payments of $65.0 million in the aggregate. The total cost of our professional and general liability insurance is sensitive to the volume and severity of cases reported. Malpractice premiums have adversely affected the ability of physicians to obtain malpractice insurance at reasonable rates in certain markets, particularly in metropolitan Chicago resulting in physicians relocating to different geographic areas. In the event physicians practicing in our hospitals are unable to obtain adequate malpractice insurance coverage, our hospitals are likely to incur a greater percentage of the amounts paid to claimants. Our professional liability exposures also increase when we employ physicians. On the other hand, some states, including Texas and Illinois, have passed tort reform legislation to place limits on non-economic damages. While we have taken multiple steps at our facilities to reduce our professional liability exposures, absent significant additional legislation to curb the size of malpractice judgments in other states in which we operate, our insurance costs may increase in the future.

Increased Cost of Compliance in a Heavily Regulated Industry

We conduct business in a heavily regulated industry. Accordingly, we maintain a comprehensive, company-wide compliance program to address healthcare regulatory and other compliance requirements. This compliance program includes, among other things, initial and periodic ethics and compliance training, a toll-free reporting hotline for employees, annual fraud and abuse audits and annual coding audits. The organizational structure of our compliance program includes oversight by our board of directors and a high-level corporate management compliance committee. Our Senior Vice President of Compliance and Ethics reports jointly to our Chairman and Chief Executive Officer and to our board of directors, serves as Chief Compliance Officer and is charged with direct responsibility for the day-to-day management of our compliance program. During fiscal 2006, we established regional compliance officers in our markets and staffed the new positions with compliance professionals 100% dedicated to compliance duties. The financial resources necessary for program oversight, enforcement and periodic improvements to our program continue to grow, especially when we add new features to our program or engage external resources to assist with these highly complex matters.

Critical Accounting Policies

The consolidated financial statements have been prepared in accordance with accounting principles generally accepted in the United States. In preparing these financial statements, we make estimates and assumptions that affect the reported amounts of assets, liabilities, revenues and expenses included in the financial statements. Management bases its estimates on historical experience and other available information, the results of which form the basis of the estimates and assumptions. We consider the following accounting policies to be critical accounting policies because they involve the most subjective and complex assumptions and assessments, are subject to a great degree of fluctuation period over period and are the most critical to our operating performance.

Revenues and Revenue Deductions

We recognize patient service revenues during the period the healthcare services are provided based upon estimated amounts due from payers. We estimate contractual adjustments and allowances based upon payment terms set forth in managed care health plan contracts and by federal and state regulations. For the majority of our patient service revenues, contractual adjustments are applied to patient accounts at the time of billing using specific payer contract terms entered into the accounts receivable systems. However, in some cases we record an estimated allowance until we receive payment. We derive most of our patient service revenues from healthcare services provided to patients with Medicare or managed care insurance coverage. During the years ended June 30, 2005, 2006 and 2007, combined Medicare and managed care revenues accounted for approximately 77% to 80% of net patient revenues. For those same periods, Medicaid revenues accounted for approximately 7% to 9% of net patient revenues. Services provided to Medicare patients are generally reimbursed at prospectively determined rates per diagnosis ("PPS"), while services provided to managed care patients are generally reimbursed based upon predetermined rates per diagnosis, per diem rates or discounted fee-for-service rates. Medicaid reimbursements vary by state. Other than Medicare, no individual payer represents more than 10% of our patient service revenues, either on a gross or net basis.

Medicare regulations and our principal managed care contracts are often complex and may include multiple reimbursement mechanisms for different types of services provided in our healthcare facilities. To obtain reimbursement for certain services under the Medicare program, we must submit annual cost reports and record estimates of amounts owed to or receivable from Medicare. These cost reports include complex calculations and estimates related to indirect medical education, reimbursable Medicare bad debts and other items that are often subject to interpretation that could result in payments that differ from our estimates. We make our estimates of amounts owed to or receivable from the Medicare program using the best information available to us and our interpretation of the applicable Medicare regulations. We include differences between original estimates and subsequent revisions to those estimates (including final cost report settlements) in the consolidated statements of operations in the period in which the revisions are made. During the years ended June 30, 2005, 2006 and 2007, we recorded increases to patient service revenues and income from continuing operations before income taxes of $5.8 million, $8.6 million and $6.3 million, respectively, related to changes in estimated third party settlements. Additionally, updated regulations and contract negotiations occur frequently, which necessitates continual review of estimation processes by management. We believe that future adjustments to our current third party settlement estimates will not significantly impact our results of operations or statement of position.

We do not pursue collection of amounts due from uninsured patients that qualify for charity care under our guidelines (currently those uninsured patients whose incomes are equal to or less than 200% of the current federal poverty guidelines set forth by the Department of Health and Human Services). We deduct charity care accounts from revenues when we determine that the account meets our charity care guidelines. We also provide discounts from billed charges and alternative payment structures for uninsured patients who do not qualify for charity care but meet certain other minimum income guidelines, primarily those uninsured patients with incomes between 200% and 500% of the federal poverty guidelines. During the years ended June 30, 2005, 2006 and 2007, we deducted $51.0 million, $71.1 million and $86.1 million of charity care from revenues, respectively.

We had premium revenues of $333.5 million, $375.0 million and $401.4 million during the years ended June 30, 2005, 2006 and 2007, respectively. Our health plans have agreements with AHCCCS, CMS and various health maintenance organizations ("HMOs") to contract to provide medical services to subscribing participants. Under these agreements, our health plans receive monthly payments based on the number of HMO participants in MHP or the number and coverage level of enrollees in PHP and AAHP. Our health plans recognize the payments as revenues in the month in which members are entitled to healthcare services, with the exception of AAHP Medicare Part D reinsurance premiums and low income subsidy cost sharing premiums that are recorded as liabilities to fund future healthcare costs or else repaid to the government.

Allowance for Doubtful Accounts and Provision for Doubtful Accounts

Our ability to collect the self-pay portions of outstanding receivables is critical to our operating performance and cash flows. The allowance for doubtful accounts was approximately 26.0% and 28.3% of accounts receivable, net of contractual discounts, as of June 30, 2006 and 2007, respectively. The primary collection risk

relates to uninsured patient accounts and patient accounts for which primary insurance has paid but patient deductibles or co-insurance portions remain outstanding. As of June 30, 2007, we estimated the allowance for doubtful accounts using a standard policy that reserves 100% of all accounts aged greater than 180 days subsequent to discharge date plus a pre-determined percentage of accounts receivable due from patients less than 180 days old. Effective July 1, 2007, we will transition to a policy that reserves 100% of all accounts greater than 365 days subsequent to discharge date plus 85% of uninsured accounts less than 365 days old plus 40% of self-pay after insurance/Medicare less than 365 days old. We adjust our estimate as necessary on a quarterly basis using a hindsight calculation that utilizes write-off data for all payer classes during the previous twelve-month period to estimate the allowance for doubtful accounts at a point in time. We also monitor cash collections and self-pay utilization. Significant changes in payer mix, business office operations, general economic conditions or healthcare coverage provided by federal or state governments or private insurers may have a significant impact on our estimates and significantly affect our future operations and cash flows.

We classify accounts pending Medicaid approval as Medicaid accounts in our accounts receivable aging report and record a manual contractual allowance for these accounts equal to the average Medicaid reimbursement rate for that specific state. We have historically been successful in qualifying approximately 50%-55% of submitted accounts for Medicaid coverage. As of June 30, 2007, we had approximately $12.0 million of Medicaid pending accounts receivable from continuing operations ($3.5 million of which was stated at gross charges with a manual contractual allowance and $8.5 million of which was stated net of contractual discounts). In the event an account is not successfully qualified for Medicaid coverage and does not meet our charity guidelines, the previously recorded Medicaid contractual adjustment remains a revenue deduction (similar to a self-pay discount), and the remaining net account balance is reclassified to uninsured status and subjected to our allowance for doubtful accounts policy. During the year ended June 30, 2007, approximately $13.2 million of net accounts receivable from continuing operations was reclassified from Medicaid pending status to uninsured status. If the account does not qualify for Medicaid coverage but does qualify as charity care, the contractual adjustment is reversed and the gross account balance is recorded as a charity deduction. During the year ended June 30, 2007, we recorded approximately $6.4 million of charity deductions from continuing operations for the net balances of accounts previously classified as Medicaid pending that did not meet Medicaid eligibility requirements.

Because we require patient verification of coverage at the time of admission, reclassifications of Medicare or managed care accounts to self-pay, other than patient coinsurance or deductible amounts, occur infrequently and are not material to our consolidated financial statements. Additionally, the impact of these classification changes is further limited by our ability to identify any necessary classification changes prior to patient discharge or soon thereafter. Due to information system limitations, we are unable to quantify patient deductible and co-insurance receivables that are included in the primary payer classification in the accounts receivable aging report at any given point in time. When classification changes occur, the account balance remains aged from the patient discharge date.

Insurance Reserves

Given the nature of our operating environment, we are subject to professional and general liability and workers compensation claims and related lawsuits in the ordinary course of business. For claims reported through May 31, 2006, our captive subsidiary insured our professional and general liability risks at a $10.0 million retention level. For claims reported subsequent to May 31, 2006, we self-insure the first $9.0 million per occurrence, and the captive subsidiary insures the next $1.0 million per occurrence. We maintain excess coverage from independent third party insurers on a claims-made basis for individual claims exceeding $10.0 million up to $75.0 million, but limited to total annual payments of $65.0 million in the aggregate. We self-insure our workers compensations claims up to $1.0 million per claim and purchase excess insurance coverage for claims exceeding $1.0 million.

The following tables summarize our professional and general liability and workers compensation reserve balances as of June 30, 2006 and 2007 and our total provision for professional and general liability and workers compensation losses and related claims payments (including discontinued operations) during the years ended June 30, 2005, 2006 and 2007, respectively.

	Professional and General Liability	Workers Compensation
	(In millions)	
Reserve balance:		
June 30, 2006	$ 58.8	$ 15.3
June 30, 2007	$ 64.6	$ 18.5
Provision for claims losses:		
Fiscal Year 2005	$ 18.8	$ 11.3
Fiscal Year 2006	$ 21.0	$ 8.9
Fiscal Year 2007	$ 20.2	$ 9.4
Claims paid:		
Fiscal Year 2005	$ 9.2	$ 6.4
Fiscal Year 2006	$ 12.7	$ 6.4
Fiscal Year 2007	$ 14.4	$ 6.2

We use actuarial information to estimate our reserves for professional and general liability and workers compensation claims. Each reserve is comprised of estimated indemnity and expense payments related to: 1) reported events ("case reserves") and 2) incurred but not reported ("IBNR") events as of the end of the period. Management uses information from its risk managers and its best judgment to estimate case reserves. Actuarial estimates are dependent on multiple variables including our loss exposures, our self-insurance limits, geographic locations in which we operate, the severity of our historical losses compared to industry averages and the reporting pattern of our historical losses compared to industry averages, among others. Most of these variables require judgment, and changes in these variables could result in significant period over period fluctuations in our estimates. We adjust these reserves from time to time as we receive updated information. During fiscal 2006 and 2007, due to changes in historical loss trends, we decreased our professional and general liability reserve related to prior fiscal years by $6.9 million and $4.5 million, respectively. During fiscal 2005, we increased our workers compensation reserve related to prior fiscal years by $2.0 million. Fiscal 2006 and 2007 adjustments to the workers compensation reserve related to prior years were not significant. Given the fact that we have operated our hospitals for relatively short periods of time, we expect that additional adjustments to prior year estimates may occur as our reporting history and loss portfolio matures.

The actuarial information includes a best estimate of IBNR using statistical confidence levels that we deem adequate. Using a higher statistical confidence level would increase the estimated reserve. The following table illustrates the sensitivity of the reserve estimates at 75% and 90% confidence levels.

	Professional and General Liability	Workers Compensation
	(In millions)	
June 30, 2006 reserve:		
As reported	$ 58.8	$ 15.3
With 75% Confidence Level	$ 69.4	$ 16.1
With 90% Confidence Level	$ 80.0	$ 16.7
June 30, 2007 reserve:		
As reported	$ 64.6	$ 18.5
With 75% Confidence Level	$ 76.9	$ 20.8
With 90% Confidence Level	$ 88.9	$ 22.6

Medical Claims Reserves

During the years ended June 30, 2005, 2006 and 2007, medical claims expense was approximately $237.2 million, $270.3 million and $297.0 million, respectively, primarily representing medical claims of PHP and AAHP. We estimate our reserve for medical claims using historical claims experience (including severity and payment lag time) and other actuarial data including number of enrollees and the enrollee's county of residence. The reserve for medical claims, including incurred but not reported claims, for our health plans was approximately $44.0 million and $57.2 million as of June 30, 2006 and 2007, respectively. While management believes that its estimation methodology effectively captures trends in medical claims costs, actual payments could differ significantly from its estimates given changes in the healthcare cost structure or adverse experience. During the years ended June 30, 2005, 2006 and 2006, approximately $36.6 million, $40.0 million and $34.2 million, respectively, of accrued and paid claims for services provided to our health plan enrollees by our hospitals and our other healthcare facilities were eliminated in consolidation. Our operating results and cash flows could be materially affected by increased or decreased utilization of our healthcare facilities by enrollees in our health plans.

Income Taxes

We believe that our tax return provisions are accurate and supportable, but certain tax matters require interpretations of tax law that may be subject to future challenge and may not be upheld under tax audit. To reflect the possibility that all of our tax positions may not be sustained, we maintain tax reserves that are subject to adjustment as updated information becomes available or as circumstances change. We record the impact of tax reserve changes to our income tax provision in the period in which the additional information, including the progress of tax audits, is obtained.

We assess the realization of our deferred tax assets to determine whether an income tax valuation allowance is required. Based on all available evidence, both positive and negative, and the weight of that evidence to the extent such evidence can be objectively verified, we determine whether it is more likely than not that all or a portion of the deferred tax assets will be realized. The factors used in this determination include the following:

- Cumulative losses in recent years
- Income/losses expected in future years
- Unsettled circumstances that, if favorably resolved, would adversely affect future operations
- Availability, or lack thereof, of taxable income in prior carryback periods that would limit realization of tax benefits
- Carryforward period associated with the deferred tax assets and liabilities
- Prudent and feasible tax planning strategies

In addition, financial forecasts used in determining the need for or amount of federal and state valuation allowances are subject to changes in underlying assumptions and fluctuations in market conditions that could significantly alter our recoverability analysis and thus have a material adverse impact on our consolidated financial condition, results of operations or cash flows.

Long-Lived Assets and Goodwill

Long-lived assets, including property, plant and equipment and amortizable intangible assets, comprise a significant portion of our total assets. We evaluate the carrying value of long-lived assets when impairment indicators are present or when circumstances indicate that impairment may exist under the provisions of SFAS 144, *Accounting for the Impairment or Disposal of Long-Lived Assets*. When we believe impairment indicators may exist, we prepare projections of the undiscounted future cash flows associated with the use of and eventual disposition of long-lived assets held for use. If the projections indicate that the carrying values of the long-lived assets are not expected to be recoverable, we reduce the carrying values to fair value. For long-lived assets held for sale, we compare the carrying values to an estimate of fair value less selling costs to determine potential impairment. We test for impairment of long-lived assets at the lowest level for which cash flows are measurable. These impairment tests are heavily influenced by assumptions and estimates that are subject to change as additional information becomes available. Given the relatively few number of hospitals we own and the significant amounts of long-lived assets

attributable to those hospitals, an impairment of the long-lived assets for even a single hospital could materially adversely impact our operating results or statement of position.

Goodwill also represents a significant portion of our total assets. We review goodwill for impairment annually during our fourth fiscal quarter or more frequently if certain impairment indicators arise under the provisions of SFAS 142, *Goodwill and Other Intangible Assets*. We review goodwill at the reporting level unit, which is one level below an operating segment. We compare the carrying value of the net assets of each reporting unit to the net present value of estimated discounted future cash flows of the reporting unit. If the carrying value exceeds the net present value of estimated discounted future cash flows, an impairment indicator exists and an estimate of the impairment loss is calculated. The fair value calculation includes multiple assumptions and estimates, including the projected cash flows and discount rates applied. Changes in these assumptions and estimates could result in goodwill impairment that could materially adversely impact our results of operations or statement of position.

We have recently experienced gradual changes to the business climate at our Chicago hospitals, the most significant being payer mix shifts, which have resulted in weaker than expected operating results at those hospitals. We believe that these trends may not be temporary in nature and may not be sufficiently offset by various initiatives to improve operating results. Accordingly, we performed an impairment test of the long-lived assets of these hospitals under SFAS 144 and SFAS 142 effective December 31, 2006. Based upon an independent third party fair value estimate, we recorded a $123.8 million ($110.5 million, net of tax benefit) impairment charge during fiscal 2007. The independent third party fair value estimate was developed using a discounted net cash flows approach and two market-based approaches. As a result of the impairment charge, we reduced goodwill for our acute care services segment $123.8 million. Further reductions in the fair value of our hospitals could materially adversely impact our financial position and results of operations.

We completed our annual goodwill impairment test during the fourth quarter of fiscal 2007 noting no impairment. However, two of our reporting units, with combined goodwill of $140.0 million, will require continual monitoring during fiscal year 2008 due to the sensitivity of the projected operating results of these reporting units to the goodwill impairment analysis. If projected future cash flows become less favorable than those projected by management, impairments may become necessary that could have a material adverse impact on our financial position and results of operations.

Selected Operating Statistics

The following table sets forth certain operating statistics for the periods indicated below.

	Year Ended June 30,		
Actual:	**2005**	**2006**	**2007**
Number of hospitals at end of period	15	15	15
Number of licensed beds at end of period	3,907	3,937	4,143
Discharges (a)	147,798	162,446	166,873
Adjusted discharges - hospitals (b)	231,322	261,422	265,448
Net revenue per adjusted discharge-hospitals (c)	$ 6,859	$ 7,332	$ 7,798
Patient days (d)	623,333	701,307	721,832
Adjusted patient days-hospitals (e)	975,593	1,128,603	1,148,233
Average length of stay (days) (f)	4.2	4.3	4.3
Outpatient surgeries (g)	67,944	76,437	76,606
Emergency room visits (h)	504,172	554,250	572,946
Occupancy rate (i)	48.5%	49.2%	48.4%
Average daily census (j)	1,708	1,921	1,978
Member lives (k)	146,700	146,200	145,600
Medical claims expense percentage (l)	71.1%	72.1%	74.0%

Same hospital:	Year ended June 30, 2005	2006
Number of hospitals at end of period	12	12
Total revenues (in millions) (m)	$ 1,797.1	$ 1,931.0
Patient service revenues (in millions) (n)	$ 1,463.6	$ 1,551.8
Discharges (o)	130,777	130,229
Average length of stay (days) (p)	4.1	4.2
Patient days (q)	541,244	552,562
Adjusted discharges-hospitals (r)	197,832	197,203
Adjusted patient days-hospitals (s)	818,764	836,732
Net revenue per adjusted discharge-hospitals (t)	$ 6,873	$ 7,378
Outpatient surgeries (u)	58,104	56,764
Emergency room visits (v)	447,257	441,847

(a) Discharges represent the total number of patients discharged (in the facility for a period in excess of 23 hours) from our hospitals and is used by management and certain investors as a general measure of inpatient volumes.

(b) Adjusted discharges-hospitals is used by management and certain investors as a general measure of combined hospital inpatient and outpatient volumes. Adjusted discharges-hospitals is computed by multiplying discharges by the sum of gross hospital inpatient and outpatient revenues and then dividing the result by gross hospital inpatient revenues.

(c) Net revenue per adjusted discharge-hospitals is calculated by dividing net hospital patient revenues by adjusted discharge-hospitals and measures the average net payment expected to be received for a patient's stay in the hospital.

(d) Patient days represent the number of days (calculated as overnight stays) our beds were occupied by patients during the periods.

(e) Adjusted patient days-hospitals is calculated by multiplying patient days by the sum of gross hospital inpatient and outpatient revenues and then dividing the result by gross hospital inpatient revenues. This computation is an indicator of combined inpatient and outpatient volumes.

(f) Average length of stay represents the average number of days an admitted patient stays in our hospitals.

(g) Outpatient surgeries represent the number of surgeries performed at hospitals or ambulatory surgery centers on an outpatient basis (patient overnight stays not necessary).

(h) Emergency room visits represent the number of patient visits to a hospital emergency room where treatment is received, regardless of whether an overnight stay is subsequently required.

(i) Occupancy rate represents the percentage of hospital licensed beds occupied by patients. Occupancy rate provides a measure of the utilization of inpatient rooms.

(j) Average daily census represents the average number of patients in our hospitals each day during our ownership.

(k) Member lives represent the total number of enrollees in PHP, AAHP and MHP as of the end of the respective period.

(l) Medical claims expense percentage is calculated by dividing medical claims expense by premium revenues.

(m) Same hospital total revenues represent revenues from entities owned (including health plans) for the full 12 months of both years presented.

(n) Same hospital patient service revenues represent patient service revenues (excluding health plan premium revenues) from entities owned for the full 12 months of both years presented.

(o) Same hospital discharges represent discharges for hospitals owned for the full 12 months of both years presented.

(p) Same hospital average length stay represents average length of stay days for hospitals owned for the full 12 months of both years presented.

(q) Same hospital patient days represent patient days for hospitals owned for the full 12 months of both years presented.

(r) Same hospital adjusted discharges-hospitals is calculated by multiplying discharges by the sum of gross hospital inpatient and outpatient revenues and then dividing the result by gross hospital inpatient revenues for all hospitals owned for the full 12 months of both years presented.

(s) Same hospital adjusted patient days-hospitals is calculated by multiplying patient days by the sum of gross hospital inpatient and outpatient revenues and then dividing the result by gross hospital inpatient revenues for all hospitals owned for the full 12 months of both years presented.

(t) Same hospital net revenue per adjusted discharge-hospitals is calculated by dividing hospital net patient revenues by adjusted discharges-hospitals for those hospitals owned for the full 12 months of both years presented. This statistic measures the average net payment expected to be received for a patient's stay in those hospitals owned during both respective periods.

(u) Same hospital outpatient surgeries represent the number of surgeries performed at hospitals or ambulatory surgery centers owned for the full 12 months of both years presented, on an outpatient basis (patient overnight stays not necessary).

(v) Same hospital emergency room visits represent the number of patient visits to receive treatment at a hospital emergency room owned for the full 12 months of both years presented, regardless of whether an overnight stay is subsequently required.

Results of Operations

The following tables present a summary of our operating results for the respective periods shown.

	Year Ended June 30,					
	2005		2006		2007	
	Amount	%	Amount	%	Amount	%
Actual:	*(Dollars in millions)*					
Patient service revenues	$ 1,703.8	83.6%	$ 2,043.6	84.5%	$ 2,179.3	84.4%
Premium revenues	333.5	16.4	375.0	15.5	401.4	15.6
Total revenues	2,037.3	100.0	2,418.6	100.0	2,580.7	100.0
Salaries and benefits (includes stock compensation of $97.4, $1.7 and $1.2 respectively)	909.2	44.6	991.4	41.0	1,067.9	41.4
Supplies	336.8	16.5	394.1	16.3	421.8	16.3
Medical claims expense	237.2	11.7	270.3	11.2	297.0	11.5
Provision for doubtful accounts	133.0	6.5	156.8	6.5	175.2	6.8
Other operating expenses	288.8	14.2	353.0	14.6	375.0	14.5
Depreciation and amortization	75.7	3.7	100.3	4.1	118.6	4.6
Interest, net	82.3	4.0	103.8	4.3	123.8	4.8
Debt extinguishment costs	62.2	3.1	0.1	0.0	–	0.0
Merger expenses	23.3	1.1	–	0.0	–	0.0
Impairment loss	–	0.0	–	0.0	123.8	4.8
Other expenses	3.3	0.2	9.1	0.4	2.8	0.1
Income (loss) from continuing operations before income taxes	(114.5)	(5.6)	39.7	1.6	(125.2)	(4.8)
Provision for income taxes	(34.7)	(1.7)	16.2	0.7	(11.6)	(0.4)
Income (loss) from continuing operations	(79.8)	(3.9)	23.5	0.9	(113.6)	(4.4)
Income (loss) from discounted operations, net of taxes	1.7	0.0	(10.6)	(0.4)	(19.1)	(0.7)
Net income (loss)	$ (78.1)	(3.9)%	$ 12.9	0.5%	$ (132.7)	(5.1)%

	Year Ended June 30,			
	2005		2006	
	Amount	%	Amount	%
Same hospital:	*(Dollars in millions)*			
Patient service revenues	$ 1,463.6	81.4%	$ 1,556.0	80.6%
Premium revenues	333.5	18.6	375.0	19.4
Total revenues	1,797.1	100.0	1,931.0	100.0
Salaries and benefits (includes stock compensation of $97.4 and $1.7, respectively)	782.7	43.6	732.2	37.9
Supplies	292.9	16.3	298.4	15.5
Medical claims expense	237.2	13.2	270.3	14.0
Provision for doubtful accounts	120.8	6.7	140.9	7.3
Other operating expenses	249.6	13.9	281.7	14.6
Depreciation and amortization	70.6	3.9	86.1	4.4
Interest, net	82.3	4.6	103.8	5.4
Debt extinguishment costs	62.2	3.4	0.1	0.0
Merger expenses	23.3	1.3	–	0.0
Other expenses	3.4	0.2	9.6	0.5
Income (loss) from continuing operations	(127.9)	(7.1)	7.9	0.4
Income (loss) from discounted operations, net of taxes	1.7	0.1	(10.6)	(0.5)
Loss before income taxes	$ (126.2)	(7.0)%	$ (2.7)	(0.1)%

Year Ended June 30, 2007 Compared to the Year Ended June 30, 2006

Revenues. Patient service revenues increased by 6.6% year over year primarily as a result of a 6.4% increase in patient revenues per adjusted hospital discharge and a 1.5% increase in adjusted hospital discharges. Outpatient volumes increased year over year with outpatient surgeries increasing 0.2% and emergency room visits increasing 3.4%. However, much of the year over year revenues improvement related to low acuity services provided to uninsured and Medicaid patients. Self-pay and Medicaid discharges increased 19.6% and 9.8%, respectively, year over year, while combined Medicare, managed care and commercial discharges were relatively flat year over year. We also continued to generate a lot of our inpatient stays from emergency room activity. We attribute this payer mix shift to the continued rising cost of healthcare insurance that has forced many people to go uninsured or else participate in a plan with higher deductibles and coinsurance. Additionally, we face continued intense competition from other hospitals to recruit and retain the best physicians to practice in their facilities. In order to improve our operating results, we must increase our elective inpatient and outpatient business to counterbalance the shift in payer mix we have experienced during fiscal 2007. We expect that our service mix and physician initiatives and our recently completed hospital expansion projects will positively impact our payer mix and acuity in the short-term. We believe our quality initiatives will be the catalyst for long-term revenue growth especially given the forecasted population growth for most of the markets in which we operate. However, environmental factors outside our control, including patient demand, payer pressures and increased competition could limit our future revenue growth.

Premium revenues increased by 7.0% during fiscal 2007 primarily as a result of having AAHP operations for the full fiscal year. Per member per month reimbursement rates are significantly higher under AAHP than under the traditional AHCCCS Medicaid program. Per member per month reimbursement for PHP also increased effective October 1, 2006, and PHP supplemental revenues increased year over year. Total average membership in PHP and AAHP decreased slightly from approximately 100,300 during fiscal 2006 to approximately 99,500 during fiscal 2007.

Costs and Expenses. Total costs and expenses, exclusive of income taxes and discontinued operations, were $2,705.9 million or 104.8% of total revenues during fiscal 2007 compared to 98.4% during fiscal 2006. Fiscal 2007 costs and expenses were negatively impacted by the impairment loss related to our Chicago hospitals and significant increases in net interest and depreciation and amortization. Salaries and benefits, supplies, medical claims and provision for doubtful accounts represent our most significant individual costs and expenses or those subject to the greatest level of fluctuation period over period.

- **Salaries and benefits**. Salaries and benefits as a percentage of total revenues increased to 41.4% during fiscal 2007 from 41.0% during fiscal 2006 primarily as a result of salaries and benefits pressures in our Phoenix market. The national nursing shortage has been particularly challenging in Phoenix during the past few years. Our salaries and benefits at our Phoenix hospitals increased by 2.5% of patient service revenues year over year primarily due to a 6.5% year over year increase in total hospital employed and contract labor full-time equivalents and the limited revenue growth previously discussed. We were successful in building our employed nurse workforce in Phoenix and decreasing our dependence on contract labor in light of the nursing shortage. We believe this transition will allow us to implement our quality initiatives more quickly and efficiently. We also successfully negotiated a new three-year union contract with a significant portion of our nurse workforce in Massachusetts during fiscal 2007.

  While we believe the nursing shortage will persist during the foreseeable future, we believe our comprehensive nursing recruiting and retention plan and nursing education programs will mitigate the impact of the nursing shortage to a certain degree and allow us to maintain or grow our nurse workforce as needed. We expect that salaries and benefits as a percentage of total revenues will increase slightly during fiscal 2008 as a result of these recruiting and retention initiatives and increased wages under the recently negotiated Massachusetts union contracts, but the ratio should be relatively stable in future years as our revenue growth strategies are implemented. However, should revenue growth not occur as expected or should we be forced to revert back to using more contract labor, our salaries and benefits as a percentage of total revenues could rise significantly in future years.

- **Supplies**. Supplies as a percentage of total revenues remained flat at 16.3% year over year. Supplies as a percentage of patient service revenues increased slightly to 19.4% during fiscal 2007 compared to 19.3% during fiscal 2006. Advances in medical technologies and new medications continue to pressure our supplies costs. We added additional corporate resources and increased our focus on supply chain management and group purchasing organization compliance during fiscal 2007 to manage supplies utilization. We expect improvement in supplies utilization during fiscal 2008 as a result of these initiatives. However, because most of our growth strategies include expansion of high acuity services, we will continue to be exposed to increased pricing pressures for pharmaceuticals and expensive medical devices including those used in cardiac and orthopedic surgeries.

- **Medical claims expense**. Medical claims expense as a percentage of premium revenues increased from 72.1% during fiscal 2006 to 74.0% during fiscal 2007 primarily as a result of increased healthcare utilization by PHP enrollees during fiscal 2007. Inpatient days for PHP enrollees increased by 3.5% year over year. Medical claims expense represents the amounts paid by the health plans for healthcare services provided to their members, including an estimate of incurred but not reported claims that is determined based upon lag data and other actuarial assumptions. Revenues and expenses between the health plans and our hospitals and related outpatient service providers of approximately $34.2 million, or 10.3% of gross health plan medical claims expense, were eliminated in consolidation during fiscal 2007.

- **Provision for doubtful accounts**. During fiscal 2007, the provision for doubtful accounts as a percentage of patient service revenues increased to 8.0% from 7.7% during fiscal 2006. During fiscal 2007, self-pay revenues as a percentage of net patient revenues increased from 9.2% to 9.7%. Self-pay discharges as a percentage of total discharges increased from 3.2% during fiscal 2006 to 3.7% during fiscal 2007. Our provision for doubtful accounts as a percentage of patient service revenues is reduced by our policy of deducting charity accounts from revenues at the time in which those accounts meet our charity care guidelines. On a combined basis, the provision for doubtful accounts and charity care deductions as a percentage of patient service revenues increased to 12.0% during fiscal 2007 compared to 11.2% during fiscal 2006. We do not expect these ratios to improve significantly in the near future given current trends in patient insurance coverage. However, we believe our upfront collection efforts and revenues growth initiatives will help mitigate future increases to these ratios.

Other operating expenses. Other operating expenses include, among others, purchased services, insurance, property taxes, rents and leases, repairs and maintenance and utilities. Other operating expenses as a percentage of total revenues were relatively flat year over year. We continue to incur increasing physician costs for coverage in our emergency rooms and other specialty programs. Our repairs and maintenance costs also increased year over year as we continue to roll out portions of our quality information systems in our hospitals.

Other. Depreciation and amortization as a percentage of total revenues increased to 4.6% during fiscal 2007 compared to 4.1% during fiscal 2006 as a result of our capital improvement and expansion initiatives. Four of our six significant expansion projects were placed into service during fiscal 2007 and portions of the other two were completed during fiscal 2007. The increase in net interest as a percentage of total revenues to 4.8% during fiscal 2007 compared to 4.3% during fiscal 2006 resulted primarily from our incurring interest on the September 2005 $175.0 million delayed draw term loan borrowing for all 12 months of fiscal 2007 and increased LIBOR rates on our term loan borrowings. As previously discussed, we incurred a $123.8 million ($110.5 million, net of tax benefit) impairment loss during fiscal 2007 related to our Chicago hospitals.

Income taxes. The effective tax rate decreased from 40.8% in fiscal 2006 to 9.3% in fiscal 2007. The significant decrease is due to the majority of the Chicago impairment loss during fiscal 2007 being nondeductible for tax purposes.

Discontinued operations. The significant year over year increase in loss from discontinued operations, net of taxes, primarily relates to the deterioration in the operating results of PMH during fiscal 2007 that led to our decision to eliminate acute care services at PMH.

Net income. The $145.6 million year over year decrease in net income resulted primarily from the after tax impact of the impairment loss recorded during fiscal 2007 and the significant increases in depreciation and amortization and net interest discussed above.

Year ended June 30, 2006 compared to Year ended June 30, 2005

Revenues. $247.4 million of the $381.3 million increase in total revenues during fiscal 2006 related to our acquisition of the Massachusetts hospitals, while same hospital revenues improved by $133.9 million. We experienced weakened demand for inpatient and outpatient healthcare services during fiscal 2006. Same hospital adjusted discharges decreased by 0.3% during fiscal 2006. Same hospital emergency room visits and outpatient surgeries decreased by 1.2% and 2.3%, respectively, during fiscal 2006. We attribute this weakened demand to multiple factors including a mild respiratory illness season, decreases in rehabilitation discharges as a result of regulatory changes, greater competition from other hospitals in recruiting and retaining quality physicians and the increase in the number of uninsured patients or those insured patients with higher coinsurance and deductible limits. Although our same hospital volumes declined during fiscal 2006, we realized an 7.3% increase in same hospital net revenue per adjusted discharge compared to fiscal 2005. We implemented successful service mix strategies and realized improved reimbursement from managed care payers and Medicare.

Premium revenues increased 12.4% during fiscal 2006 as a result of the start of AAHP's operations on January 1, 2006. During fiscal 2006, approximately 3,500 PHP members became AAHP members. Per member per month reimbursement rates are significantly higher under AAHP than under the traditional AHCCCS Medicaid program. Per member per month reimbursement for PHP also increased effective October 1, 2005. Total average membership in PHP and AAHP increased from approximately 99,000 during fiscal 2005 to approximately 100,300 during fiscal 2006.

Costs and Expenses. Total costs and expenses, exclusive of income taxes and discontinued operations, were $2,378.9 million or 98.4% of total revenues during fiscal 2006, an improvement from 105.6% during fiscal 2005. Fiscal 2005 costs and expenses were negatively impacted by costs associated with the Merger. Salaries and benefits, supplies, medical claims and provision for doubtful accounts represent our most significant individual costs and expenses or those subject to the greatest level of fluctuation period over period.

- **Salaries and benefits.** Salaries and benefits as a percentage of total revenues decreased to 41.0% during fiscal 2006 from 44.6% during fiscal 2005. The decrease resulted primarily from a $95.7 million decrease in stock compensation. Absent the effect of stock compensation, this ratio would have increased to 40.9% during fiscal 2006 compared to 39.8% during fiscal 2005. Our fiscal 2006 salaries and benefits as a percentage of total revenues was adversely impacted by the additional six months of operations of the Massachusetts hospitals. We incurred higher salaries and benefits costs in Massachusetts, because approximately 1,550 of those employees were unionized as of June 30, 2006. On a same hospital basis, salaries and benefits excluding stock compensation as a percentage of total revenues decreased to 37.8% during fiscal 2006 compared to 38.1% during fiscal 2005.

  The national nursing shortage hindered our ability to fully manage salaries and benefits. We experienced particular difficulty in retaining and recruiting nurses in our metropolitan Phoenix market and were required to utilize more costly and less efficient temporary nurse staffing.

- **Supplies**. Supplies as a percentage of total revenues decreased to 16.3% during fiscal 2006 from 16.5% during fiscal 2005. Supplies as a percentage of patient service revenues decreased to 19.3% during fiscal 2006 compared to 19.8% during fiscal 2005. The year over year improvement in this ratio resulted from our efforts to increase utilization of our group purchasing organization and to implement our materials management strategies in Massachusetts.

- **Medical claims expense.** Medical claims expense as a percentage of premium revenues increased from 71.1% during fiscal 2005 to 72.1% during fiscal 2006 primarily as a result of the start of AAHP operations on January 1, 2006. Medical claims expense represents the amounts paid by the health plans for healthcare services provided to their members, including an estimate of incurred but not reported claims that is determined based upon lag data and other actuarial assumptions. Revenues and expenses

between the health plans and our hospitals and related outpatient service providers of approximately $40.0 million, or 12.9% of gross health plan medical claims expense, were eliminated in consolidation during fiscal 2006.

- **Provision for doubtful accounts.** During fiscal 2006, the provision for doubtful accounts as a percentage of patient service revenues remained relatively flat with that of fiscal 2005. During fiscal 2006, self-pay revenues as a percentage of net patient revenues decreased from 11.0% to 9.2%. Under our hindsight estimation methodology, our provision for doubtful accounts may be adversely affected by delays in the timing of non self-pay account collections period over period. We experienced improved upfront cash collections and success in qualifying patients for coverage under Medicaid or similar programs during fiscal 2006. Our provision for doubtful accounts as a percentage of patient service revenues is reduced by our policy of deducting charity accounts from revenues at the time in which those accounts meet our charity care guidelines. On a combined basis, the provision for doubtful accounts and charity care deductions as a percentage of patient service revenues increased to 11.2% during fiscal 2006 compared to 10.8% during fiscal 2005.

Other operating expenses. Other operating expenses include, among others, purchased services, insurance, property taxes, rents and leases, repairs and maintenance and utilities. Other operating expenses as a percentage of total revenues increased to 14.6% during fiscal 2006 compared to 14.2% during fiscal 2005. This increase resulted primarily from increased repairs and maintenance of $11.3 million.

Other. Depreciation and amortization as a percentage of total revenues increased to 4.1% during fiscal 2006 compared to 3.7% during fiscal 2005 as a result of our capital improvement and expansion initiatives. The increase in net interest as a percentage of total revenues to 4.3% during fiscal 2006 compared to 4.0% during fiscal 2005 resulted primarily from our $175.0 million delayed draw term loan borrowing in September 2005. We incurred significant debt extinguishment costs and other expenses related to the Merger during fiscal 2005.

Income taxes. The effective tax rate increased from 30.3% in fiscal 2005 to 40.8% in fiscal 2006. This increase was due to certain Merger-related costs that were non-deductible for tax purposes during fiscal 2005.

Discontinued operations. The significant loss from discontinued operations during fiscal 2006 was primarily attributable to the after tax impact of a $15.0 million impairment charge related to the excess carrying value of our California hospital asset group, which was sold in October 2006, over the asset group's fair value.

Net income. The $91.0 million year over year increase in net income resulted from the increased revenues as described above in excess of increased expenses. Net income during fiscal 2005 was adversely affected by the significant Merger-related costs.

Liquidity and Capital Resources

Operating Activities

At June 30, 2007, we had working capital of $156.4 million, including cash and cash equivalents of $120.1 million. Working capital at June 30, 2006 was $193.0 million. Cash provided by operating activities decreased from $149.3 million during fiscal 2006 to $123.3 million during fiscal 2007. The significant decrease was due to a $23.2 million growth in net accounts receivable from continuing operations, a $7.1 million reduction in cash flows from discontinued operations and a $6.5 million increase in interest payments during fiscal 2007 compared to fiscal 2006. Net days in accounts receivable from continuing operations increased approximately 2 days year over year. Cash provided by discontinued operations decreased year over year primarily due to the deterioration in operations at the California hospitals and PMH during fiscal 2007 that exceeded the net decrease in working capital at those hospitals.

Investing Activities

Cash used in investing activities decreased from $245.4 million during fiscal 2006 to $118.5 million during fiscal 2007, primarily as a result of $111.2 million period over period decrease in capital expenditures. During fiscal 2007, capital spending on our six significant expansion projects described below slowed considerably as certain of

these projects were completed in their entirety and portions of others were completed at various times throughout fiscal 2007.

In May 2004 and July 2005, our board of directors approved major expansion projects at six of our existing hospitals in San Antonio and metropolitan Phoenix. Through June 30, 2007, we have spent approximately $296.1 million related to these projects and expect to incur the remaining $40.9 million during our next two fiscal years. All of these projects will result in additional capacity at each of the six hospitals. In addition, most of the projects will facilitate an expansion of clinical service capabilities. The following table summarizes these major expansion projects as of September 1, 2007.

Hospital	Estimated Construction Period		Approximate Additional Licensed Bed Capacity	Approximate Additional Licensed Beds Completed	Additional Emergency Room Positions	Additional Operating Rooms	Additional Labor & Delivery Rooms
	Begin	Completed					
Phoenix							
Arrowhead Hospital	Q4 FY 04	Q1 FY 07	100	100	✓	✓	✓
Paradise Valley Hospital	Q1 FY 07	Q3 FY 09	22 (4)	0	(2)	✓	✓
West Valley Hospital	Q1 FY 06	Q4 FY 07	57	57	✓	✓	(1)
San Antonio							
North Central Baptist Hospital	Q4 FY 04	Q2 FY 07	140	140	✓	✓	✓
Northeast Baptist Hospital	Q4 FY 04	Q2 FY 07	33 (3)	33	✓	✓	✓
St. Luke's Baptist Hospital	Q2 FY 06	Q4 FY 07	27	27			

(1) Increased post partum capacity to better utilize labor, delivery and recovery suites.
(2) An expanded emergency room was opened in July 2004, expanding capacity from 16 to 28 bays.
(3) In addition to increasing the number of licensed beds by 33, the expansion project allows for the utilization of an additional 67 previously licensed beds.
(4) In addition to increasing the number of licensed beds by 22, the expansion will allow for the utilization of an additional 18 previously licensed beds.

We anticipate spending a total of $140.0 million to $160.0 million in capital expenditures during fiscal 2008. This estimate includes significant spending for our clinical information systems necessary to support our quality initiatives and all other renovation projects and technology upgrades at our facilities. These capital expenditures will be funded by cash flows from operations and availability under our revolving credit facility. We believe our capital expenditure program is sufficient to service, expand and improve our existing facilities to meet our quality objectives.

Financing Activities

Cash provided by financing activities decreased from $140.5 million during fiscal 2006 to an $8.3 million use of cash during fiscal 2007, due to the $175.0 million term loan borrowing during September 2005 and quarterly term loan principal repayments during fiscal 2007.

As of June 30, 2007, we had outstanding $1,528.7 million in aggregate indebtedness and $218.4 million of available borrowing capacity under our revolving credit facility ($250.0 million net of outstanding letters of credit of $31.6 million). Our liquidity requirements are significant, primarily due to debt service requirements. The 9.0% Notes require semi-annual interest payments. However, prior to October 1, 2009, the interest expense on the 11.25% Notes will consist solely of non-cash accretions of principal.

Our previous senior secured credit facilities executed in September 2004 consisted of a revolving credit facility and the initial term loan facility. Our revolving credit facility provides for loans in a total principal amount of up to $250.0 million, and matures in September 2010. The initial term loan facility, which was scheduled to mature in September 2011, provided for loans in a total principal amount of up to $800.0 million as follows: (1) $475.0 million borrowed on September 23, 2004 to finance the Merger, to refinance our then existing indebtedness and to pay fees and expenses relating thereto; (2) $150.0 million borrowed on December 31, 2004 and February 18,

2005 to finance the acquisition of the Massachusetts hospitals and for other general corporate purposes and (3) $175.0 million borrowed in September 2005 to fund capital expenditures and for other general corporate purposes.

On September 26, 2005, we refinanced and repriced all $795.7 million of the outstanding term loans under the initial term loan facility by borrowing $795.7 million of replacement term loans (the "2005 term loan facility").

The 2005 term loan facility borrowings bear interest at a rate equal to, at our option, a base rate plus 1.25% per annum or LIBOR plus 2.25% per annum. These rates reflect a savings of 1.0% per annum over the interest rate options for our previous initial term loan facility. The borrowings under the revolving credit facility currently bear interest at a rate equal to, at our option, a base rate plus 1.25% per annum or LIBOR plus 2.25% per annum. These rates are subject to increase by up to 0.25% per annum should our leverage ratio exceed certain designated levels.

We are required to pay a commitment fee to the lenders under the revolving credit facility in respect of the unutilized commitments thereunder at a rate equal to 0.50% per annum. We also pay customary letter of credit fees.

The 2005 term loan facility and the revolving credit facility contain a number of covenants that, among other things, restrict, subject to certain exceptions, our ability, and the ability of our subsidiaries, to sell assets, incur additional indebtedness or issue preferred stock, repay other indebtedness (including the 9.0% Notes and 11.25% Notes), pay dividends and distributions or repurchase our capital stock, create liens on assets, make investments, loans or advances, make certain acquisitions, engage in mergers or consolidations, enter into sale and leaseback transactions, engage in certain transactions with affiliates, amend certain material agreements governing our indebtedness, including the 9.0% Notes and 11.25% Notes, change the business conducted by our subsidiaries and enter into hedging agreements. In addition, the senior credit facilities require us to maintain the following financial covenants: a maximum total leverage ratio, a maximum senior leverage ratio, a minimum interest coverage ratio and a maximum capital expenditures limitation.

As of June 30, 2007, our capital expenditures, as defined in the senior credit agreement, were below the maximum covenant amount, and we were in compliance with the other debt covenant ratios as defined in our senior secured credit agreement, as follows.

	Debt Covenant Ratio	Actual Ratio
Interest coverage ratio requirement	2.00x	2.47x
Total leverage ratio limit	5.95x	4.76x
Senior leverage ratio limit	3.75x	2.41x

The senior credit facilities and the indentures governing the 9.0% Notes and the 11.25% Notes limit our ability to:

- incur additional indebtedness or issue preferred stock;
- pay dividends on or make other distributions or repurchase our capital stock or make other restricted payments;
- make investments;
- enter into certain transactions with affiliates;
- pay dividends or other similar payments by our subsidiaries;
- create liens on *pari passu* or subordinated indebtedness without securing the notes;
- designate the issuers' subsidiaries as unrestricted subsidiaries; and

- sell certain assets or merge with or into other companies or otherwise dispose of all or substantially all of their assets.

The table below summarizes our credit ratings as of the date of this filing.

	Standard & Poor's	Moody's
Corporate credit rating	B	B2
9.0% Senior Subordinated Notes	CCC+	Caa1
11.25% Senior Discount Notes	CCC+	Caa1
Senior credit facilities	B+	Ba3

We expect that cash generated from our operations and cash available to us under our revolving credit facility will be sufficient to meet our working capital needs, debt service requirements and planned capital expenditure programs that we consider necessary to continue our growth. However, we cannot assure you that our operations will generate sufficient cash or that future borrowings under our refinanced senior credit facilities will be available to enable us to meet these requirements and needs.

We continually assess our capital structure to ensure the optimal mix of debt and equity. As market conditions warrant, we and our primary equity sponsors, including The Blackstone Group L.P. and its affiliates, may from time to time, at our or their sole discretion, purchase, repay, redeem or retire any of our outstanding 9.0% Notes, 11.25% Notes, term or revolving loan borrowings or equity securities (including any publicly issued securities) in privately negotiated or open market transactions, by tender offer or otherwise.

We also intend to continue to pursue acquisitions or partnering arrangements, either in existing markets or new markets, which fit our growth strategies. To finance such transactions, we might have to draw upon amounts available under our revolving credit facility or seek additional funding sources. However, should our operating results and borrowing capacities not sufficiently support these capital projects or acquisition opportunities, our growth strategies may not be fully realized. Our future operating performance, ability to service or refinance our new debt and ability to draw upon other sources of capital will be subject to future economic conditions and other business factors, many of which are beyond our control.

Guarantees and Off Balance Sheet Arrangements

We are a party to certain rent shortfall agreements with certain unconsolidated entities, physician income guarantees and service agreement guarantees and other guarantee arrangements, including parent-subsidiary guarantees, in the ordinary course of business. We have not engaged in any transaction or arrangement with an unconsolidated entity that is reasonably likely to materially affect liquidity.

Obligations and Commitments

The following table reflects a summary of obligations and commitments outstanding with their payment dates as of June 30, 2007.

	Payments due by period				
	Within 1 year	During Years 2-3	During Years 4-5	After 5 years	Total
Contractual Cash Obligations:			*(In millions)*		
Long-term debt (1)	$ 119.0	$ 248.3	$ 981.9	$ 1,005.4	$ 2,354.6
Operating leases (2)	27.4	42.0	25.8	40.9	136.1
Purchase obligation (2)	22.6	–	–	–	22.6
Health claims payable (3)	57.2	–	–	–	57.2
Estimated self-insurance liabilities (4)	22.7	37.0	18.4	6.2	84.3
Subtotal	$ 248.9	$ 327.3	$ 1,026.1	$ 1,052.5	$ 2,654.8

	Payments due by period				
	Within 1 year	During Years 2-3	During Years 4-5	After 5 years	Total
Other Commitments:			*(In millions)*		
Construction and capital improvements (5)	$ 38.4	$ 12.1	$ –	$ –	$ 50.5
Guarantees of surety bonds (6)	19.0	–	–	–	19.0
Letters of credit (7)	–	–	31.6	–	31.6
Physician commitments (8)	4.9	–	–	–	4.9
Subtotal	$ 62.3	$ 12.1	$ 31.6	$ –	$ 106.0
Total obligations and commitments	$ 311.2	$ 339.4	$ 1,057.7	$ 1,052.5	$ 2,760.8

(1) Includes both principal and interest portions of outstanding debt. The interest portion of our variable rate debt assumes that the 7.61% rate as of June 30, 2007 remains stable over the remaining term of the debt.

(2) These obligations are not reflected in our consolidated balance sheet.

(3) Represents estimated payments to be made in future periods for healthcare costs incurred by enrollees in PHP, AAHP and MHP and is separately stated on our consolidated balance sheet.

(4) Includes the current and long-term portions of our professional and general liability, workers' compensation and employee health reserves.

(5) Represents our estimate of amounts we are committed to fund in future periods through executed agreements to complete projects included as construction in progress on our consolidated balance sheet.

(6) Represents performance bonds we have purchased related to medical claims liabilities of PHP.

(7) Amounts relate primarily to instances in which we have letters of credit outstanding with the third party administrator of our self-insured workers' compensation program.

(8) Includes physician guarantee liabilities recognized in our consolidated balance sheet under the provisions of FSP 45-3, *Application of FASB Interpretation No. 45 to Minimum Revenue Guarantees Granted to a Business or Its Owners*, and liabilities for other fixed expenses under physician relocation agreements not yet paid.

Healthcare Reform

In recent years, an increasing number of legislative proposals have been introduced or proposed to Congress and in some state legislatures that would significantly affect the services provided by and reimbursement to healthcare providers in our markets. The cost of certain proposals would be funded in significant part by reduction in payments by government programs, including Medicare and Medicaid, to healthcare providers or by taxes levied on hospitals or other providers. While we are unable to predict which, if any, proposals for healthcare reform will be adopted, we cannot assure you that proposals adverse to our business will not be adopted.

Federal and State Regulation and Investigations

The healthcare industry is subject to extensive federal, state and local laws and regulations relating to licensing, conduct of operations, ownership of facilities, addition of facilities and services, confidentiality and security issues associated with medical records, financial arrangements with physicians and other referral sources, and billing for services and prices for services. These laws and regulations are extremely complex and the penalties for violations are severe. In many instances, the industry does not have the benefit of significant regulatory or judicial interpretation of these laws and regulations. As a result of these laws and regulations, some of our activities could become the subject of governmental investigations or inquiries. Both federal and state government agencies have heightened and coordinated civil and criminal enforcement efforts as part of numerous ongoing investigations of hospital companies. Several hospital companies have settled allegations raised during such investigations for substantial sums out of concern for the possible exclusion from the Medicare and Medicaid programs. In the event of a determination that we are in violation of any of these laws, rules or regulations, or if further changes in the regulatory framework occur, our results of operations could be significantly harmed.

Effects of Inflation and Changing Prices

Various federal, state and local laws have been enacted that, in certain cases, limit our ability to increase prices. Revenues for acute hospital services rendered to Medicare patients are established under the federal government's prospective payment system. We believe that hospital industry operating margins have been, and may continue to be, under significant pressure because of changes in payer mix and growth in operating expenses in excess of the increase in prospective payments under the Medicare program. In addition, as a result of increasing regulatory and competitive pressures, our ability to maintain operating margins through price increases to non-Medicare patients is limited.

Item 7A. Quantitative and Qualitative Disclosures About Market Risk.

We are subject to market risk from exposure to changes in interest rates based on our financing, investing, and cash management activities. As of June 30, 2007, we had in place $1,031.9 million of senior credit facilities bearing interest at variable rates at specified margins above either the agent bank's alternate base rate or its LIBOR rate. The senior credit facilities consist of $781.9 million in term loans maturing in September 2011 and a $250.0 million revolving credit facility maturing in September 2010 (of which $31.6 million of capacity was utilized by outstanding letters of credit as of June 30, 2007). Although changes in the alternate base rate or the LIBOR rate would affect the cost of funds borrowed in the future, we believe the effect, if any, of reasonably possible near-term changes in interest rates would not be material to our results of operations or cash flows. Holding other variables constant, including levels of indebtedness, a 0.125% increase in interest rates would have an annual estimated impact on pre-tax income and cash flows of approximately $1.0 million.

The $250.0 million revolving credit facility bears interest at the alternate base rate plus a margin ranging from 1.00%-1.50% per annum or the LIBOR rate plus a margin ranging from 2.00%-2.50% per annum, in each case dependent upon our leverage ratio. Our current rate is LIBOR plus 2.25%. The revolving credit facility matures in September 2010. The $781.9 million in outstanding term loans bear interest at the alternate base rate plus a margin of 1.25% per annum or the LIBOR rate plus a margin of 2.25% per annum and mature in September 2011. Our current rate is approximately 7.6%.

From time to time, we use derivatives such as interest rate swaps to manage our market risk associated with variable rate debt or similar derivatives for fixed rate debt. We do not hold or issue derivative instruments for trading purposes and are not a party to any instruments with leverage features.

Item 8. Financial Statements and Supplementary Data.

INDEX TO CONSOLIDATED FINANCIAL STATEMENTS

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

Board of Directors
Vanguard Health Systems, Inc.

We have audited the accompanying consolidated balance sheets of Vanguard Health Systems, Inc. as of June 30, 2007 and 2006 and the related consolidated statements of operations, stockholders' equity and cash flows for the years ended June 30, 2007 and 2006 and for the period from September 23, 2004 to June 30, 2005 and the related consolidated statements of operations, stockholders' equity and cash flows of Vanguard Health Systems, Inc. (Predecessor) for the period from July 1, 2004 to September 22, 2004. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. We were not engaged to perform an audit of the Company's internal control over financial reporting. Our audits included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Vanguard Health Systems, Inc. at June 30, 2007 and 2006 and the consolidated results of its operations and its cash flows for the years ended June 30, 2007 and 2006 and the period from September 23, 2004 to June 30, 2005 and the consolidated results of its operations and its cash flows for the period from July 1, 2004 to September 22, 2004 (Predecessor) in conformity with U.S. generally accepted accounting principles.

/s/ Ernst & Young LLP

Nashville, Tennessee
September 11, 2007

VANGUARD HEALTH SYSTEMS, INC.
CONSOLIDATED BALANCE SHEETS

	June 30, 2006	June 30, 2007
	(In millions except share and per share amounts)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 123.6	$ 120.1
Restricted cash	–	6.2
Accounts receivable, net of allowance for doubtful accounts of approximately $103.5 and $113.2 at June 30, 2006 and 2007, respectively	294.1	287.3
Inventories	45.3	46.8
Assets held for sale	52.1	–
Prepaid expenses and other current assets	45.9	57.7
Total current assets	561.0	518.1
Property, plant and equipment, net of accumulated depreciation	1,159.5	1,186.6
Goodwill	812.8	689.2
Intangible assets, net of accumulated amortization	69.0	68.0
Investments in and advances to affiliates	8.2	7.3
Other assets	40.0	62.2
Total assets	$ 2,650.5	$ 2,531.4
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Accounts payable	$ 151.8	$ 144.1
Accrued salaries and benefits	78.5	75.0
Accrued health claims	44.0	57.2
Accrued interest	13.3	13.4
Other accrued expenses and current liabilities	72.1	64.0
Current maturities of long-term debt	8.3	8.0
Total current liabilities	368.0	361.7
Minority interests in equity of consolidated entities	9.4	9.3
Other liabilities	73.0	82.3
Long-term debt, less current maturities	1,510.9	1,520.7
Commitments and contingencies		
Stockholders' equity:		
Common Stock; $.01 par value, 1,000,000 shares authorized, 749,550 shares issued and outstanding at June 30, 2006 and 2007, respectively	–	–
Additional paid-in capital	643.7	644.6
Retained earnings (deficit)	45.5	(87.2)
Total stockholders' equity	689.2	557.4
Total liabilities and stockholders' equity	$ 2,650.5	$ 2,531.4

See accompanying notes.

VANGUARD HEALTH SYSTEMS, INC.
CONSOLIDATED STATEMENTS OF OPERATIONS

	For the Year Ended June 30,		
	Combined Basis		
	2005	2006	2007
		(In millions)	
Patient service revenues	$ 1,703.8	$ 2,043.6	$ 2,179.3
Premium revenues	333.5	375.0	401.4
Total revenues	2,037.3	2,418.6	2,580.7
Costs and expenses:			
Salaries and benefits (includes stock compensation of $97.4, $1.7 and $1.2, respectively)	909.2	991.4	1,067.9
Supplies	336.8	394.1	421.8
Medical claims expense	237.2	270.3	297.0
Purchased services	109.0	128.1	141.2
Provision for doubtful accounts	133.0	156.8	175.2
Other operating expenses	152.7	191.0	196.4
Rents and leases	27.1	33.9	37.4
Depreciation and amortization	75.7	100.3	118.6
Interest, net	82.3	103.8	123.8
Debt extinguishment costs	62.2	0.1	–
Merger expenses	23.3	–	–
Impairment loss	–	–	123.8
Other expenses	3.3	9.1	2.8
Income (loss) from continuing operations before income taxes	(114.5)	39.7	(125.2)
Income tax expense (benefit)	(34.7)	16.2	(11.6)
Income (loss) from continuing operations	(79.8)	23.5	(113.6)
Income (loss) from discontinued operations, net of taxes	1.7	(10.6)	(19.1)
Net income (loss)	(78.1)	12.9	(132.7)
Preferred stock dividends	(1.0)	–	–
Net income (loss) attributable to common stockholders	$ (79.1)	$ 12.9	$ (132.7)

See accompanying notes.

VANGUARD HEALTH SYSTEMS, INC.
CONSOLIDATED STATEMENTS OF OPERATIONS

	Predecessor		
	July 1, 2004 through September 22, 2004	September 23, 2004 through June 30, 2005	Year ended June 30, 2005 (combined basis)
		(In millions)	
Patient service revenues	$ 325.6	$ 1,378.2	$ 1,703.8
Premium revenues	72.3	261.2	333.5
Total revenues	397.9	1,639.4	2,037.3
Costs and expenses:			
Salaries and benefits (includes stock compensation of $96.7, $0.7 and $97.4, respectively)	248.2	661.0	909.2
Supplies	63.7	273.1	336.8
Medical claims expense	55.0	182.2	237.2
Purchased services	19.4	89.6	109.0
Provision for doubtful accounts	27.8	105.2	133.0
Other operating expenses	32.8	119.9	152.7
Rents and leases	5.1	22.0	27.1
Depreciation and amortization	16.0	59.7	75.7
Interest, net	9.0	73.3	82.3
Debt extinguishment costs	62.2	–	62.2
Merger expenses	23.1	0.2	23.3
Other expenses	(0.1)	3.4	3.3
Income (loss) from continuing operations before income taxes	(164.3)	49.8	(114.5)
Income tax expense (benefit)	(52.2)	17.5	(34.7)
Income (loss) from continuing operations	(112.1)	32.3	(79.8)
Income from discontinued operations, net of taxes	1.4	0.3	1.7
Net income (loss)	(110.7)	32.6	(78.1)
Preferred stock dividends	(1.0)	–	(1.0)
Net income (loss) attributable to common stockholders	$ (111.7)	$ 32.6	$ (79.1)

See accompanying notes.

VANGUARD HEALTH SYSTEMS, INC.
CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

	Preferred Stock		Common Stock		Additional Paid-In Capital	Retained Earnings (Deficit)	Total Stockholders' Equity
	Shares	Amount	Shares	Amount			
			(In millions, except share amounts)				
Balance at June 30, 2004 (predecessor)	–	$ –	232,749	$ –	$ 348.7	$ 63.3	$ 412.0
Issuance of common stock	–	–	35	–	–	–	–
Payable-In-Kind Preferred Stock dividends	–	–	–	–	(1.0)	–	(1.0)
Stock compensation (non-cash)	–	–	–	–	0.1	–	0.1
Net loss, July 1, 2004 through September 22, 2004	–	–	–	–	–	(110.7)	(110.7)
Retirement of common stock in connection with merger	–	–	(232,784)	–	(354.9)	–	(354.9)
Elimination of accrued dividends for Payable-In-Kind Preferred Stock	–	–	–	–	7.1	–	7.1
Elimination of retained deficit as of merger date	–	–	–	–	–	47.4	47.4
Balance at September 22, 2004 (predecessor)	–	–	–	–	–	–	–
Issuance of common stock	–	–	749,550	–	749.6	–	749.6
Issuance of equity incentive units of Holdings	–	–	–	–	5.7	–	5.7
Adjustment to record rollover equity contributions by management investors to predecessor basis	–	–	–	–	(113.3)	–	(113.3)
Stock compensation (non-cash)	–	–	–	–	0.7	–	0.7
Adjustment to income tax effect of cancellation and payouts of stock options in connection with merger	–	–	–	–	0.5	–	0.5
Net income, September 23, 2004 to June 30, 2005	–	–	–	–	–	32.6	32.6
Balance at June 30, 2005	–	–	749,550	–	643.2	32.6	675.8
Stock compensation (non-cash)	–	–	–	–	1.7	–	1.7
Repurchase of equity incentive units	–	–	–	–	(1.5)	–	(1.5)
Issuance of common stock	–	–	141	–	0.1	–	0.1
Repurchase of common stock	–	–	(141)	–	(0.1)	–	(0.1)
Adjustment to income tax effect of options payouts in connection with merger	–	–	–	–	0.3	–	0.3
Net income	–	–	–	–	–	12.9	12.9
Balance at June 30, 2006	–	–	749,550	–	643.7	45.5	689.2
Stock compensation (non-cash)	–	–	–	–	1.2	–	1.2
Repurchase of equity incentive units	–	–	–	–	(0.2)	–	(0.2)
Issuance of common stock	–	–	195	–	0.2	–	0.2
Repurchase of common stock	–	–	(195)	–	(0.3)	–	(0.3)
Net loss	–	–	–	–	–	(132.7)	(132.7)
Balance at June 30, 2007	–	$ –	749,550	$ –	$ 644.6	$ (87.2)	$ 557.4

See accompanying notes.

VANGUARD HEALTH SYSTEMS, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS

	For the Year Ended June 30,		
	Combined Basis 2005	2006	2007
	(In millions)		
Operating activities:			
Net income (loss)	$ (78.1)	$ 12.9	$ (132.7)
Adjustments to reconcile net income (loss) to net cash provided by operating activities			
Loss (income) from discontinued operations	(1.7)	10.6	19.1
Depreciation and amortization	75.7	100.3	118.6
Provision for doubtful accounts	133.0	156.8	175.2
Amortization of loan costs	3.2	4.0	4.5
Accretion of principal on senior discount notes	11.0	15.7	17.5
Debt extinguishment costs	62.2	0.1	–
Loss (gain) on disposal of assets	0.6	1.5	(4.1)
Stock compensation	97.4	1.7	1.2
Deferred income taxes	(37.6)	8.5	(12.7)
Merger expenses	23.3	–	–
Impairment loss	–	–	123.8
Changes in operating assets and liabilities, net of effects of acquisitions			
Accounts receivable	(139.8)	(162.4)	(204.0)
Establishment of accounts receivable for acquisitions	(53.3)	–	–
Inventories	(2.8)	(5.2)	(1.9)
Prepaid expenses and other current assets	(6.1)	3.6	(23.3)
Accounts payable	54.7	2.4	7.4
Accrued expenses and other liabilities	47.2	(11.9)	31.1
Net cash provided by operating activities – continuing operations	188.9	138.6	119.7
Net cash provided by operating activities – discontinued operations	12.9	10.7	3.6
Net cash provided by operating activities	201.8	149.3	123.3
Investing activities:			
Acquisitions	(138.6)	(1.2)	(0.2)
Capital expenditures	(224.2)	(275.5)	(164.3)
Proceeds from asset sales	0.7	11.1	9.5
Purchases of short-term investments	(87.8)	(128.4)	(120.0)
Sales of short-term investments	145.8	128.4	120.0
Other	(6.2)	0.6	2.0
Net cash used in investing activities – continuing operations	(310.3)	(265.0)	(153.0)
Net cash provided by (used in) investing activities – discontinued operations	(14.0)	19.6	34.5
Net cash used in investing activities	(324.3)	(245.4)	(118.5)
Financing activities:			
Proceeds from issuance of common stock	495.5	–	–
Proceeds from joint venture partner contributions	8.0	–	–
Proceeds from long-term debt	1,347.7	175.0	–
Payments of long-term debt and capital leases	(690.4)	(31.4)	(8.0)
Payments of loan costs and debt termination fees	(44.4)	(0.7)	–
Payments to retire stock, equity incentive units and stock options	(964.9)	(2.5)	(0.5)
Proceeds from the exercise of stock options	0.1	0.1	0.2
Net cash provided by (used in) financing activities	151.6	140.5	(8.3)
Increase (decrease) in cash and cash equivalents	29.1	44.4	(3.5)
Cash and cash equivalents at beginning of year	50.1	79.2	123.6
Cash and cash equivalents at end of year	$ 79.2	$ 123.6	$ 120.1

VANGUARD HEALTH SYSTEMS, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS
(continued)

	For the Year Ended June 30,		
	Combined Basis 2005	2006	2007
		(In millions)	
Supplemental cash flow information:			
Net interest paid	$ 79.4	$ 101.3	$ 107.8
Net income taxes paid (received)	$ (1.0)	$ 2.1	$ 0.9
Supplemental noncash activities:			
Payable-In-Kind Preferred Stock dividends	$ 1.0	$ –	$ –
Capitalized interest	$ 4.3	$ 8.3	$ 3.0
Acquisitions:			
Cash paid, net of cash received	$ 138.6	$ 1.2	$ 0.2
Fair value of assets acquired	112.0	(3.3)	–
Liabilities assumed	24.8	0.7	–
Additional paid-in capital	–	(0.3)	–
Net assets acquired	87.2	(4.3)	–
Goodwill and intangible assets acquired	$ 51.4	$ 5.5	$ 0.2
Dispositions:			
Cash received	$ –	$ 28.7	$ 37.0
Fair value of assets sold	–	(14.8)	(42.1)
Gain on sale	–	11.1	–
Escrow receivable	–	–	3.0
Liabilities assumed by buyer	–	–	5.5
Goodwill and intangible assets disposed	$ –	$ 2.8	$ 3.4

See accompanying notes.

VANGUARD HEALTH SYSTEMS, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS

	Predecessor		
	July 1, 2004 through September 22, 2004	September 23, 2004 through June 30, 2005	Year ended June 30, 2005 (combined basis)
		(In millions)	
Operating activities:			
Net income (loss)	$ (110.7)	$ 32.6	$ (78.1)
Adjustments to reconcile net income (loss) to net cash provided by operating activities			
Income from discontinued operations	(1.4)	(0.3)	(1.7)
Depreciation and amortization	16.0	59.7	75.7
Provision for doubtful accounts	27.8	105.2	133.0
Amortization of loan costs	0.5	2.7	3.2
Accretion of principal on senior discount notes	–	11.0	11.0
Debt extinguishment costs	62.2	–	62.2
Loss on disposal of assets	0.6	–	0.6
Stock compensation	96.7	0.7	97.4
Deferred income taxes	(50.9)	13.3	(37.6)
Merger expenses	23.1	0.2	23.3
Changes in operating assets and liabilities, net of effects of acquisitions			
Accounts receivable	(37.0)	(102.8)	(139.8)
Establishment of accounts receivable for acquisitions	–	(53.3)	(53.3)
Inventories	–	(2.8)	(2.8)
Prepaid expenses and other current assets	2.4	(8.5)	(6.1)
Accounts payable	41.3	13.4	54.7
Income tax payable	–	9.0	9.0
Accrued expenses and other long-term liabilities	10.3	27.9	38.2
Net cash provided by operating activities – continuing operations	80.9	108.0	188.9
Net cash provided (used in) by operating activities – discontinued operations	(2.1)	15.0	12.9
Net cash provided by operating activities	78.8	123.0	201.8
Investing activities:			
Acquisitions	(50.8)	(87.8)	(138.6)
Capital expenditures	(27.1)	(197.1)	(224.2)
Proceeds from asset sales	0.5	0.2	0.7
Purchases of short-term investments	–	(87.8)	(87.8)
Sales of short-term investments	30.0	115.8	145.8
Other	0.1	(6.3)	(6.2)
Net cash used in investing activities – continuing operations	(47.3)	(263.0)	(310.3)
Net cash used in investing activities – discontinued operations	(2.7)	(11.3)	(14.0)
Net cash used in investing activities	(50.0)	(274.3)	(324.3)

VANGUARD HEALTH SYSTEMS, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS
(continued)

	Predecessor		
	July 1, 2004 through September 22, 2004	September 23, 2004 through June 30, 2005	Year ended June 30, 2005 (combined basis)
		(In millions)	
Financing activities:			
Proceeds from issuance of common stock	494.9	0.6	495.5
Proceeds from joint venture partner contributions	–	8.0	8.0
Proceeds from long-term debt	1,174.7	173.0	1,347.7
Payments of long-term debt and capital leases	(683.9)	(6.5)	(690.4)
Payments of loan costs and debt termination fees	(40.9)	(3.5)	(44.4)
Payments to retire stock and stock options	(964.9)	–	(964.9)
Proceeds from the exercise of stock options	0.1	–	0.1
Net cash provided by (used in) financing activities	(20.0)	171.6	151.6
Increase in cash and cash equivalents	8.8	20.3	29.1
Cash and cash equivalents at beginning of period	50.1	58.9	50.1
Cash and cash equivalents at end of period	$ 58.9	$ 79.2	$ 79.2
Cash paid for interest	$ 23.6	$ 55.8	$ 79.4
Cash received for income taxes	$ (0.1)	$ (0.9)	$ (1.0)

See accompanying notes.

1. Business and Basis of Presentation

Business

Vanguard Health Systems, Inc. ("Vanguard") is an investor-owned healthcare company whose affiliates own and operate hospitals and related healthcare businesses in urban and suburban areas. As of June 30, 2007, Vanguard's affiliates owned and managed 15 acute care hospitals with 4,143 licensed beds and related outpatient service locations complementary to the hospitals providing healthcare services in San Antonio, Texas; metropolitan Phoenix, Arizona; metropolitan Chicago, Illinois; and Massachusetts. Vanguard also owns managed health plans in Chicago and Phoenix and two surgery centers in Orange County, California.

Basis of Presentation

The accompanying consolidated financial statements include the accounts of subsidiaries and affiliates controlled by Vanguard. Vanguard generally considers control to represent the majority of an entity's voting interests. Vanguard also consolidates any entities for which it receives the majority of the entity's expected returns or is at risk for the majority of the entity's expected losses based upon its investment or financial interest in the entity. All material intercompany accounts and transactions have been eliminated. As none of Vanguard's common shares are publicly held, no earnings per share information is presented in the accompanying consolidated financial statements. The majority of Vanguard's expenses are "cost of revenue" items. Costs that could be classified as general and administrative include certain Vanguard corporate office costs, which approximated $26.1 million, $30.6 million and $30.2 million for the years ended June 30, 2005 (combined basis), 2006 and 2007, respectively.

Use of Estimates

In preparing Vanguard's consolidated financial statements in conformity with accounting principles generally accepted in the United States, management makes estimates and assumptions that affect the amounts recorded or classification of items in the consolidated financial statements and accompanying notes. Actual results could differ from those estimates.

2. Summary of Critical and Significant Accounting Policies

Critical Accounting Policies

Vanguard considers the following accounting policies to be most critical to its operating performance and to involve the most subjective and complex assumptions and estimates.

Revenues and Revenue Deductions

Vanguard recognizes patient service revenues during the period the healthcare services are provided based upon estimated amounts due from payers. Vanguard estimates contractual adjustments and allowances based upon payment terms set forth in managed care health plan contracts and by federal and state regulations. For the majority of its patient service revenues, Vanguard applies contractual adjustments to patient accounts at the time of billing using specific payer contract terms entered into the accounts receivable systems, but in some cases Vanguard records an estimated allowance until payment is received. Vanguard derives most of its patient service revenues from healthcare services provided to patients with Medicare or managed care insurance coverage. During fiscal 2005, 2006 and 2007, combined Medicare and managed care revenues accounted for 77%, 80% and 78% of net patient revenues, respectively. For those same periods, Medicaid revenues accounted for 7%, 7% and 9% of net patient revenues, respectively. Services provided to Medicare patients are generally reimbursed at prospectively determined rates per diagnosis ("PPS"), while services provided to managed care patients are generally reimbursed

based upon predetermined rates per diagnosis, per diem rates or discounted fee-for-service rates. Medicaid reimbursements vary by state. Other than Medicare, no individual payer represents more than 10% of Vanguard's patient service revenues, either on a gross or net basis.

Medicare regulations and Vanguard's principal managed care contracts are often complex and may include multiple reimbursement mechanisms for different types of services provided in its healthcare facilities. To obtain reimbursement for certain services under the Medicare program, Vanguard must submit annual cost reports and record estimates of amounts owed to or receivable from Medicare. These cost reports include complex calculations and estimates related to indirect medical education, reimbursable Medicare bad debts and other items that are often subject to interpretation that could result in payments that differ from recorded estimates. Vanguard estimates amounts owed to or receivable from the Medicare program using the best information available and its interpretation of the applicable Medicare regulations. Vanguard includes differences between original estimates and subsequent revisions to those estimates (including final cost report settlements) in the consolidated statements of operations in the period in which the revisions are made. Net adjustments for final third party settlements increased patient service revenues and income from continuing operations before income taxes by $5.8 million, $8.6 million and $6.3 million during the years ended June 30, 2005 (combined basis), 2006 and 2007, respectively. Additionally, updated regulations and contract negotiations occur frequently, which necessitates continual review of estimation processes by management. Management believes that future adjustments to its current third party settlement estimates will not significantly impact Vanguard's results of operations or financial position.

Vanguard does not pursue collection of amounts due from uninsured patients that qualify for charity care under its guidelines (currently those uninsured patients whose incomes are equal to or less than 200% of the current federal poverty guidelines set forth by the Department of Health and Human Services). Vanguard deducts charity care accounts from revenues when it determines that the account meets its charity care guidelines. Vanguard also provides discounts from billed charges and alternative payment structures for uninsured patients who do not qualify for charity care but meet certain other minimum income guidelines, primarily those uninsured patients with incomes between 200% and 500% of the federal poverty guidelines. During the years ended June 30, 2005 (combined basis), 2006 and 2007, Vanguard deducted $51.0 million, $71.1 million and $86.1 million of charity care from revenues, respectively.

Vanguard participates in the Bexar County, Texas upper payment limit ("UPL") Medicaid payment program. Vanguard recognizes revenues from the UPL program when Vanguard becomes entitled to the expected reimbursements, including a federal match portion, and such reimbursements are reasonably assured. During the year ended June 30, 2007, Vanguard recorded $11.6 million of revenues for UPL payments received in April 2007 that relate to services provided during fiscal years 2005 and 2006. The UPL payment also positively impacted loss from continuing operations before income taxes by $5.9 million during the year ended June 30, 2007 related to services provided in fiscal years 2005 and 2006. While revenue fluctuations between periods are possible given the timing of the federal match funding, Vanguard does not expect these fluctuations to significantly impact its results of operations or cash flows in future periods.

Vanguard had premium revenues of $333.5 million, $375.0 million and $401.4 million during the years ended June 30, 2005 (combined basis), 2006 and 2007, respectively. Vanguard's health plans, Phoenix Health Plan ("PHP"), Abrazo Advantage Health Plan ("AAHP") and MacNeal Health Providers ("MHP"), have agreements with the Arizona Health Care Cost Containment System ("AHCCCS"), Centers for Medicare and Medicaid Services ("CMS") and various health maintenance organizations ("HMOs"), respectively, to contract to provide medical services to subscribing participants. Under these agreements, Vanguard's health plans receive monthly payments based on the number of HMO participants in MHP or the number and coverage level of enrollees in PHP and AAHP. Vanguard's health plans recognize the payments as revenues in the month in which members are entitled to healthcare services with the exception of AAHP Medicare Part D reinsurance premiums and low income subsidy cost sharing premiums that are recorded as a liability to fund future healthcare costs or else repaid to the government.

Allowance for Doubtful Accounts and Provision for Doubtful Accounts

Vanguard's ability to collect the self-pay portions of outstanding receivables is critical to its operating performance and cash flows. The allowance for doubtful accounts was approximately 26.0% and 28.3% of accounts

receivable, net of contractual discounts, as of June 30, 2006 and 2007, respectively. The primary collection risk relates to uninsured patient accounts and patient accounts for which primary insurance has paid but patient deductibles or co-insurance portions remain outstanding. As of June 30, 2007, Vanguard estimated the allowance for doubtful accounts using a standard policy that reserves 100% of all accounts aged greater than 180 days subsequent to discharge date plus a pre-determined percentage of accounts receivable due from patients less than 180 days old. Effective July 1, 2007, Vanguard will implement a policy that reserves 100% of all accounts greater than 365 days subsequent to discharge date plus 85% of uninsured accounts less than 365 days old plus 40% of self-pay after insurance/Medicare less than 365 days old in order to address increasing self-pay utilization. Vanguard does not expect this policy change to significantly impact its provision for doubtful accounts. Vanguard adjusts its estimate as necessary on a quarterly basis using a hindsight calculation that utilizes write-off data for all payer classes during the previous twelve-month period to estimate the allowance for doubtful accounts at a point in time. Vanguard also monitors cash collections and self-pay utilization. Significant changes in payer mix, business office operations, general economic conditions or healthcare coverage provided by federal or state governments or private insurers may have a significant impact on Vanguard's estimates and significantly affect its future operations and cash flows.

Vanguard classifies accounts pending Medicaid approval as Medicaid accounts in its accounts receivable aging report and records a manual contractual allowance for these accounts equal to the average Medicaid reimbursement rate for that specific state. Vanguard has historically been successful in qualifying approximately 50%-55% of submitted accounts for Medicaid coverage. As of June 30, 2007, Vanguard had approximately $12.0 million of Medicaid pending accounts receivable from continuing operations ($3.5 million of which was stated at gross charges with a manual contractual allowance and $8.5 million of which was stated net of contractual discounts). In the event an account is not successfully qualified for Medicaid coverage and does not meet Vanguard's charity guidelines, the previously recorded Medicaid contractual adjustment remains a revenue deduction (similar to a self-pay discount), and the remaining net account balance is reclassified to uninsured status and subjected to Vanguard's allowance for doubtful accounts policy. During the year ended June 30, 2007, approximately $13.2 million of net accounts receivable from continuing operations was reclassified from Medicaid pending status to uninsured status. If the account does not qualify for Medicaid coverage but does qualify as charity care, the contractual adjustment is reversed and the gross account balance is recorded as a charity deduction. During the year ended June 30, 2007, Vanguard recorded approximately $6.4 million of charity deductions from continuing operations for the net balances of accounts previously classified as Medicaid pending that did not meet Medicaid eligibility requirements.

Because Vanguard requires patient verification of coverage at the time of admission, reclassifications of Medicare or managed care accounts to self-pay, other than patient coinsurance or deductible amounts, occur infrequently and are not material to its financial statements. Additionally, the impact of these classification changes is further limited by Vanguard's ability to identify any necessary classification changes prior to patient discharge or soon thereafter. Due to information system limitations, Vanguard is unable to quantify patient deductible and co-insurance receivables that are included in the primary payer classification in the accounts receivable aging report at any given point in time. When classification changes occur, the account balance remains aged from the patient discharge date.

A summary of Vanguard's allowance for doubtful accounts activity, including those for discontinued operations, during the three most recent fiscal years follows (in millions).

	Balance at Beginning of Period	Additions Charged to Costs and Expenses	Accounts Written Off, Net of Recoveries	Balance at End of Period
Allowance for doubtful accounts:				
Predecessor period July 1, 2004 through September 22, 2004	$ 63.5	$ 31.5	$ 27.3	$ 67.7
Successor period September 23, 2004 through June 30, 2005	$ 67.7	$ 119.8	$ 97.4	$ 90.1
Year ended June 30, 2006	$ 90.1	$ 178.1	$ 164.7	$ 103.5
Year ended June 30, 2007	$ 103.5	$ 191.3	$ 181.6	$ 113.2

Insurance Reserves

Given the nature of its operating environment, Vanguard is subject to professional and general liability and workers compensation claims and related lawsuits in the ordinary course of business. For professional and general liability claims incurred from June 1, 2002 to May 31, 2006, Vanguard's wholly owned captive subsidiary insured its professional and general liability risks at a $10.0 million retention level. For professional and general liability claims incurred subsequent to May 31, 2006, Vanguard self-insures the first $9.0 million per claim, and the captive subsidiary insures the next $1.0 million per claim. Vanguard maintains excess coverage from independent third party insurers on a claims-made basis for individual claims exceeding $10.0 million up to $75.0 million, but limited to total annual payments of $65.0 million in the aggregate.

Vanguard insures its excess coverage under a retrospectively rated policy, and premiums under this policy are recorded based on Vanguard's historical claims experience. Vanguard self-insures its workers compensations claims up to $1.0 million per claim and purchases excess insurance coverage for claims exceeding $1.0 million. The following tables summarize Vanguard's professional and general liability and workers compensation reserve balances as of June 30, 2006 and 2007 and its total provision for professional and general liability and workers compensation losses and related claims payments during the years ended June 30, 2005 (combined basis), 2006 and 2007, respectively.

	Professional and General Liability	Workers Compensation
	(In millions)	
Reserve balance:		
June 30, 2006	$ 58.8	$ 15.3
June 30, 2007	$ 64.6	$ 18.5
Provision for claims losses:		
Fiscal Year 2005	$ 18.8	$ 11.3
Fiscal Year 2006	$ 21.0	$ 8.9
Fiscal Year 2007	$ 20.2	$ 9.4
Claims paid:		
Fiscal Year 2005	$ 9.2	$ 6.4
Fiscal Year 2006	$ 12.7	$ 6.4
Fiscal Year 2007	$ 14.4	$ 6.2

Vanguard utilizes actuarial information to estimate its reserves for professional and general liability and workers compensation claims. Each reserve is comprised of estimated indemnity and expense payments related to: 1) reported events ("case reserves") and 2) incurred but not reported ("IBNR") events as of the end of the period. Management uses information from its risk managers and its best judgment to estimate case reserves. Actuarial IBNR estimates are dependent on multiple variables including Vanguard's loss exposures, its self-insurance limits, geographic locations in which it operates, the severity of its historical losses compared to industry averages and the reporting pattern of its historical losses compared to industry averages, among others. Most of these variables require judgment, and changes in these variables could result in significant period over period fluctuations in Vanguard's estimates. Vanguard discounts its workers compensation reserve using actuarial estimates of projected cash payments in future periods. Vanguard adjusts these reserves from time to time as it receives updated information. During fiscal 2006 and 2007, due to changes in historical loss trends, Vanguard decreased its professional and general liability reserve related to prior fiscal years by $6.9 million and $4.5 million, respectively. During fiscal 2005, Vanguard increased its workers compensation reserve related to prior fiscal years by $2.0 million. Adjustments to the workers compensation reserve related to prior years during fiscal 2006 and 2007 were not significant. Given the fact that Vanguard has operated its hospitals for relatively short periods of time, management expects that additional adjustments to prior year estimates may occur as Vanguard's reporting history and loss portfolio matures.

Vanguard's best estimate of IBNR utilizes statistical confidence levels that are below 75%. Using a higher statistical confidence level would increase the estimated reserve. The following table illustrates the sensitivity of the reserve estimates at 75% and 90% confidence levels.

	Professional and General Liability	Workers Compensation
	(In millions)	
June 30, 2006 reserve:		
As reported	$ 58.8	$ 15.3
With 75% Confidence Level	$ 69.4	$ 16.1
With 90% Confidence Level	$ 80.0	$ 16.7
June 30, 2007 reserve:		
As reported	$ 64.6	$ 18.5
With 75% Confidence Level	$ 76.9	$ 20.8
With 90% Confidence Level	$ 88.9	$ 22.6

Medical Claims Reserves

During the years ended June 30, 2005 (combined basis), 2006 and 2007, medical claims expense was approximately $237.2 million, $270.3 million and $297.0 million, respectively, primarily representing medical claims of PHP. Vanguard estimates PHP's reserve for medical claims using historical claims experience (including severity and payment lag time) and other actuarial data including number of enrollees and the county in which the enrollee resides. The reserve for medical claims, including incurred but not reported claims, for PHP and AAHP was approximately $44.0 million and $57.2 million as of June 30, 2006 and 2007, respectively. While management believes that its estimation methodology effectively captures trends in medical claims costs, actual payments could differ significantly from its estimates given changes in the healthcare cost structure or adverse experience. During the years ended June 30, 2005 (combined basis), 2006 and 2007, approximately $36.6 million, $40.0 million and $34.2 million, respectively, of accrued and paid claims for services provided to Vanguard's health plan enrollees by its hospitals and its other healthcare facilities were eliminated in consolidation. Vanguard's operating results and cash flows could be materially affected by increased or decreased utilization of its healthcare facilities by enrollees in its health plans.

Income Taxes

Income taxes are computed on the liability method of accounting whereby deferred tax assets and liabilities are determined based on differences between financial reporting and tax bases of assets and liabilities and are increased using the enacted tax rates and laws that will be in effect when the differences are expected to reverse. Management believes that Vanguard's tax return provisions are accurate and supportable, but certain tax matters require interpretations of tax law that may be subject to future challenge and may not be upheld under tax audit. To reflect the possibility that all of its tax positions may not be sustained, Vanguard maintains tax reserves that are subject to adjustment as updated information becomes available or as circumstances change. Vanguard records the impact of tax reserve changes to its income tax provision in the period in which the additional information, including the progress of tax audits, is obtained.

Vanguard assesses the realization of its deferred tax assets to determine whether an income tax valuation allowance is required. Based on all available evidence, both positive and negative, and the weight of that evidence to the extent such evidence can be objectively verified, Vanguard determines whether it is more likely than not that all or a portion of the deferred tax assets will be realized. The factors used in this determination include the following:

- Cumulative losses in recent years
- Income/losses expected in future years
- Unsettled circumstances that, if favorably resolved, would adversely affect future operations
- Availability, or lack thereof, of taxable income in prior carryback periods that would limit realization of tax benefits

- Carryforward period associated with the deferred tax assets and liabilities
- Prudent and feasible tax planning strategies

In addition, financial forecasts used in determining the need for or amount of federal and state valuation allowances are subject to changes in underlying assumptions and fluctuations in market conditions that could significantly alter Vanguard's recoverability analysis and thus have a material adverse impact on its consolidated financial condition, results of operations or cash flows.

Long-Lived Assets and Goodwill

Long-lived assets, including property, plant and equipment and amortizable intangible assets, comprise a significant portion of our total assets. Vanguard evaluates the carrying value of long-lived assets when impairment indicators are present or when circumstances indicate that impairment may exist under the provisions of SFAS 144, *Accounting for the Impairment or Disposal of Long-Lived Assets*. When management believes impairment indicators may exist, projections of the undiscounted future cash flows associated with the use of and eventual disposition of long-lived assets held for use are prepared. If the projections indicate that the carrying values of the long-lived assets are not expected to be recoverable, Vanguard reduces the carrying values to fair value. For long-lived assets held for sale, Vanguard compares the carrying values to an estimate of fair value less selling costs to determine potential impairment. Vanguard tests for impairment of long-lived assets at the lowest level for which cash flows are measurable. These impairment tests are heavily influenced by assumptions and estimates that are subject to change as additional information becomes available. Given the relatively few number of hospitals Vanguard owns and the significant amounts of long-lived assets attributable to those hospitals, an impairment of the long-lived assets for even a single hospital could materially adversely impact its operating results or financial position.

Goodwill also represents a significant portion of Vanguard's total assets. Vanguard reviews goodwill for impairment annually during its fourth fiscal quarter or more frequently if certain impairment indicators arise under the provisions of SFAS 142, *Goodwill and Other Intangible Assets*. Vanguard reviews goodwill at the reporting level unit, which is one level below an operating segment. Vanguard compares the carrying value of the net assets of each reporting unit to the net present value of estimated discounted future cash flows of the reporting unit. If the carrying value exceeds the net present value of estimated discounted future cash flows, an impairment indicator exists and an estimate of the impairment loss is calculated. The fair value calculation includes multiple assumptions and estimates, including the projected cash flows and discount rates applied. Changes in these assumptions and estimates could result in goodwill impairment that could materially adversely impact our results of operations or statement of position.

In December 2006, Vanguard recorded at impairment charge related to its Chicago hospitals. See Note 7 for further discussion of this impairment charge.

Vanguard completed its annual goodwill impairment test during the fourth quarter of fiscal 2007 noting no impairment. However, two of its reporting units, with combined goodwill of $140.0 million, will require continual monitoring during fiscal year 2008 due to the sensitivity of the projected operating results of these reporting units to the goodwill impairment analysis. If projected future cash flows become less favorable than those projected by management, impairments may become necessary that could have a material adverse impact on Vanguard's financial position and results of operations.

Cash and Cash Equivalents

Vanguard considers all highly liquid investments with maturity of 90 days or less when purchased to be cash equivalents. Vanguard manages its credit exposure by placing its investments in high quality securities and by periodically evaluating the relative credit standing of the financial institutions holding its cash and investments.

Restricted Cash

As of June 30, 2007, Vanguard had restricted cash balances of $6.2 million. Approximately $3.0 million of this balance represented the remaining proceeds from the sale of the California hospitals that were placed in escrow

on the sale date and distributed to Vanguard in July 2007. Vanguard also maintains restricted cash accounts related to liquidity requirements of AAHP and certain other arrangements.

Short-Term Investments

As part of its normal cash management program, Vanguard may from time to time invest in short-term investments, including investments in market auction rate debt securities through contracts with financial intermediaries. These investments are classified as available-for-sale under Statement of Financial Accounting Standards No. 115, "*Accounting for Certain Investments in Debt and Equity Securities.*" Vanguard has historically renewed the contracts at each auction date, which typically occurs every 28 days. Vanguard expects to maintain this strategy should it invest in these contracts or similar securities in the future. Purchases of short-term investments totaled $87.8 million, $128.4 million and $120.0 million during the years ended June 30, 2005 (combined basis), 2006 and 2007, respectively. Proceeds from the sales of short-term investments totaled $145.8 million, $128.4 million and $120.0 million during the years ended June 30, 2005 (combined basis), 2006 and 2007, respectively. Vanguard considers a sale or purchase to occur upon the redemption of or investment in a new contract with a different underlying auction rate debt security. Investment income recognized at the maturity of the contracts is included as a reduction to net interest in the accompanying consolidated statements of operations. Because the contracts are redeemed at cost, Vanguard does not reflect unrealized gains or losses in these investments in its consolidated financial statements or notes thereto. Vanguard had no outstanding investments in market auction rate debt securities as of June 30, 2006 or 2007.

Accounts Receivable

Vanguard's primary concentration of credit risk is patient accounts receivable, which consists of amounts owed by various governmental agencies, insurance companies and private patients. Vanguard manages the receivables by regularly reviewing its accounts and contracts and by providing appropriate allowances for contractual discounts and uncollectible amounts. Medicare program receivables comprised approximately 21% and 18% of net patient receivables as of June 30, 2006 and 2007, respectively. Medicare revenues are included in the acute care services operating segment. Medicaid programs comprised approximately 16% and 13% of net patient receivables as of June 30, 2006 and 2007, respectively. Remaining receivables relate primarily to various HMO and Preferred Provider Organization ("PPO") payers, managed Medicare and Medicaid payers, commercial insurers and private patients. Concentration of credit risk for these payers is limited by the number of patients and payers.

Inventories

Inventory, consisting of medical supplies and pharmaceuticals, is stated at the lower of cost (first-in, first-out) or market.

Property, Plant and Equipment

During fiscal 2005, Vanguard adjusted the stated values of property, plant and equipment that existed as of the date of the Merger based upon guidance set forth in Emerging Issues Task Force No. 88-16, *Basis in Leveraged Buyout Transactions* ("EITF 88-16") using appraisals received from an independent third party. Purchases of property, plant and equipment subsequent to the Merger are stated at cost. Routine maintenance and repairs are charged to expense as incurred. Expenditures that increase values, change capacities or extend useful lives are capitalized. Depreciation is computed using the straight-line method over the estimated useful lives of the assets, which approximate 18 months to 44 years. Depreciation expense was approximately $15.5 million, $57.1 million, $72.6 million, $97.1 million and $115.4 million for the predecessor period July 1, 2004 through September 22, 2004, the successor period September 23, 2004 through June 30, 2005, the combined year ended June 30, 2005, the year ended June 30, 2006 and the year ended June 30, 2007, respectively. Vanguard tests its property, plant and equipment and other long-lived assets for impairment as management becomes aware of impairment indicators.

During fiscal 2005 (combined basis), 2006 and 2007, Vanguard capitalized $4.3 million, $8.3 million and $3.0 million of interest, respectively, associated with certain of its hospital construction and expansion projects. Vanguard estimates that it is contractually obligated to expend approximately $50.5 million related to projects classified as construction in progress as of June 30, 2007. Vanguard also capitalizes costs associated with

developing computer software for internal use under the provisions of AICPA Statement of Position 98-1 ("SOP 98-1"). Under SOP 98-1, Vanguard capitalizes both internal and external direct costs, excluding training, during the application development stage primarily for the purpose of customizing vendor software to integrate with our hospitals' information systems. The following table provides the gross asset balances for each major class of asset and total accumulated depreciation as of June 30, 2006 and 2007 (in millions).

	June 30, 2006	June 30, 2007
Class of asset:		
Land and improvements	$ 130.7	$ 131.8
Buildings and improvements	684.8	794.2
Equipment	412.5	485.0
Construction in progress	86.3	46.3
	1,314.3	1,457.3
Less: accumulated depreciation	(154.8)	(270.7)
Net property, plant and equipment	$ 1,159.5	$ 1,186.6

Amortization of Intangible Assets

Vanguard completed the allocation of the Merger excess purchase price during fiscal 2005 and 2006 resulting in changes to the values of goodwill and other intangible assets (See Note 3). Amounts allocated to intangible assets are amortized over their useful lives, which equal 10 years, except for those indefinite-lived intangible assets for which no amortization is recorded. Deferred loan costs and syndication costs are amortized over the life of the applicable credit facility or notes. Physician income and service agreement guarantee intangible assets are recorded based upon the estimated future payments under the contracts and are amortized over the contract service periods.

Employee Health Insurance

Vanguard maintains self-insured medical and dental plans for a limited number of its employees. Claims are accrued under the self-insured plans as the incidents that give rise to them occur. Unpaid claims accruals are based on the estimated ultimate cost of settlement, including claim settlement expenses, in accordance with an average lag time and historical experience. The reserve for self-insured medical and dental plans was approximately $1.6 million and $1.2 million as of June 30, 2006 and 2007, respectively, and is included in accrued salaries and benefits in the accompanying consolidated balance sheets.

Market and Labor Risks

Vanguard operates primarily in four geographic markets. Should economic or other factors limit its ability to provide healthcare services in one or more of these markets, Vanguard's cash flows and results of operations could be materially adversely impacted. Approximately 1,600 full-time employees in Vanguard's Massachusetts hospitals are subject to collective organizing agreements. This group represents approximately 9% of Vanguard's workforce. During fiscal 2007, Vanguard entered into a new three-year contract with the union representing the majority of this group that ends on December 31, 2009. Should Vanguard experience significant future labor disruptions related to these unionized employees, its cash flows and results of operations could be materially adversely impacted.

Stock-Based Compensation

Vanguard accounts for stock-based employee compensation granted prior to July 1, 2006 under the provisions of Statement of Financial Accounting Standards No. 123, *Accounting for Stock-Based Compensation* ("SFAS 123"). Effective July 1, 2003, Vanguard adopted SFAS 123 on a prospective basis, an acceptable transition method set forth in SFAS No. 148, *Accounting for Stock-Based Compensation Transition and Disclosure* ("SFAS 148"). For grants dated July 1, 2006 and subsequent, Vanguard accounts for stock-based employee compensation

under the provisions of Statement of Financial Accounting Standards No. 123(R), *Share-Based Payment* ("SFAS 123(R)"). Vanguard also adopted SFAS 123(R) on a prospective basis and such adoption did not significantly impact any indicator of Vanguard's results of operations or cash flows.

The following table sets forth the weighted average assumptions utilized in the minimum value pricing model for stock option grants under the 2004 Option Plan prior to July 1, 2006 and those utilized in the Black-Scholes-Merton valuation model for grants under the 2004 Option Plan subsequent to July 1, 2006.

	Minimum Value	Black-Scholes-Merton
Risk-free interest rate	4.5%	4.7%
Dividend yield	0.0%	0.0%
Volatility (annual)	N/A	37.7%
Expected option life	10 years	6.5 years

For stock options included in the Black-Scholes-Merton valuation model, Vanguard used historical stock price information of certain peer group companies for a period of time equal to the expected option life period to determine estimated volatility. Vanguard determined the expected life of the stock options by averaging the contractual life of the options and the vesting period of the options.

For purposes of pro forma disclosures, the estimated fair value of options is amortized to expense on a straight-line basis over the options' vesting period. The following table reflects the pro forma impact on net income (loss) assuming Vanguard had adopted SFAS 123 since the inception of its stock option grants as opposed to adopting SFAS 123 on July 1, 2003 using the prospective method set forth in SFAS 148 (in millions).

	Predecessor		
	July 1, 2004 through September 22, 2004	September 23, 2004 through June 30, 2005	Year ended June 30, 2005 (combined basis)
Net income (loss), as reported	$ (110.7)	$ 32.6	$ (78.1)
Add: Stock-based compensation expense included in net income (loss), net of taxes	66.1	0.4	66.5
Less: Pro forma stock-based compensation expense determined under fair value method, net of taxes	(76.7)	(0.4)	(77.1)
Pro forma net income (loss)	$ (121.3)	$ 32.6	$ (88.7)

Fair Value of Financial Instruments

Cash and Cash Equivalents and Restricted Cash

The carrying amounts reported for cash and cash equivalents and restricted cash approximate fair value because of the short-term maturity of these instruments.

Accounts Receivable and Accounts Payable

The carrying amounts reported for accounts receivable and accounts payable approximate fair value because of the short-term maturity of these instruments.

Long-Term Debt

The fair values of Vanguard's 9.0% Notes and 11.25% Notes as of June 30, 2007 were approximately $567.8 million and $178.2 million, respectively, based upon stated market prices. The fair values are subject to change as market conditions change.

Recently Issued Accounting Pronouncements

In February 2007, the Financial Accounting Standards Board ("FASB") issued Statement of Financial Accounting Standards No. 159, *The Fair Value Option for Financial Assets and Financial Liabilities* ("SFAS 159"). SFAS 159 gives entities the option to voluntarily choose, at certain election dates, to measure many financial assets and liabilities at fair value. Elections are made on an instrument by instrument basis and are irrevocable once made. Subsequent changes to the fair value of any instrument for which an election is made are reflected through earnings. SFAS 159 is effective for Vanguard as of July 1, 2008 with early adoption permitted. Vanguard does not expect SFAS 159 to have a significant impact on its future financial position, results of operations or cash flows.

On September 15, 2006, the FASB issued Statement of Financial Accounting Standards No. 157, *Fair Value Measurement* ("SFAS 157"). SFAS 157 sets forth comprehensive guidance for measuring fair value of assets and liabilities. Under the provisions of SFAS 157, fair value should be based on the assumptions market participants would use to complete the sale of an asset or transfer of a liability. SFAS 157 provides a hierarchy of information to be used to determine the applicable market assumptions, and fair value measurements would be separately disclosed under each applicable layer of the hierarchy. SFAS 157 does not expand or restrict the use of fair value for measuring assets and liabilities but provides a single methodology to be used when fair value accounting is applied. SFAS 157 is effective for Vanguard's fiscal year beginning July 1, 2008 with early adoption permitted. Vanguard does not expect the adoption of SFAS 157 to significantly impact its future financial position, results of operations or cash flows.

In July 2006, the FASB issued Interpretation No. 48, *Accounting for Uncertainty in Income Taxes, an interpretation of FASB Statement No. 109, Accounting for Income Taxes* ("FIN 48"). FIN 48 sets forth the minimum recognition criteria tax positions are required to meet before being recognized in the financial statements. FIN 48 requires recognition when a tax position is more likely than not to be sustained upon examination. Measurement of the tax position is determined as the largest amount of benefit, determined on a cumulative probability basis, which is more likely than not to be realized upon ultimate settlement. FIN 48 also provides guidance regarding derecognition and classification of tax positions, interest and penalties and multiple expanded disclosures including a rollforward of aggregate unrecognized tax benefits and detail for tax uncertainties for which it is reasonably possible that estimated tax benefits will significantly change during the subsequent twelve months. FIN 48 is effective for Vanguard's fiscal year beginning July 1, 2007. Vanguard does not expect FIN 48 to have a significant impact on its financial position, results of operations or cash flows but would require potential balance sheet reclassifications and significant additional disclosures in its consolidated financial statements.

3. Merger Transaction

On September 23, 2004, affiliates of The Blackstone Group ("Blackstone"), a private equity firm, purchased a majority equity interest in VHS Holdings LLC ("Holdings"), which became the principal stockholder of

Vanguard in a merger transaction (the "Merger"). Pursuant to the Merger agreement, the former holders of Vanguard shares received $1.22 billion, net of debt repayments, transaction costs, tender premiums and consent fees and the redemption of payable-in-kind preferred stock. The transaction was valued at approximately $1.97 billion prior to transaction fees and expenses.

As of June 30, 2007, Blackstone beneficially owns approximately 66% of the equity interests in Vanguard through its subscription and purchase of approximately $494.9 million aggregate amount of Class A membership units in Holdings and common stock of Vanguard in connection with the Merger.

Certain investment funds affiliated with Morgan Stanley Capital Partners (collectively, "MSCP"), Vanguard's previous private equity sponsor, contributed $130.0 million and management (along with certain other investors) contributed approximately $124.1 million by contributing shares of Vanguard common stock and/or utilizing cash proceeds from the Merger to purchase Class A membership units in Holdings. These stockholders, on a combined basis, beneficially own as of June 30, 2007, approximately 34% of the equity interests in Vanguard. Certain members of management also purchased $5.7 million of the equity incentive units in Holdings in connection with the Merger.

Vanguard accounted for the transaction as a purchase under the guidance set forth in EITF 88-16. Under EITF 88-16, the transaction was deemed to be a purchase by new controlling investors for which Holdings' interests in Vanguard were valued using a partial change in accounting basis. In effect, the membership units of Holdings owned by the management investors were valued using predecessor basis, while the membership units of Holdings owned by Blackstone, MSCP and other certain investors were recorded at fair value.

The following table summarizes the sources and uses of funds to finance the Merger (in millions):

Sources:		Amount
Senior credit facilities[1]:		
Term loan facility	$	475.0
Revolving loan facility		–
Issuance of 9.0% senior subordinated notes[2]		575.0
Issuance of 11.25% senior discount notes[3]		124.7
Cash equity contribution by Blackstone		494.9
Rollover equity contribution by MSCP		130.0
Rollover equity contribution by management and certain other investors		96.6
Cash equity contribution by management and certain other investors		22.5
Cash equity contribution by Baptist Health Services[4]		5.0
Cash equity contribution for purchase of equity incentive units by certain members of senior management		5.7
Vanguard cash on hand		38.3
	$	1,967.7
Uses:		
Purchase price of Vanguard equity	$	1,220.0
Redemption of Payable In Kind Preferred Stock issued in connection with the acquisition of MacNeal Hospital		28.6
Repayment of Vanguard's existing senior credit facilities		300.0
Repurchase of substantially all of Vanguard's outstanding 9.75% Notes and payment of related tender premium and consent fees[5]		349.2
Payment of fees and expenses related to the new senior credit facilities, the 9.0% Notes and the 11.25% Notes		41.6
Payment of capitalized Merger-related fees and expenses		28.3
	$	1,967.7

(1) The new senior credit agreement governed senior secured term loan facilities of $800.0 million, of which $475.0 million was drawn at closing, and a new revolving loan facility of $250.0 million, none of which was utilized at closing with the exception of $27.7 million of outstanding letters of credit.

(2) Vanguard issued and sold $575.0 million of 9.0% senior subordinated notes due 2014 (the "9.0% Notes").

(3) Vanguard issued and sold $216.0 million aggregate principal amount at maturity ($124.7 million in gross proceeds) of 11.25% senior discount notes due 2015 (the "11.25% Notes").

(4) Baptist Health Services made its $5.0 million cash equity contribution from some of the proceeds of the conversion of its 8.18% subordinated convertible notes and Series B Payable-In-Kind Preferred Stock into the right to receive common shares of Vanguard.

(5) Vanguard had outstanding $300.0 million of 9.75% senior subordinated notes due 2011 (the "9.75% Notes").

The following table sets forth the Merger purchase price allocation under EITF 88-16 including a reconciliation of such purchase price allocation to the Merger fair value detailed above (in millions).

Cash	$	86.9
Accounts receivable, net		235.3
Prepaid expenses and other current assets		64.8
Property, plant and equipment		795.8
Goodwill		821.2
Intangible assets		79.4
Other assets		60.1
Total assets acquired		2,143.5
Current liabilities		190.8
Debt		5.1
Other liabilities		93.2
Total liabilities assumed		289.1
Allocated purchase price		1,854.4
Predecessor basis limitation under EITF 88-16		113.3
Fair value of net assets acquired	$	1,967.7

Vanguard incurred $96.7 million in stock compensation expense in connection with the Merger related to the payment to stock option holders under its various former stock option plans as calculated under the provisions of Accounting Principles Board Opinion No. 25 for option grants prior to July 1, 2003, and under SFAS 123 for option grants on or after July 1, 2003. Vanguard incurred debt extinguishment costs of $62.2 million in connection with the Merger representing the write-off of loan costs under the 2004 senior secured credit facility and related fees of $16.6 million, tender premiums and consent fees of $50.2 million and a $4.6 million credit for the recognition of the remaining deferred gain under an interest rate swap agreement related to the 9.75% Notes. Vanguard capitalized $41.6 million of fees and expenses related to the execution of the new senior secured credit facilities and the issuance of the 9.0% Notes and the 11.25% Notes on the Merger date.

Vanguard also incurred costs of $51.6 million directly related to the Merger, of which $23.1 million, $0.2 million and $23.3 million is reflected as Merger expenses in the accompanying consolidated statements of operations for the predecessor period July 1, 2004 through September 22, 2004, the successor period September 23, 2004 through June 30, 2005 and the combined year ended June 30, 2005, respectively. The remaining $28.3 million is included in goodwill in the accompanying consolidated balance sheets as set forth by the provisions of Statement of Financial Accounting Standards No. 141.

The table below provides a detail of the Merger-related costs (in millions).

		Merger Expenses		Goodwill
Advisory fees	$	10.0	$	4.0
Legal and accounting fees		1.4		3.8
Transaction completion fees to Blackstone and bonuses to management		6.1		20.3
Bridge loan commitment fees		5.3		–
Other		0.5		0.2
	$	23.3	$	28.3

4. Acquisitions and Dispositions

Fiscal 2007 Disposition

On October 1, 2006, certain of Vanguard's subsidiaries completed the sale of their three hospitals in Orange County, California (West Anaheim Medical Center, Huntington Beach Hospital and La Palma Intercommunity Hospital) to subsidiaries of Prime Healthcare, Inc. for net proceeds of $40.0 million, comprised of cash proceeds of $37.0 million and $3.0 million of proceeds placed in escrow which was distributed to a subsidiary of Vanguard on July 2, 2007. Approximately $12.8 million of retained working capital, including $25.3 million of patient accounts receivable, was excluded from the sale. See Note 5 for discussion of discontinued operations treatment related to the sale of these hospitals.

Fiscal 2006 Disposition

On March 8, 2006, certain subsidiaries of Vanguard sold medical office buildings in California to an independent third party for net sales proceeds of approximately $28.7 million. The net book value of the property, plant and equipment sold was approximately $14.8 million, and Vanguard allocated approximately $2.8 million of existing goodwill to the disposed assets. Vanguard recognized a gain on the sale of approximately $11.1 million ($8.3 million net of taxes) during fiscal 2006 that is included in discontinued operations, net of taxes in the accompanying consolidated statement of operations for the year ended June 30, 2006. See Note 5 for discussion of discontinued operations treatment related to the sale of these assets.

Fiscal 2005 Acquisition

On December 31, 2004, certain of Vanguard's subsidiaries acquired the property, plant and equipment, investments and certain current assets and assumed certain current liabilities of three acute-care hospitals with a then total of 768 licensed beds and related healthcare businesses located in or around Worcester, Framingham and Natick, Massachusetts (the "Massachusetts Hospitals") from subsidiaries of Tenet Healthcare Corporation. Vanguard paid $87.7 million at closing, including the base purchase price of $103.5 million for the property, plant and equipment and investments of the Massachusetts Hospitals less $15.8 million for the excess of the current liabilities assumed and closing costs incurred over the current assets acquired. Vanguard funded the purchase price by borrowing $60.0 million from the $150.0 million acquisition delayed draw term facility under its senior secured credit facilities, entered into in connection with the Merger, and using $27.4 million of cash on hand. Vanguard invested an estimated additional $37.4 million during the third quarter of fiscal 2005 related to the build-up of working capital at the Massachusetts Hospitals. On February 18, 2005, Vanguard borrowed the remaining $90.0 million available to it under the acquisition delayed draw term facility to fund the working capital build-up at the Massachusetts Hospitals and to fund capital expenditures projects. The acquisition of these hospitals gave Vanguard an established presence in the suburban Boston area and central Massachusetts area with an opportunity to grow the hospitals by adding new services. The results of operations of the Massachusetts Hospitals are included in the accompanying consolidated statements of operations for the period January 1, 2005 to June 30, 2005 and for all of fiscal 2006 and 2007.

Purchase Price Allocations

The purchase price for the fiscal 2005 acquisition was allocated as follows (in millions).

	Massachusetts Hospitals
Fair value of assets acquired:	
Prepaids and other current assets	$ 7.3
Property, plant and equipment	101.4
Goodwill and intangible assets	–
Other assets	2.1
Gross assets acquired	110.8
Liabilities assumed	23.1
Cash paid for net assets acquired	$ 87.7

Pro Forma Results

The following table shows the unaudited pro forma results of consolidated operations as if the acquisition of the Massachusetts Hospitals during fiscal 2005 had occurred at the beginning of the immediately preceding period presented, after giving effect to certain adjustments, including the depreciation and amortization of the assets acquired based upon their estimated fair values, changes in net interest expense resulting from changes in consolidated debt and changes in income taxes (in millions).

	Predecessor		Combined Basis
	July 1, 2004 through September 22, 2004	September 23, 2004 through June 30, 2005	Year ended June 30, 2005
Revenues	$ 498.2	$ 1,764.6	$ 2,262.8
Income (loss) from continuing operations before income taxes	$ (172.1)	$ 40.3	$ (131.8)
Income tax expense (benefit)	(55.1)	13.9	(41.2)
Income (loss) from continuing operations	(117.0)	26.4	(90.6)
Income from discontinued operations	1.4	0.3	1.7
Net income (loss)	$ (115.6)	$ 26.7	$ (88.9)

The pro forma information presented above does not intend to indicate what Vanguard's results of operations would have been if the acquisition had in fact occurred at the beginning of the periods presented, and is not intended to be a projection of future results.

5. Discontinued Operations

As previously discussed, Vanguard disposed of its California medical office buildings during fiscal 2006 and its California hospitals during fiscal 2007. The operations of the California hospitals and medical office buildings are included in discontinued operations, net of taxes in the accompanying statements of operations for all periods presented as set forth by SFAS 144, *Accounting for the Impairment or Disposal of Long-Lived Assets* ("SFAS 144") and EITF 03-13, *Applying the Conditions of Paragraph 42 of FASB Statement No. 144 in Determining Whether to Report Discontinued Operations* ("EITF 03-13"). The post-transaction direct cash flows that previously precluded the California medical office buildings operations from being included in discontinued operations under EITF 03-13 were eliminated upon the sale of the California hospitals.

During fiscal 2006, prior to the sale of the California hospitals, Vanguard recorded an impairment charge of $15.0 million ($9.4 million net of taxes) to write down its basis in the net property, plant and equipment of these hospitals to estimated fair value using a discounted cash flows model. The California hospitals assets were not originally classified as assets held for sale at June 30, 2006, because the Board of Directors had not yet approved the sale. However, the accompanying balance sheet as of June 30, 2006, now includes these assets as assets held for sale, and the previously recorded impairment charge is included in discontinued operations, net of taxes in the accompanying consolidated statement of operations for the year ended June 30, 2006.

In June 2007, Vanguard ceased providing acute care services at Phoenix Memorial Hospital ("PMH") and began leasing certain floors of the building to various third party healthcare providers. The leases are 5-year and 7-year leases with renewal options. When comparing the projected lease income to the historical total revenues of PMH, Vanguard determined that the expected cash inflows under the leases were insignificant and deemed indirect cash flows. Thus, the acute care operations of PMH are included in discontinued operations, net of taxes in the accompanying statements of operations for all periods presented as set forth by SFAS 144 and EITF 03-13.

The following table sets forth the components of discontinued operations, net of taxes for the years ended June 30, 2005 (combined basis), 2006 and 2007, respectively (in millions).

	Year ended June 30,		
	2005	2006	2007
Total revenues	$ 231.6	$ 234.1	$ 91.7
Operating expenses	222.8	239.3	115.9
Allocated interest	6.0	7.2	2.7
Impairment loss	–	15.0	–
Loss (gain) on sale of assets	–	(11.1)	1.7
Income tax expense (benefit)	1.1	(5.7)	(9.5)
Loss (income) from discontinued operations, net of taxes	$ (1.7)	$ 10.6	$ 19.1

The interest allocations for the years ended June 30, 2005 (combined basis), 2006 and 2007 were based upon the ratio of net assets to be sold to the sum of Vanguard's total net assets and Vanguard's outstanding debt. Income taxes were calculated using an effective tax rate of approximately 39.3%, 35.0% and 33.2% for the years ended June 30, 2005 (combined basis), 2006 and 2007, respectively.

The following table sets forth the components of assets held for sale and liabilities to be assumed by purchaser as of June 30, 2006 that are included in the acute care services segment (in millions).

	June 30, 2006
Current assets-CA hospitals	$ 3.7
Net property, plant and equipment-CA hospitals	40.0
Goodwill-CA hospitals	3.0
Net intangible assets-CA hospitals	0.4
Net property, plant and equipment-other	5.0
Total assets held for sale	52.1
Liabilities to be assumed by purchaser	(7.4)
Net assets to be divested	$ 44.7

6. Prepaid Expenses and Other Current Assets

Prepaid expenses and other current assets in the accompanying consolidated balance sheets consist of the following at June 30, 2006 and 2007 (in millions).

	2006	2007
Prepaid insurance	$ 7.5	$ 6.0
Other prepaid expenses	9.0	10.1
Deferred taxes assets	8.9	8.9
Other receivables	20.5	32.7
	$ 45.9	$ 57.7

7. Impairment of Long-Lived Assets

In recent periods, Vanguard experienced gradual changes to the business climate at its Chicago hospitals, the most significant being payer mix shifts, which have resulted in weaker than expected operating results at those hospitals. Vanguard believes that these trends may not be temporary in nature and may not be sufficiently offset by various initiatives to improve operating results. Accordingly, Vanguard performed an impairment test of the long-lived assets of these hospitals under SFAS 144 and SFAS 142 effective December 31, 2006. Based upon independent third party estimates of the fair value of the hospitals, Vanguard recorded a $123.8 million ($110.5 million, net of tax benefit) impairment charge during December 2006. The independent third party fair value estimates were developed using a discounted net cash flows approach and two market-based approaches. As a result of the impairment charge, Vanguard reduced goodwill for its acute care services segment $123.8 million during December 2006. Vanguard will continue to monitor the operating environment in Chicago and could further reduce the carrying value of these assets should conditions deteriorate further.

8. Goodwill and Intangible Assets

The following table provides information regarding the intangible assets, including deferred loan costs, included in the accompanying consolidated balance sheets as of June 30, 2006 and 2007 (in millions).

	Gross Carrying Amount		Accumulated Amortization	
Class of Intangible Asset	2006	2007	2006	2007
Amortized intangible assets:				
Deferred loan costs	$ 43.8	$ 43.8	$ 6.7	$ 11.2
Contracts	31.4	31.4	5.5	8.6
Physician income and other guarantees	2.0	13.8	0.3	5.4
Other	1.3	1.3	0.2	0.3
Subtotal	78.5	90.3	12.7	25.5
Indefinite-lived intangible assets:				
License and accreditation	3.2	3.2	–	–
Total	$ 81.7	$ 93.5	$ 12.7	$ 25.5

Amortization expense for the predecessor period July 1, 2004 through September 22, 2004, the successor period September 23, 2004 through June 30, 2005, the combined year ended June 30, 2005 and the years ended June 30, 2006 and 2007 was approximately $0.5 million, $2.5 million, $3.0 million, $3.2 million and $3.2 million, respectively. Vanguard expects amortization expense for these intangible assets, excluding deferred loan costs that are amortized to interest expense and physician income and service agreement guarantees that are amortized to other operating expenses, to approximate $3.2 million during the fiscal years ending June 30, 2008 through June 30, 2012. The lives over which intangible assets are amortized range from two years to eleven years.

The following table presents the changes in the carrying amount of goodwill from June 30, 2005 through June 30, 2007 (in millions).

	Acute Care Services	Health Plans	Total
Balance as of June 30, 2005	$ 745.0	$ 68.1	$ 813.1
Blackstone merger adjustments	(5.8)	11.3	5.5
California hospital goodwill reclassified to assets held for sale	(3.0)	–	(3.0)
Sale of California medical office buildings	(2.8)	–	(2.8)
Balance as of June 30, 2006	733.4	79.4	812.8
Chicago hospitals goodwill impairment	(123.8)	–	(123.8)
Acquisition of physician practice	0.2	–	0.2
Balance as of June 30, 2007	$ 609.8	$ 79.4	$ 689.2

Vanguard completed its annual impairment test of goodwill and indefinite-lived intangible assets during the fourth quarter of fiscal 2007 noting no impairment. Approximately $148.6 million of Vanguard's goodwill is deductible for tax purposes.

9. Other Accrued Expenses and Current Liabilities

The following table presents summaries of items comprising other accrued expenses and current liabilities in the accompanying consolidated balance sheets as of June 30, 2006 and 2007 (in millions).

	2006	2007
Due from third-party payers	$ (5.7)	$ (6.7)
Property taxes	14.3	15.3
Current portion of insurance risks	19.5	21.5
Construction retention payable	6.7	1.7
Accrued income guarantees	1.3	4.3
Liabilities from entities held for sale	7.4	–
Other	28.6	27.9
	$ 72.1	$ 64.0

10. Long-Term Debt

A summary of Vanguard's long-term debt at June 30, 2006 and 2007 follows (in millions).

	2006	2007
9.0% Senior Subordinated Notes	$ 575.0	$ 575.0
11.25% Senior Discount Notes	151.4	168.9
Term loans payable under credit facility	789.7	781.9
Capital leases	0.4	–
Other	2.7	2.9
	1,519.2	1,528.7
Less: current maturities	(8.3)	(8.0)
	$ 1,510.9	$ 1,520.7

9.75% Notes

On July 30, 2001, Vanguard received gross proceeds of $300.0 million through the issuance of the 9.75% Notes due August 2011. Interest on the 9.75% Notes was payable semi-annually on February 1 and August 1. Payment of the principal and interest of the 9.75% Notes was subordinate to amounts owed for Vanguard's existing and future senior indebtedness and was guaranteed, jointly and severally, on an unsecured senior subordinated basis by most of Vanguard's subsidiaries. Vanguard was subject to certain restrictive covenants under the Indenture governing the 9.75% Notes. In connection with the Merger, Vanguard completed a tender offer to repurchase the 9.75% Notes and a consent solicitation adopting amendments to the indenture that amended or eliminated substantially all of the restrictive covenants contained in the indenture. Holders of $299.0 million of the 9.75% Notes tendered their notes for repurchase by Vanguard and consented to the proposed amendments to the indenture. Vanguard paid tender premiums and consent fees of $50.2 million related to the repurchase on the Merger date. Vanguard repurchased the remaining $1.0 million of 9.75% Notes in October 2005 and paid additional tender premiums and consent fees of $0.1 million.

9.0% Notes

In connection with the Merger on September 23, 2004, two of Vanguard's wholly owned subsidiaries, Vanguard Health Holding Company II, LLC and Vanguard Holding Company II, Inc. (collectively the "Issuers"), completed a private placement of $575.0 million 9.0% Notes. Interest on the 9.0% Notes is payable semi-annually on October 1 and April 1, with the first interest payment made on April 1, 2005. The 9.0% Notes are general unsecured senior subordinated obligations and rank junior in right of payment to all existing and future senior

indebtedness of the Issuers. All payments on the 9.0% Notes are guaranteed jointly and severally on a senior subordinated basis by Vanguard and its domestic subsidiaries, other than those subsidiaries that do not guarantee the obligations of the borrowers under the senior credit facilities.

At any time prior to October 1, 2007, the Issuers may redeem up to 35% of the aggregate principal amount of the 9.0% Notes with the net proceeds of certain equity offerings at a redemption price of 109% of the principal amount of the 9.0% Notes plus accrued and unpaid interest. Prior to October 1, 2009, the issuers may redeem the 9.0% Notes, in whole or in part, at a price equal to 100% of the principal amount thereof plus a make-whole premium. On or after October 1, 2009, the Issuers may redeem all or part of the 9.0% Notes at various redemption prices given the date of redemption as set forth in the indenture governing the 9.0% Notes. The initial redemption price for the 9.0% Notes is equal to 104.50% of their principal amount, plus accrued and unpaid interest. The redemption price declines each year after 2009. The redemption price will be 100% of the principal amount, plus accrued and unpaid interest, beginning on October 1, 2012.

On January 26, 2005, Vanguard exchanged all of its outstanding 9.0% senior subordinated notes due 2014 for new 9.0% senior subordinated notes due 2014 with identical terms and conditions, except that they were registered under the Securities Act of 1933. Terms and conditions of the exchange offer were set forth in the registration statement on Form S-4 filed with the Securities and Exchange Commission that became effective on December 23, 2004.

11.25% Notes

In connection with the Merger on September 23, 2004, two of Vanguard's wholly owned subsidiaries, Vanguard Health Holding Company I, LLC and Vanguard Holding Company I, Inc. (collectively the "Discount Issuers"), completed a private placement of $216.0 million aggregate principal amount at maturity ($124.7 million in gross proceeds) of 11.25% Notes. The 11.25% Notes accrete at the stated rate compounded semi-annually on April 1 and October 1 of each year to, but not including, October 1, 2009. From and after October 1, 2009, cash interest on the 11.25% Notes will accrue at 11.25% per annum, and will be payable on April 1 and October 1 of each year, commencing on April 1, 2010 until maturity. The 11.25% Notes are general senior unsecured obligations and rank junior in right of payment to all existing and future senior indebtedness of the Discount Issuers but senior to any of the Discount Issuers' future senior subordinated indebtedness. All payments on the 11.25% Notes are guaranteed by Vanguard as a holding company guarantee.

At any time prior to October 1, 2007, the Discount Issuers may redeem up to 35% of the aggregate principal amount at maturity of the 11.25% Notes with the net proceeds of certain equity offerings at 111.25% of the accreted value of the 11.25% Notes plus accrued and unpaid interest. Prior to October 1, 2009, the issuers may redeem the 11.25% Notes, in whole or in part, at a price equal to 100% of the accreted value thereof, plus accrued and unpaid interest, plus a make-whole premium. On or after October 1, 2009, the Discount Issuers may redeem all or a part of the 11.25% Notes at various redemption prices given the date of redemption as set forth in the indenture governing the 11.25% Notes. The initial redemption price for the 11.25% Notes on October 1, 2009 is equal to 105.625% of their principal amount, plus accrued and unpaid interest. The redemption price declines each year after 2009. The redemption price will be 100% of the principal amount, plus accrued and unpaid interest, beginning on October 1, 2012.

On January 26, 2005, Vanguard exchanged all of its outstanding 11.25% senior discount notes due 2015 for new 11.25% senior discount notes due 2015 with identical terms and conditions, except that they were registered under the Securities Act of 1933. Terms and conditions of the exchange offer were set forth in the registration statement on Form S-4 filed with the Securities and Exchange Commission that became effective on December 23, 2004.

Credit Facility Debt

On May 18, 2004, Vanguard entered into a new senior secured credit facility (the "2004 credit facility") which refinanced the previous amended 2001 credit facility. The 2004 credit facility consisted of $300.0 million in seven-year term loans and a $245.0 million, five-year revolving credit facility. The interest rate on the term loans was either: 1) LIBOR plus a margin of 2.00% to 2.25% per annum dependent upon Vanguard's consolidated

leverage ratio or 2) a base rate plus a margin of 1.00% to 1.25% per annum dependent upon Vanguard's consolidated leverage ratio. Proceeds from the 2004 credit facility were used to repay all outstanding term and revolving loans under the previous amended 2001 credit facility, to pay closing and other refinancing costs and to provide funds for working capital, capital expenditures and general corporate purposes. Immediately prior to the Merger, Vanguard had no cash borrowings under its previous revolving credit facility but had utilized capacity related to the issuance of letters of credit totaling $27.7 million in respect of its self-insured workers compensation program, as well as, a performance guaranty required by the state agency that regulates PHP.

In connection with the Merger on September 23, 2004, two of Vanguard's wholly owned subsidiaries, Vanguard Health Holding Company II, LLC and Vanguard Health Company II, Inc. (the "Co-borrowers"), entered into new senior secured credit facilities (the "merger credit facilities") with various lenders and Bank of America, N.A. as administrative agent and Citicorp North America, Inc. as syndication agent, and repaid all amounts outstanding under the 2004 credit facility. The merger credit facilities include a seven-year term loan facility in the aggregate principal amount of $800.0 million (of which $475.0 million was funded at closing) and a six-year $250.0 million revolving credit facility (of which $27.7 million of capacity was utilized at closing for letters of credit related to certain performance guarantees). Of the $325.0 million unfunded term loans, $150.0 million was made available to finance the acquisition of hospitals and related businesses provided that the acquisition occurred on or prior to February 20, 2005, and to fund capital expenditures and other corporate needs. Also, $175.0 million was made available for working capital, capital expenditures and other general corporate purposes until September 23, 2005. Vanguard borrowed $60.0 million of the available $150.0 million acquisition delayed draw term loan facility in order to fund a portion of the acquisition purchase price of the Massachusetts Hospitals on December 31, 2004 and borrowed the remaining $90.0 million on February 18, 2005 to fund the working capital of the Massachusetts Hospitals and to fund capital expenditures. Vanguard borrowed the final $175.0 million of delayed draw term loans in September 2005. All of such loans were scheduled to mature on September 23, 2011.

On September 26, 2005, the Co-borrowers refinanced and repriced all $795.7 million of the then outstanding term loans under the merger credit facilities by borrowing $795.7 million of replacement term loans that also mature on September 23, 2011 (the "2005 term loan facility"). In addition, upon the occurrence of certain events, the Co-borrowers may request an incremental term loan facility to be added to the 2005 term loan facility in an amount not to exceed $300.0 million in the aggregate, subject to receipt of commitments by existing lenders or other financing institutions and to the satisfaction of certain other conditions. The revolving loan facility under the merger credit facilities did not change in connection with the term loan refinancing. As of June 30, 2007, $781.9 million was outstanding under the 2005 term loan facility. The total remaining capacity of the revolving credit facility, net of letters of credit, was $218.4 million as of June 30, 2007.

The 2005 term loan facility borrowings bear interest at a rate equal to, at Vanguard's option, either LIBOR plus 2.25% per annum or a base rate plus 1.25% per annum. These interest rates reflect a savings of 1.00% per annum over the interest rate options for term loan borrowings under the merger credit facilities. Borrowings under the revolving credit facility currently bear interest at a rate equal to, at Vanguard's option, LIBOR plus 2.25% per annum or a base rate plus 1.25% per annum, subject to an increase of up to 0.25% per annum should Vanguard's leverage ratio increase over certain designated levels. Vanguard also pays a commitment fee to the lenders under the revolving credit facility in respect of unutilized commitments thereunder at a rate equal to 0.50% per annum. Vanguard pays customary letter of credit fees.

Vanguard is subject to certain restrictive and financial covenants under the credit agreement governing the 2005 term loan facility and the revolving credit facility including a total leverage ratio, senior leverage ratio, interest coverage ratio and capital expenditure restrictions. Vanguard was in compliance with each of these financial covenants as of June 30, 2007. Obligations under the credit agreement are unconditionally guaranteed by Vanguard and Vanguard Health Holding Company I, LLC ("VHS Holdco I") and, subject to certain exceptions, each of VHS Holdco I's wholly-owned domestic subsidiaries (the "U.S. Guarantors"). Obligations under the credit agreement are also secured by substantially all of the assets of Vanguard Health Holding Company II, LLC ("VHS Holdco II") and the U.S. Guarantors including a pledge of 100% of the membership interests of VHS Holdco II, 100% of the capital stock of substantially all U.S. Guarantors (other than VHS Holdco I) and 65% of the capital stock of each of VHS Holdco II's non-U.S. subsidiaries that are directly owned by VHS Holdco II or one of the U.S. Guarantors and a security interest in substantially all tangible and intangible assets of VHS Holdco II and each U.S. Guarantor.

Deferred Loan Costs

Vanguard incurred offering costs of approximately $11.5 million for the 9.75% Notes, which were being amortized over the 10-year life of the 9.75% Notes. Vanguard capitalized $8.2 million of new loan costs in connection with the execution of the 2004 credit facility. Approximately $0.5 million of the interest expense during the predecessor period July 1, 2004 through September 22, 2004 related to the amortization of the 2004 credit facility costs.

In connection with the Merger, Vanguard extinguished the deferred offering costs related to its 9.75% Notes and the deferred loan costs related to its existing 2004 credit facility. Vanguard incurred an additional $43.9 million of deferred offering and loan costs related to the 9.0% Notes, the 11.25% Notes and term and revolving loan borrowings under the merger credit facilities and the 2005 term loan facility. Vanguard incurred $2.7 million, $4.0 million and $4.4 million of interest expense, respectively, during the successor period September 23, 2004 through June 30, 2005 and the years ended June 30, 2006 and 2007 related to the amortization of these offering and loan costs.

Future Maturities

Future maturities of Vanguard's debt as of June 30, 2007 follow (in millions).

Fiscal Year	Amount
2008	$ 8.0
2009	7.9
2010	8.0
2011	7.9
Thereafter	1,544.0
	$ 1,575.8

Other Information

Vanguard conducts substantially all of its business through its subsidiaries. Most of Vanguard's subsidiaries jointly and severally guarantee the 9.0% Notes on an unsecured senior subordinated basis. Certain of Vanguard's other consolidated wholly-owned and non wholly-owned entities do not guarantee the 9.0% Notes in conformity with the provisions of the indenture governing the 9.0% Notes and do not guarantee Vanguard's 2005 term loan facility in conformity with the provisions thereof. The condensed consolidating financial information for the parent company, the issuers of the 9.0% Notes, the issuers of the 11.25% Notes, the guarantor subsidiaries, the combined non-guarantor subsidiaries, certain eliminations and consolidated Vanguard as of June 30, 2006 and 2007, and for the predecessor period July 1, 2004 through September 22, 2004, the successor period September 23, 2004 through June 30, 2005, the combined year ended June 30, 2005 and the years ended June 30, 2006 and 2007, follows.

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING BALANCE SHEETS
June 30, 2006

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
ASSETS							
Current assets:							
Cash and cash equivalents	$ –	$ –	$ –	$ 38.5	$ 85.1	$ –	$ 123.6
Accounts receivable, net	–	–	–	249.3	44.8	–	294.1
Inventories	–	–	–	40.1	5.2	–	45.3
Assets held for sale	–	–	–	45.6	6.5	–	52.1
Prepaid expenses and other current assets	0.1	–	–	28.7	20.8	(3.7)	45.9
Total current assets	0.1	–	–	402.2	162.4	(3.7)	561.0
Property, plant and equipment, net	–	–	–	1,073.5	86.0	–	1,159.5
Goodwill	–	–	–	725.5	87.3	–	812.8
Intangible assets, net	–	33.5	3.6	3.7	28.2	–	69.0
Investments in and advances to affiliates	608.8	–	–	8.2	26.6	(635.4)	8.2
Other assets	–	–	–	39.7	0.3	–	40.0
Total assets	$ 608.9	$ 33.5	$ 3.6	$ 2,252.8	$ 390.8	$ (639.1)	$ 2,650.5
LIABILITIES AND STOCKHOLDERS' EQUITY							
Current liabilities:							
Accounts payable	$ –	$ –	$ –	$ 136.8	$ 15.0	$ –	$ 151.8
Accrued expenses and other current liabilities	–	13.3	–	130.2	78.9	(14.5)	207.9
Current maturities of long-term debt	–	8.0	–	–	0.3	–	8.3
Total current liabilities	–	21.3	–	267.0	94.2	(14.5)	368.0
Other liabilities	–	–	–	25.0	63.4	(6.0)	82.4
Long-term debt, less current maturities	–	1,356.8	151.4	2.7	–	–	1,510.9
Intercompany	(80.3)	(1,136.2)	(120.8)	1,462.1	23.8	(148.6)	–
Stockholders' equity	689.2	(208.4)	(27.0)	496.0	209.4	(470.0)	689.2
Total liabilities and stockholders' equity	$ 608.9	$ 33.5	$ 3.6	$ 2,252.8	$ 390.8	$ (639.1)	$ 2,650.5

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING BALANCE SHEETS
June 30, 2007

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
ASSETS							
Current assets:							
Cash and cash equivalents	$ –	$ –	$ –	$ 11.7	$ 108.4	$ –	$ 120.1
Restricted cash	–	–	–	4.4	1.8	–	6.2
Accounts receivable, net	–	–	–	260.0	27.3	–	287.3
Inventories	–	–	–	41.8	5.0	–	46.8
Prepaid expenses and other current assets	0.1	–	–	37.8	22.4	(2.6)	57.7
Total current assets	0.1	–	–	355.7	164.9	(2.6)	518.1
Property, plant and equipment, net	–	–	–	1,112.1	74.5	–	1,186.6
Goodwill	–	–	–	605.6	83.6	–	689.2
Intangible assets, net	–	29.2	3.4	11.1	24.3	–	68.0
Investments in and advances to affiliates	608.8	–	–	–	26.6	(635.4)	–
Other assets	–	–	–	69.4	0.1	–	69.5
Total assets	$ 608.9	$ 29.2	$ 3.4	$ 2,153.9	$ 374.0	$ (638.0)	$ 2,531.4
LIABILITIES AND STOCKHOLDERS' EQUITY							
Current liabilities:							
Accounts payable	$ –	$ –	$ –	$ 132.8	$ 11.3	$ –	$ 144.1
Accrued expenses and other current liabilities	–	13.4	–	123.8	87.9	(15.5)	209.6
Current maturities of long-term debt	–	8.0	–	(0.2)	0.2	–	8.0
Total current liabilities	–	21.4	–	256.4	99.4	(15.5)	361.7
Other liabilities	–	–	–	50.6	45.3	(4.3)	91.6
Long-term debt, less current maturities	–	1,348.9	168.9	2.9	–	–	1,520.7
Intercompany	51.5	(1,013.2)	(120.9)	1,368.3	51.8	(337.5)	–
Stockholders' equity	557.4	(327.9)	(44.6)	475.7	177.5	(280.7)	557.4
Total liabilities and stockholders' equity	$ 608.9	$ 29.2	$ 3.4	$ 2,153.9	$ 374.0	$ (638.0)	$ 2,531.4

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF OPERATIONS
For the year ended June 30, 2005
(Combined Basis)

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Patient service revenues	$ –	$ –	$ –	$ 1,583.8	$ 146.3	$ (26.3)	$ 1,703.8
Premium revenues	–	–	–	43.5	319.8	(29.8)	333.5
Total revenues	–	–	–	1,627.3	466.1	(56.1)	2,037.3
Salaries and benefits	–	–	–	834.9	74.3	–	909.2
Supplies	–	–	–	312.1	24.7	–	336.8
Medical claims expense	–	–	–	26.6	236.9	(26.3)	237.2
Purchased services	–	–	–	92.1	16.9	–	109.0
Provision for doubtful accounts	–	–	–	122.2	10.8	–	133.0
Other operating expenses	0.1	–	–	140.2	42.2	(29.8)	152.7
Rents and leases	–	–	–	21.1	6.0	–	27.1
Depreciation and amortization	–	–	–	63.6	12.1	–	75.7
Interest, net	–	72.7	11.1	(3.6)	2.1	–	82.3
Management fees	–	–	–	(8.1)	8.1	–	–
Debt extinguishment costs	50.2	–	–	12.0	–	–	62.2
Merger expenses	17.0	–	–	6.3	–	–	23.3
Other	–	–	–	3.4	(0.1)	–	3.3
Total costs and expenses	67.3	72.7	11.1	1,622.8	434.0	(56.1)	2,151.8
Income (loss) from continuing operations before income taxes	(67.3)	(72.7)	(11.1)	4.5	32.1	–	(114.5)
Income tax expense (benefit)	(34.7)	–	–	(2.4)	11.1	(8.7)	(34.7)
Equity in earnings of subsidiaries	(45.5)	–	–	–	–	45.5	–
Income (loss) from continuing operations	(78.1)	(72.7)	(11.1)	6.9	21.0	54.2	(79.8)
Income (loss) from discontinued operations, net of taxes	–	–	–	4.0	(2.3)	–	1.7
Net income (loss)	$ (78.1)	$ (72.7)	$ (11.1)	$ 10.9	$ 18.7	$ 54.2	$ (78.1)

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF OPERATIONS
For the year ended June 30, 2006

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Patient service revenues	$ –	$ –	$ –	$ 1,929.0	$ 144.5	$ (29.9)	$ 2,043.6
Premium revenues	–	–	–	47.9	358.9	(31.8)	375.0
Total revenues	–	–	–	1,976.9	503.4	(61.7)	2,418.6
Salaries and benefits	1.7	–	–	914.8	74.9	–	991.4
Supplies	–	–	–	369.3	24.8	–	394.1
Medical claims expense	–	–	–	29.1	271.1	(29.9)	270.3
Purchased services	–	–	–	110.1	18.0	–	128.1
Provision for doubtful accounts	–	–	–	149.7	7.1	–	156.8
Other operating expenses	0.2	–	–	179.5	43.1	(31.8)	191.0
Rents and leases	–	–	–	27.2	6.7	–	33.9
Depreciation and amortization	–	–	–	86.0	14.3	–	100.3
Interest, net	–	109.5	15.9	(22.3)	0.7	–	103.8
Management fees	–	–	–	(6.7)	6.7	–	–
[illegible] extinguishment costs	0.1	–	–	–	–	–	0.1
Other	–	–	–	8.4	0.7	–	9.1
Total costs and expenses	2.0	109.5	15.9	1,845.1	468.1	(61.7)	2,378.9
Income (loss) from continuing operations before income taxes	(2.0)	(109.5)	(15.9)	131.8	35.3	–	39.7
Income tax expense (benefit)	16.2	–	–	5.1	7.6	(12.7)	16.2
Equity in earnings of subsidiaries	31.1	–	–	–	–	(31.1)	–
Income (loss) from continuing operations	12.9	(109.5)	(15.9)	126.7	27.7	(18.4)	23.5
Loss from discontinued operations, net of taxes	–	–	–	(9.4)	(1.2)	–	(10.6)
Net income (loss)	$ 12.9	$ (109.5)	$ (15.9)	$ 117.3	$ 26.5	$ (18.4)	$ 12.9

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF OPERATIONS
For the year ended June 30, 2007

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Patient service revenues	$ –	$ –	$ –	$ 2,053.9	$ 150.9	$ (25.5)	$ 2,179.3
Premium revenues	–	–	–	56.5	345.3	(0.4)	401.4
Total revenues	–	–	–	2,110.4	496.2	(25.9)	2,580.7
Salaries and benefits	1.2	–	–	986.6	80.1	–	1,067.9
Supplies	–	–	–	394.1	27.7	–	421.8
Medical claims expense	–	–	–	35.6	286.9	(25.5)	297.0
Purchased services	–	–	–	126.6	14.6	–	141.2
Provision for doubtful accounts	–	–	–	169.2	6.0	–	175.2
Other operating expenses	0.2	–	–	171.2	25.4	(0.4)	196.4
Rents and leases	–	–	–	30.8	6.6	–	37.4
Depreciation and amortization	–	–	–	104.1	14.5	–	118.6
Interest, net	–	119.5	17.7	(8.2)	(5.2)	–	123.8
Management fees	–	–	–	(8.2)	8.2	–	–
Impairment loss	–	–	–	120.1	3.7	–	123.8
Other	–	–	–	2.8	–	–	2.8
Total costs and expenses	1.4	119.5	17.7	2,124.7	468.5	(25.9)	2,705.9
Income (loss) from continuing operations before income taxes	(1.4)	(119.5)	(17.7)	(14.3)	27.7	–	(125.2)
Income tax expense (benefit)	(11.6)	–	–	–	2.1	(2.1)	(11.6)
Equity in earnings of subsidiaries	(142.9)	–	–	–	–	142.9	–
Income (loss) from continuing operations	(132.7)	(119.5)	(17.7)	(14.3)	25.6	145.0	(113.6)
Loss from discontinued operations, net of taxes	–	–	–	(6.0)	(13.1)	–	(19.1)
Net income (loss)	$ (132.7)	$ (119.5)	$ (17.7)	$ (20.3)	$ 12.5	$ 145.0	$ (132.7)

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF OPERATIONS
For the Predecessor Period July 1, 2004 through September 22, 2004

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Patient service revenues	$ –	$ –	$ –	$ 293.9	$ 31.7	$ –	$ 325.6
Premium revenues	–	–	–	9.7	69.0	(6.4)	72.3
Total revenues	–	–	–	303.6	100.7	(6.4)	397.9
Salaries and benefits	–	–	–	231.9	16.3	–	248.2
Supplies	–	–	–	58.4	5.3	–	63.7
Medical claims expense	–	–	–	1.9	53.1	–	55.0
Purchased services	–	–	–	15.8	3.6	–	19.4
Provision for doubtful accounts	–	–	–	25.3	2.5	–	27.8
Other operating expenses	–	–	–	27.3	11.9	(6.4)	32.8
Rents and leases	–	–	–	4.1	1.0	–	5.1
Depreciation and amortization	–	–	–	14.4	1.6	–	16.0
Interest, net	–	–	–	7.9	1.1	–	9.0
Management fees	–	–	–	(2.0)	2.0	–	–
[illegible] extinguishment costs	50.2	–	–	12.0	–	–	62.2
Merger expenses	17.0	–	–	6.1	–	–	23.1
Other	–	–	–	–	(0.1)	–	(0.1)
Total costs and expenses	67.2	–	–	403.1	98.3	(6.4)	562.2
Income (loss) from continuing operations before income taxes	(67.2)	–	–	(99.5)	2.4	–	(164.3)
Income tax expense (benefit)	(52.2)	–	–	(1.1)	0.2	0.7	(52.2)
Equity in earnings of subsidiaries	(95.7)	–	–	–	–	95.5	–
Income (loss) from continuing operations	(110.7)	–	–	(98.4)	2.2	94.8	(112.1)
Income (loss) from discontinued operations, net of taxes	–	–	–	1.7	(0.3)	–	1.4
Net income (loss)	$ (110.7)	$ –	$ –	$ (96.7)	$ 1.9	$ 94.8	$ (110.7)

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF OPERATIONS
For the Successor Period September 23, 2004 through June 30, 2005

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Patient service revenues	$ –	$ –	$ –	$ 1,289.9	$ 114.6	$ (26.3)	$ 1,378.2
Premium revenues	–	–	–	33.8	250.8	(23.4)	261.2
Total revenues	–	–	–	1,323.7	365.4	(49.7)	1,639.4
Salaries and benefits	–	–	–	603.0	58.0	–	661.0
Supplies	–	–	–	253.7	19.4	–	273.1
Medical claims expense	–	–	–	24.7	183.8	(26.3)	182.2
Purchased services	–	–	–	76.3	13.3	–	89.6
Provision for doubtful accounts	–	–	–	96.9	8.3	–	105.2
Other operating expenses	0.1	–	–	112.9	30.3	(23.4)	119.9
Rents and leases	–	–	–	17.0	5.0	–	22.0
Depreciation and amortization	–	–	–	49.2	10.5	–	59.7
Interest, net	–	72.7	11.1	(11.5)	1.0	–	73.3
Management fees	–	–	–	(6.1)	6.1	–	–
[illegible]ger expenses	–	–	–	0.2	–	–	0.2
Other	–	–	–	3.4	–	–	3.4
Total costs and expenses	0.1	72.7	11.1	1,219.7	335.7	(49.7)	1,589.6
Income (loss) from continuing operations before income taxes	(0.1)	(72.7)	(11.1)	104.0	29.7	–	49.8
Income tax expense (benefit)	17.5	–	–	(1.3)	10.9	(9.6)	17.5
Equity in earnings of subsidiaries	50.2	–	–	–	–	(50.2)	–
Income (loss) from continuing operations	32.6	(72.7)	(11.1)	105.3	18.8	(40.6)	32.3
Income (loss) from discontinued operations, net of taxes	–	–	–	2.3	(2.0)	–	0.3
Net income (loss)	$ 32.6	$ (72.7)	$ (11.1)	$ 107.6	$ 16.8	$ (40.6)	$ 32.6

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS
For the year ended June 30, 2005
(Combined Basis)

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Operating activities:							
Net income (loss)	$ (78.1)	$ (72.7)	$ (11.1)	$ 10.9	$ 18.7	$ 54.2	$ (78.1)
Adjustments to reconcile net income (loss) to net cash provided by (used in) operating activities							
Loss (income) from discontinued operations	–	–	–	(4.0)	2.3	–	(1.7)
Depreciation and amortization	–	–	–	63.6	12.1	–	75.7
Provision for doubtful accounts	–	–	–	122.2	10.8	–	133.0
Deferred income taxes	(37.6)	–	–	–	–	–	(37.6)
Amortization of loan costs	–	2.6	0.1	0.5	–	–	3.2
Accretion of principal on senior discount notes	–	–	11.0	–	–	–	11.0
Loss on sale of assets	–	–	–	0.6	–	–	0.6
Stock compensation	–	–	–	97.4	–	–	97.4
Debt extinguishment costs	50.2	–	–	12.0	–	–	62.2
Merger expenses	17.0	–	–	6.3	–	–	23.3
Changes in operating assets and liabilities, net of effects of acquisitions:							
Equity in earnings of subsidiaries	45.5	–	–	–	–	(45.5)	–
Accounts receivable	–	–	–	(122.8)	(17.0)	–	(139.8)
Establishment of accounts receivables for acquisitions	–	–	–	(53.3)	–	–	(53.3)
Inventories	–	–	–	(2.4)	(0.4)	–	(2.8)
Prepaid expenses and other current assets	(2.8)	–	–	5.3	(8.6)	–	(6.1)
Accounts payable	–	–	–	55.4	(0.7)	–	54.7
Accrued expenses and other liabilities	5.5	14.4	–	1.5	34.5	(8.7)	47.2
Net cash provided by (used in) operating activities – continuing operations	(0.3)	(55.7)	–	193.2	51.7	–	188.9
Net cash provided by operating activities – discontinued operations	–	–	–	7.6	5.3	–	12.9
Net cash provided by (used in) operating activities	(0.3)	(55.7)	–	200.8	57.0	–	201.8
Investing activities:						–	
Acquisitions	(51.2)	–	–	(87.4)	–	–	(138.6)
Capital expenditures	–	–	–	(210.3)	(13.9)	–	(224.2)
Proceeds from asset sales	–	–	–	0.7	–	–	0.7
Purchases of short-term investments	–	–	–	(77.8)	(10.0)	–	(87.8)
Sales of short-term investments	–	–	–	107.8	38.0	–	145.8
Other	6.7	–	–	(12.9)	(22.6)	22.6	(6.2)
Net cash provided by (used in) investing activities – continuing operations	(44.5)	–	–	(279.9)	(8.5)	22.6	(310.3)
Net cash used in operating activities – discontinued operations	–	–	–	(7.8)	(6.2)	–	(14.0)
Net cash provided by (used in) investing activities	(44.5)	–	–	(287.7)	(14.7)	22.6	(324.3)

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS
For the year ended June 30, 2005
(Combined Basis)
(continued)

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Financing activities:							
Proceeds from long-term debt	1,347.7		–	–	–	–	1,347.7
Payments of long-term debt and capital leases	(682.0)	(4.3)	–	(3.4)	(0.7)	–	(690.4)
Payments of loan costs and debt termination fees	(44.4)	–	–	–	–	–	(44.4)
Proceeds from joint venture partner contributions	–	–	–	8.0	–	–	8.0
Proceeds from issuance of common stock	495.5	–	–	–	–	–	495.5
Payments to retire stock and stock options	(964.9)	–	–	–	–	–	(964.9)
Cash provided by (used in) intercompany activity	(106.4)	60.0	–	73.2	(4.2)	(22.6)	–
Exercise of stock options	0.1	–	–	–	–	–	0.1
Net cash provided by (used in) financing activities	45.6	55.7	–	77.8	(4.9)	(22.6)	151.6
Net increase (decrease) in cash and cash equivalents	0.8	–	–	(9.1)	37.4	–	29.1
Cash and cash equivalents, beginning of period	–	–	–	3.2	46.9	–	50.1
Cash and cash equivalents, end of period	$ 0.8	$ –	$ –	$ (5.9)	$ 84.3	$ –	$ 79.2

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS
For the year ended June 30, 2006

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Operating activities:							
Net income (loss)	$ 12.9	$ (109.5)	$ (15.9)	$ 117.3	$ 26.5	$ (18.4)	$ 12.9
Adjustments to reconcile net income (loss) to net cash provided by (used in) operating activities							
Loss from discontinued operations	–	–	–	9.4	1.2	–	10.6
Depreciation and amortization	–	–	–	86.0	14.3	–	100.3
Provision for doubtful accounts	–	–	–	149.7	7.1	–	156.8
Deferred income taxes	8.5	–	–	–	–	–	8.5
Amortization of loan costs	–	3.8	0.2	–	–	–	4.0
Accretion of principal on senior discount notes	–	–	15.7	–	–	–	15.7
Loss (gain) on sale of assets	–	–	–	6.1	(4.6)	–	1.5
Stock compensation	1.7	–	–	–	–	–	1.7
Debt extinguishment costs	0.1	–	–	–	–	–	0.1
Changes in operating assets and liabilities, net of effects of acquisitions:							
Equity in earnings of subsidiaries	(31.1)	–	–	–	–	31.1	–
Accounts receivable	–	–	–	(158.5)	(3.9)	–	(162.4)
Inventories	–	–	–	(5.5)	0.3	–	(5.2)
Prepaid expenses and other current assets	11.7	–	–	(40.0)	31.9	–	3.6
Accounts payable	–	–	–	4.4	(2.0)	–	2.4
Accrued expenses and other liabilities	(3.8)	(1.1)	–	37.6	(31.9)	(12.7)	(11.9)
Net cash provided by (used in) operating activities – continuing operations	–	(106.8)	–	206.5	38.9	–	138.6
Net cash provided by operating activities – discontinued operations	–	–	–	4.4	6.3	–	10.7
Net cash provided by (used in) operating activities	–	(106.8)	–	210.9	45.2	–	149.3
Investing activities:						–	
Acquisitions	–	–	–	(1.2)	–	–	(1.2)
Capital expenditures	–	–	–	(264.7)	(10.8)	–	(275.5)
Proceeds from asset sales	–	–	–	11.1	–	–	11.1
Purchases of short-term investments	–	–	–	–	(128.4)	–	(128.4)
Sales of short-term investments	–	–	–	–	128.4	–	128.4
Other	–	–	–	(17.8)	(4.2)	22.6	0.6
Net cash used in investing activities – continuing operations	–	–	–	(272.6)	(15.0)	22.6	(265.0)
Net cash provided by (used in) operating activities – discontinued operations	–	–	–	24.3	(4.7)	–	19.6
Net cash used in investing activities	–	–	–	(248.3)	(19.7)	22.6	(245.4)

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS
For the year ended June 30, 2006
(continued)

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Financing activities:							
Proceeds from long-term debt	–	175.0	–	–	–	–	175.0
Payments of long-term debt and capital leases	–	(30.0)	–	(0.8)	(0.6)	–	(31.4)
Payments of loan costs and debt termination fees	–	–	–	(0.7)	–	–	(0.7)
Payments to retire stock and stock options	(2.5)	–	–	–	–	–	(2.5)
Cash provided by (used in) intercompany activity	1.6	(38.2)	–	83.3	(24.1)	(22.6)	–
Exercise of stock options	0.1	–	–	–	–	–	0.1
Net cash provided by (used in) financing activities	(0.8)	106.8	–	81.8	(24.7)	(22.6)	140.5
Net increase (decrease) in cash and cash equivalents	(0.8)	–	–	44.4	0.8	–	44.4
Cash and cash equivalents, beginning of period	0.8	–	–	(5.9)	84.3	–	79.2
Cash and cash equivalents, end of period	$ –	$ –	$ –	$ 38.5	$ 85.1	$ –	$ 123.6

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS
For the year ended June 30, 2007

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Operating activities:							
Net income (loss)	$ (132.7)	$ (119.5)	$ (17.7)	$ (20.3)	$ 12.5	$ 145.0	$ (132.7)
Adjustments to reconcile net income (loss) to net cash provided by (used in) operating activities							
Loss from discontinued operations	–	–	–	6.0	13.1	–	19.1
Depreciation and amortization	–	–	–	104.1	14.5	–	118.6
Provision for doubtful accounts	–	–	–	169.2	6.0	–	175.2
Deferred income taxes	(12.7)	–	–	–	–	–	(12.7)
Amortization of loan costs	–	4.3	0.2	–	–	–	4.5
Accretion of principal on senior discount notes	–	–	17.5	–	–	–	17.5
Gain on sale of assets	–	–	–	(4.1)	–	–	(4.1)
Stock compensation	1.2	–	–	–	–	–	1.2
Impairment loss	–	–	–	120.1	3.7	–	123.8
Changes in operating assets and liabilities, net of effects of acquisitions:							
Equity in earnings of subsidiaries	142.9	–	–	–	–	(142.9)	–
Accounts receivable	–	–	–	(206.9)	2.9	–	(204.0)
Inventories	–	–	–	(2.9)	1.0	–	(1.9)
Prepaid expenses and other current assets	–	–	–	(21.8)	(1.5)	–	(23.3)
Accounts payable	–	–	–	11.2	(3.8)	–	7.4
Accrued expenses and other liabilities	1.3	0.1	–	54.6	(22.8)	(2.1)	31.1
Net cash provided by (used in) operating activities – continuing operations	–	(115.1)	–	209.2	25.6	–	119.7
Net cash provided by operating activities – discontinued operations		–	–	0.5	3.1	–	3.6
Net cash provided by (used in) operating activities	–	(115.1)	–	209.7	28.7	–	123.3
Investing activities:						–	
Acquisitions	–	–	–	(0.2)	–	–	(0.2)
Capital expenditures	–	–	–	(153.3)	(11.0)	–	(164.3)
Proceeds from asset sales	–	–	–	9.5	–	–	9.5
Purchases of short-term investments	–	–	–	–	(120.0)	–	(120.0)
Sales of short-term investments	–	–	–	–	120.0	–	120.0
Other	–	–	–	1.8	0.2	–	2.0
Net cash used in investing activities – continuing operations	–	–	–	(142.2)	(10.8)	–	(153.0)
Net cash provided by (used in) operating activities – discontinued operations	–	–	–	36.3	(1.8)	–	34.5
Net cash used in investing activities	–	–	–	(105.9)	(12.6)	–	(118.5)

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS
For the year ended June 30, 2007
(continued)

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Financing activities:							
Payments of long-term debt and capital leases	–	(7.9)	–	(0.2)	(0.1)	–	(8.2)
Payments to retire stock, equity incentive units and stock options	–	–	–	(0.3)	–	–	(0.3)
Cash provided by (used in) intercompany activity	–	123.0	–	(130.3)	7.3	–	–
Exercise of stock options	–	–	–	0.2	–	–	0.2
Net cash provided by (used in) financing activities	–	115.1	–	(130.6)	7.2	–	(8.3)
Net increase (decrease) in cash and cash equivalents	–	–	–	(26.8)	23.3	–	(3.5)
Cash and cash equivalents, beginning of period	–	–	–	38.5	85.1	–	123.6
Cash and cash equivalents, end of period	$ –	$ –	$ –	$ 11.7	$ 108.4	$ –	$ 120.1

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS
For the Predecessor Period July 1, 2004 through September 22, 2004

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Operating activities:							
Net income (loss)	$ (110.7)	$ –	$ –	$ (96.7)	$ 1.9	$ 94.8	$ (110.7)
Adjustments to reconcile net income (loss) to net cash provided by operating activities							
Loss (income) from discontinued operations	–	–	–	(1.7)	0.3	–	(1.4)
Depreciation and amortization	–	–	–	14.4	1.6	–	16.0
Provision for doubtful accounts	–	–	–	25.3	2.5	–	27.8
Deferred income taxes	(50.9)	–	–	–	–	–	(50.9)
Amortization of loan costs	–	–	–	0.5	–	–	0.5
Loss on sale of assets	–	–	–	0.6	–	–	0.6
Stock compensation	–	–	–	96.7	–	–	96.7
Debt extinguishment costs	50.2	–	–	12.0	–	–	62.2
Merger expenses	17.0	–	–	6.1	–	–	23.1
Changes in operating assets and liabilities, net of effects of acquisitions:							
Equity in earnings of subsidiaries	95.7	–	–	–	–	(95.7)	–
Accounts receivable	–	–	–	(35.3)	(1.7)	–	(37.0)
Inventories	–	–	–	0.2	(0.2)	–	–
Prepaid expenses and other current assets	6.3	–	–	(14.3)	10.4	–	2.4
Accounts payable	–	–	–	41.6	(0.3)	–	41.3
Accrued expenses and other liabilities	(2.0)	–	–	2.4	9.0	0.9	10.3
Net cash provided by operating activities – continuing operations	5.6	–	–	51.8	23.5	–	80.9
Net cash used in operating activities – discontinued operations	–	–	–	(1.8)	(0.3)	–	(2.1)
Net cash provided by operating activities	5.6	–	–	50.0	23.2	–	78.8
Investing activities:							
Acquisitions	(50.8)	–	–	–	–	–	(50.8)
Capital expenditures	–	–	–	(25.2)	(1.9)	–	(27.1)
Proceeds from asset sales	–	–	–	0.5	–	–	0.5
Sales of short-term investments	–	–	–	30.0	–	–	30.0
Other	–	–	–	0.4	(0.3)	–	0.1
Net cash provided by (used in) investing activities – continuing operations	(50.8)	–	–	5.7	(2.2)	–	(47.3)
Net cash used in operating activities – discontinued operations	–	–	—,	(1.6)	(1.1)	–	(2.7)
Net cash provided by (used in) investing activities	(50.8)	–	–	4.1	(3.3)	–	(50.0)

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS
For the Predecessor Period July 1, 2004 through September 22, 2004
(continued)

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Financing activities:							
Proceeds from long-term debt	1,174.7	–	–	–	–	–	1,174.7
Payments of long-term debt and capital leases	(683.2)	–	–	(0.4)	(0.3)	–	(683.9)
Payments of loan costs and debt termination fees	(40.9)	–	–	–	–	–	(40.9)
Proceeds from issuance of common stock	494.9	–	–	–	–	–	494.9
Payments to retire stock and stock options	(964.9)	–	–	–	–	–	(964.9)
Cash provided by (used in) intercompany activity	64.8	–	–	(51.2)	(13.6)	–	–
Exercise of stock options	0.1	–	–	–	–	–	0.1
Net cash provided by (used in) financing activities	45.5	–	–	(51.6)	(13.9)	–	(20.0)
Net increase in cash and cash equivalents	0.3	–	–	2.5	6.0	–	8.8
Cash and cash equivalents, beginning of period	–	–	–	3.2	46.9	–	50.1
Cash and cash equivalents, end of period	$ 0.3	$ –	$ –	$ 5.7	$ 52.9	$ –	$ 58.9

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS
For the Successor Period September 23, 2004 through June 30, 2005

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Operating activities:							
Net income (loss)	$ 32.6	$ (72.7)	$ (11.1)	$ 107.6	$ 16.8	$ (40.6)	$ 32.6
Adjustments to reconcile net income (loss) to net cash provided by (used in) operating activities							
Loss (income) from discontinued operations	–	–	–	(2.3)	2.0	–	(0.3)
Depreciation and amortization	–	–	–	49.2	10.5	–	59.7
Provision for doubtful accounts	–	–	–	96.9	8.3	–	105.2
Deferred income taxes	13.3	–	–	–	–	–	13.3
Amortization of loan costs	–	2.6	0.1	–	–	–	2.7
Accretion of principal on senior discount notes	–	–	11.0	–	–	–	11.0
Stock compensation	–	–	–	0.7	–	–	0.7
Merger expenses	–	–	–	0.2	–	–	0.2
Changes in operating assets and liabilities, net of effects of acquisitions:							
Equity in earnings of subsidiaries	(50.2)	–	–	–	–	50.2	–
Accounts receivable	–	–	–	(87.5)	(15.3)	–	(102.8)
Establishment of accounts receivables for acquisitions	–	–	–	(53.3)	–	–	(53.3)
Inventories	–	–	–	(2.6)	(0.2)	–	(2.8)
Prepaid expenses and other current assets	(9.1)	–	–	19.6	(19.0)	–	(8.5)
Accounts payable	–	–	–	13.8	(0.4)	–	13.4
Accrued expenses and other liabilities	7.5	14.4	–	(0.9)	25.5	(9.6)	36.9
Net cash provided by (used in) operating activities – continuing operations	(5.9)	(55.7)	–	141.4	28.2	–	108.0
Net cash provided by operating activities – discontinued operations	–	–	–	9.4	5.6	–	15.0
Net cash provided by (used in) operating activities	(5.9)	(55.7)	–	150.8	33.8	–	123.0
Investing activities:						–	
Acquisitions	(0.4)	–	–	(87.4)	–	–	(87.8)
Capital expenditures	–	–	–	(185.1)	(12.0)	–	(197.1)
Proceeds from asset sales	–	–	–	0.2	–	–	0.2
Purchases of short-term investments	–	–	–	(77.8)	(10.0)	–	(87.8)
Sales of short-term investments	–	–	–	77.8	38.0	–	115.8
Other	6.7	–	–	(13.3)	(22.3)	22.6	(6.3)
Net cash provided by (used in) investing activities – continuing operations	6.3	–	–	(285.6)	(6.3)	22.6	(263.0)
Net cash used in operating activities – discontinued operations	–	–	–	(6.2)	(5.1)	–	(11.3)
Net cash provided by (used in) investing activities	6.3	–	–	(291.8)	(11.4)	22.6	(274.3)

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS
For the Successor Period September 23, 2004 through June 30, 2005
(continued)

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Financing activities:							
Proceeds from long-term debt	173.0	–	–	–	–	–	173.0
Payments of long-term debt and capital leases	1.2	(4.3)	–	(3.0)	(0.4)	–	(6.5)
Payments of loan costs and debt termination fees	(3.5)	–	–	–	–	–	(3.5)
Proceeds from joint venture partner contributions	–	–	–	8.0	–	–	8.0
Proceeds from issuance of common stock	0.6	–	–	–	–	–	0.6
Cash provided by (used in) intercompany activity	(171.2)	60.0	–	124.4	9.4	(22.6)	–
Net cash provided by (used in) financing activities	0.1	55.7	–	129.4	9.0	(22.6)	171.6
Net increase (decrease) in cash and cash equivalents	0.5	–	–	(11.6)	31.4	–	20.3
Cash and cash equivalents, beginning of period	0.3	–	–	5.7	52.9	–	58.9
Cash and cash equivalents, end of period	$ 0.8	$ –	$ –	$ (5.9)	$ 84.3	$ –	$ 79.2

11. Income Taxes

Significant components of income tax expense/benefit attributable to continuing operations are as follows (in millions):

	Combined Basis		
	2005	2006	2007
Current:			
Federal	$ 0.6	$ 2.2	$ 0.9
State	1.1	(0.3)	0.1
	1.7	1.9	1.0
Deferred:			
Federal	(32.7)	13.6	(13.7)
State	(8.6)	(3.9)	(4.8)
	(41.3)	9.7	(18.5)
Increase in valuation allowance	4.9	4.6	5.9
Total	$ (34.7)	$ 16.2	$ (11.6)

The following table presents the income taxes associated with continuing operations and discontinued operations as reflected in the accompanying consolidated statements of operations (in millions).

	Combined Basis		
	2005	2006	2007
Continuing operations	$ (34.7)	$ 16.2	$ (11.6)
Discontinued operations	1.1	(5.7)	(9.5)
Total	$ (33.6)	$ 10.5	$ (21.1)

The increases in the valuation allowance during all three years presented result from state net operating loss carryforwards that may not ultimately be utilized because of the uncertainty regarding Vanguard's ability to generate taxable income in certain states. The effective income tax rate differed from the federal statutory rate for the years ended June 30, 2005 (combined basis), 2006 and 2007 as follows:

	Combined Basis		
	2005	2006	2007
Income tax expense at federal statutory rate	35.0%	35.0%	35.0%
Income tax expense at state statutory rate	6.8	(10.1)	3.6
Nondeductible expenses and other	(0.4)	1.9	(0.6)
Increase in valuation allowance	(4.3)	11.6	(4.7)
Nondeductible merger-related costs	(6.8)	–	–
Nondeductible goodwill	–	2.4	–
Nondeductible impairment loss	–	–	(24.0)
Effective income tax rate	30.3%	40.8%	9.3%

Deferred income taxes reflect the net tax effects of temporary differences between the carrying amounts of assets and liabilities for financial reporting purposes and the amounts used for income tax purposes. Significant components of Vanguard's deferred tax assets and liabilities as of June 30, 2006 and 2007, were approximately as follows (in millions):

	2006	2007
Deferred tax assets:		
Net operating loss carryover	$ 71.7	$ 77.4
Excess tax basis over book basis of accounts receivable	2.3	5.9
Accrued expenses and other	10.2	12.8
Deferred loan costs	3.1	2.5
Professional liabilities reserves	2.2	10.7
Self-insurance reserves	11.7	10.1
Alternative minimum tax credit and other credits	1.9	2.3
Total deferred tax assets	103.1	121.7
Valuation allowance	(11.9)	(22.5)
Total deferred tax assets, net of valuation allowance	91.2	99.2
Deferred tax liabilities:		
Depreciation, amortization and fixed assets basis differences	44.3	29.7
Excess book basis over tax basis of prepaid assets and other	7.4	7.9
Total deferred tax liabilities	51.7	37.6
Net deferred tax assets and liabilities	$ 39.5	$ 61.6

Net non-current deferred tax assets of $30.6 million and $52.7 million as of June 30, 2006 and 2007, respectively, are included in the accompanying consolidated balance sheets in other assets. Net current deferred tax assets were $8.9 million as of both June 30, 2006 and 2007.

During fiscal 2007, Vanguard increased the valuation allowance by $10.6 million, of which $4.7 million related to discontinued operations. $5.0 million of the valuation allowance attributable to operations existed as of the Merger date described in Note 3. Any subsequent recognition of tax benefits associated with the pre-Merger valuation allowances will be accounted for as a reduction of goodwill attributable to the Merger in accordance with applicable accounting standards. During fiscal 2006, Vanguard increased goodwill by a total of $4.5 million to adjust the tax accounts that existed as of the Merger date given the final Merger purchase price allocation and the IRS examination discussed below.

As of June 30, 2007, Vanguard had generated net operating loss ("NOL") carryforwards for federal income tax purposes and state income tax purposes of approximately $164.0 million and $489.0 million, respectively. The federal and state NOL carryforwards expire from 2022 to 2027 and 2007 to 2027, respectively. Approximately $3.6 million of these NOLs are subject to annual limitations for federal purposes. These limitations are not expected to significantly affect Vanguard's ability to ultimately recognize the benefit of these NOLs in future years.

On May 18, 2006, Texas repealed its current income tax and replaced it with a gross margins tax to be accounted for as an income tax. Vanguard became subject to the Texas margins tax on July 1, 2006.

On July 26, 2006, the Internal Revenue Service ("IRS") notified Vanguard regarding its findings related to the examination of Vanguard's tax returns for the years ended June 30, 2003 and 2004. Vanguard reached a settlement with the IRS on all issues. Vanguard's tax reserves were adjusted to reflect the final settlement.

12. Stockholder's Equity

Vanguard has the authority to issue 1,000,000 shares of common stock, par value $.01 per share.

Common Stock of Vanguard and Class A Membership Units of Holdings

Immediately prior to the Merger, Vanguard had authorized 600,000 shares of common stock, of which 232,784 shares were outstanding. A portion of the proceeds of the Merger were used to pay the holders of the common stock for their stock and the holders of outstanding options under the 1998 Stock Option Plan, the 2000 Stock Option Plan, the Initial Option Plan and the Carry Option Plan for the excess of the Merger consideration over the exercise prices of such options. In connection with the Merger, Blackstone, MSCP, management and other investors purchased $624.0 million of Class A Membership Units of Holdings. Holdings then invested the $624.0 million in the common stock of Vanguard, and in addition Blackstone invested $125.0 million directly in the common stock of Vanguard. In February 2005, other investors purchased approximately $0.6 million of Class A membership units of Holdings. Holdings then invested the $0.6 million in the common stock of Vanguard.

Equity Incentive Membership Units of Holdings

In connection with the Merger, certain members of senior management purchased Class B, Class C and Class D membership units in Holdings (collectively the "equity incentive units") for approximately $5.7 million pursuant to the Amended and Restated Limited Liability Company Operating Agreement of Holdings dated September 23, 2004 ("LLC Agreement"). The value of the equity incentive units was determined by an independent third party appraiser. The Class B and D units vest 20% on each of the first five anniversaries of the purchase date, while the Class C units vest on the eighth anniversary of the purchase date subject to accelerated vesting upon the occurrence of a sale by Blackstone of at least 25% of its Class A units at a price per unit exceeding 2.5 times the per unit price paid on September 23, 2004. Upon a change of control (as defined in the LLC Agreement), all Class B and D units fully vest, and Class C units fully vest if the change in control constitutes a liquidity event (as defined in the LLC Agreement). In exchange for a cash payment of $5.7 million, Vanguard issued to Holdings 83,890 warrants with an exercise price of $1,000 per share and 35,952 warrants with an exercise price of $3,000 per share to purchase Vanguard's common stock. The warrants may be exercised at any time. Vanguard reserved 119,842 shares of its common stock to be issued upon exercise of the warrants.

During fiscal 2006 and fiscal 2007, Vanguard and Holdings repurchased a total of 33,708 outstanding equity incentive units from former executive officers for approximately $1.7 million. The purchase price for unvested units was based upon the lower of cost or fair market value (determined by an independent appraisal) or the lower of cost or fair market value less a 25% discount, as set forth in the LLC Agreement. The purchase price for vested units was fair market value or fair market value less a 25% discount.

Redeemable Payable-In-Kind Preferred Stock

On February 1, 2000, to satisfy a portion of the purchase price for the acquisition of MacNeal Hospital and related assets, Vanguard issued 20,000 shares of its payable-in-kind convertible redeemable preferred stock ("PIK Preferred Shares") with a par value of $0.01 per share. Dividends payable in the form of additional PIK Preferred Shares accrued at an annual rate of 8%. On January 3, 2003, Vanguard issued 30,000 shares of payable-in-kind convertible redeemable preferred stock ("Series B PIK Preferred Shares") with par value of $0.01 per share to satisfy a portion of the purchase price of its acquisition of the Baptist Health System hospitals. Dividends payable in the form of additional Series B PIK Preferred Shares accrued at an annual rate of 6.25%. Each series of preferred stock was valued by an independent appraiser at $1,000 per share for purposes of the respective acquisitions.

In connection with the Merger, Vanguard redeemed all 27,210 outstanding PIK Preferred Shares at $1,000 per share plus accrued dividends for approximately $28.6 million. In connection with the Merger, all 31,875 outstanding Series B PIK Preferred Shares plus accrued dividends were converted into per share Merger consideration based upon the right of the holder of the Series B PIK Preferred Shares to receive common shares of Vanguard at the $3,500 per share conversion price.

Put and Call Features of Acquisition Subsidiary Stock

For a period of 30 days commencing June 1, 2007 and each June 1 thereafter, University of Chicago Hospitals ("UCH") has the right to require Vanguard to purchase its shares in the subsidiary that acquired Louis A. Weiss Memorial Hospital for a purchase price equal to four times the acquisition subsidiary's Adjusted EBITDA (as defined in the shareholders agreement between the parties) for the most recent 12 months of operations less all indebtedness of the acquisition subsidiary (including capital leases) at such time, multiplied by UCH's percentage interest in the acquisition subsidiary on the date of purchase. Similarly, during the same 30-day periods, Vanguard has the right to require UCH to sell to it UCH's shares in the acquisition subsidiary for a purchase price equal to the greater of (i) six times the acquisition subsidiary's Adjusted EBITDA (as defined in the shareholders agreement among the parties) for the most recent 12 months of operations less all indebtedness of the acquisition subsidiary (including capital leases) at such time, times UCH's percentage interest in the acquisition subsidiary on the date of purchase, and (ii) the price paid by UCH for its interest in the acquisition subsidiary minus dividends or other distributions to UCH in respect of that interest.

13. Stock Based Compensation

As previously discussed, Vanguard used the minimum value pricing model permitted under SFAS 123 to determine stock compensation costs related to stock option grants prior to July 1, 2006. On July 1, 2006, Vanguard adopted the provisions of SFAS 123(R), to account for stock option grants subsequent to July 1, 2006. Vanguard adopted SFAS 123(R) on a prospective basis as required for companies that chose to adopt SFAS 123 using the transition guidance set forth in SFAS 148. During the combined fiscal year 2005, Vanguard incurred stock compensation of $97.4 million primarily as a result of $96.7 million incurred during the predecessor period July 1, 2004 through September 22, 2004 related to Merger payments to stock option holders under Vanguard's former stock option plans as calculated under the provisions of APB 25 for option grants prior to July 1, 2003, and under SFAS 123 for option grants on or after July 1, 2003. During fiscal years 2006 and 2007, Vanguard incurred stock compensation of $1.7 million and $1.2 million, respectively, related to grants under its 2004 Stock Incentive Plan.

Carry Option Plan

On June 1, 1998, the Vanguard board of directors (the "Board") approved the first grant of options, each exercisable for one share of common stock at an exercise price of $170.12, under the Vanguard Health Systems, Inc. Carry Option Plan (the "Carry Option Plan"). In November 2001, the Board approved a second grant of options under the Carry Option Plan, bringing the total number of outstanding options to 29,822, the maximum allowed pursuant to the Amended and Restated Shareholders Agreement dated as of June 1, 2000 and the Carry Option Plan. On the Merger date, the number of exercisable options under the Carry Option Plan was determined to be 10,625 based upon calculations set forth in the plan document. Pursuant to the merger agreement, on September 23, 2004, Vanguard cancelled all options under the Carry Option Plan, terminated the plan and paid the option holders promptly thereafter the excess of the Merger consideration over the exercise price of exercisable options.

Initial Option Plan

The purpose of the Vanguard Health Systems, Inc. Nonqualified Initial Option Plan (the "Initial Option Plan") was primarily to grant option awards to those employees who agreed to work for Vanguard for no cash salaries or cash salaries below fair market value during the eleven months ended May 31, 1998. On June 1, 1998, the Board approved the grant of 3,595 options, each exercisable for one share of common stock, at an exercise price of $170.12 per share. The maximum number of shares of common stock reserved for grant of awards under the Initial Option Plan was 3,595. Each of the 3,595 granted options vested on June 1, 1999 (one-year vesting period). 3,396 of the options became exercisable on June 1, 1999, and the other 199 options became exercisable on the Merger date. Pursuant to the merger agreement, on September 23, 2004, Vanguard cancelled all options under the Initial Option Plan, terminated the plan and paid the option holders promptly thereafter the excess of the Merger consideration over the exercise price of the options.

1998 Stock Option Plan

The purpose of the Vanguard Health Systems, Inc. 1998 Stock Option Plan, as amended effective June 1, 2000 (the "1998 Stock Option Plan"), was to afford an incentive to executive officers, other key employees, directors and consultants of Vanguard to acquire a proprietary interest in Vanguard, to continue as employees, directors, or consultants, to increase their efforts on behalf of Vanguard and to promote the success of its business. The maximum number of shares of Vanguard's common stock reserved for the grant of options under the 1998 Stock Option Plan, as recomputed at the Merger date given calculations set forth in the plan document, was 13,196. Options granted under the 1998 Stock Option plan were designated as either (i) incentive stock options or non-qualified stock options and (ii) Liquidity Event Options or Non-Liquidity Event Options; although certain restrictions existed as to the number of options that could be granted, outstanding and exercisable under each designation. All 11,398 outstanding options under the 1998 Stock Option Plan immediately vested on the Merger date. Pursuant to the merger agreement, on September 23, 2004, Vanguard cancelled all options under the 1998 Stock Option Plan, terminated the plan and paid the option holders promptly thereafter the excess of the Merger consideration over the exercise price of the options.

2000 Stock Option Plan

Effective June 1, 2000, the Vanguard Health Systems 2000 Stock Option Plan (the "2000 Stock Option Plan") was approved by the Board for the same purpose as the 1998 Stock Option Plan. The maximum number of shares of Vanguard's common stock reserved for the grant of options under the 2000 Stock Option Plan was 13,187. Options granted under the 2000 Stock Option plan were designated as either (i) incentive stock options or non-qualified stock options and (ii) Liquidity Event Options or Non-Liquidity Event Options; although certain restrictions existed as to the number of options that could be granted, outstanding and exercisable under each designation. All 13,067 outstanding options under the 2000 Stock Option Plan immediately vested on the Merger date. Pursuant to the merger agreement, on September 23, 2004, Vanguard cancelled all options under the 2000 Stock Option Plan, terminated the plan and paid the option holders promptly thereafter the excess of the Merger consideration over the exercise price of the options.

2004 Stock Incentive Plan

After the Merger, Vanguard adopted the 2004 Stock Incentive Plan ("the 2004 Option Plan"). As of June 30, 2007, the 2004 Option Plan, as amended, allows for the issuance of up to 101,117 options to purchase common stock of Vanguard to its employees. The stock options may be granted as Liquidity Event Options, Time Options or Performance Options at the discretion of the Board. The Liquidity Event Options vest 100% at the eighth anniversary of the date of grant and have an exercise price per share as determined by the Board or a committee thereof. The Time Options vest 20% at each of the first five anniversaries of the date of grant and have an exercise price per share as determined by the Board or a committee thereof. The Performance Options vest 20% at each of the first five anniversaries of the date of grant and have an exercise price equal to $3,000 per share or as determined by the Board. The Time Options and Performance Options immediately vest upon a change of control, while the Liquidity Event Options immediately vest only upon a qualifying Liquidity Event, as defined in the Plan Document. As of June 30, 2007, 65,574 options were outstanding under the 2004 Option Plan.

The following tables summarize options transactions during the predecessor period July 1, 2004 through September 22, 2004, the successor period September 23, 2004 through June 30, 2005 and the years ended June 30, 2006 and 2007.

	Carry Option Plan		Initial Option Plan	
	# of Options	Weighted Average Exercise Price	# of Options	Weighted Average Exercise Price
Options outstanding at June 30, 2004 (predecessor)	29,822	$ 170.12	3,595	$ 170.12
Options granted	–	–	–	–
Options exercised	–	–	–	–
Options cancelled	(29,822)	170.12	(3,595)	170.12
Options outstanding at September 22, 2004 (predecessor) and subsequent periods	–	$ –	–	$ –
Options available for grant at June 30, 2007	–	$ –	–	$ –
Options exercisable at June 30, 2007	–	$ –	–	$ –

	1998 Stock Option Plan		2000 Stock Option Plan		2004 Stock Incentive Plan	
	# of Options	Wtd Avg Exercise Price	# of Options	Wtd Avg Exercise Price	# of Options	Wtd Avg Exercise Price
Options outstanding at June 30, 2004 (predecessor)	9,808	$ 1,014.99	12,297	$ 1,701.18	–	$ –
Options granted	1,590	1,701.18	992	1,701.18	–	–
Options exercised	–	–	(35)	1,701.18	–	–
Options cancelled	(11,398)	1,110.71	(13,254)	1,701.18	–	–
Options outstanding at September 22, 2004 (predecessor)	–	–	–	–	–	–
Options granted	–	–	–	–	40,078	1,600.00
Options exercised	–	–	–	–	–	–
Options cancelled	–	–	–	–	(1,894)	1,600.00
Options outstanding at June 30, 2005	–	–	–	–	38,184	1,600.00
Options granted	–	–	–	–	41,297	1,675.81
Options exercised	–	–	–	–	(141)	1,000.00
Options cancelled	–	–	–	–	(8,683)	1,611.03
Options outstanding at June 30, 2006	–	–	–	–	70,657	1,644.12
Options granted	–	–	–	–	10,110	1,715.06
Options exercised	–	–	–	–	(195)	1,000.00
Options cancelled	–	–	–	–	(14,998)	1,624.81
Options outstanding at June 30, 2007	–	$ –	–	$ –	65,574	$ 1,661.39
Options available for grant at June 30, 2007	–	$ –	–	$ –	35,207	$ 1,724.91
Options exercisable at June 30, 2007	–	$ –	–	$ –	10,487	$ 1,950.16

The following table provides information relating to the 2004 Option Plan as of June 30, 2007.

Exercise price	$1,000.00	$1,150.37	$1,167.50	$3,000.00
Number outstanding	20,197	19,758	5,915	19,704
Weighted average remaining contractual life	7.7 years	8.5 years	9.6 years	8.0 years
Weighted average fair value	$361.23	$431.11	$590.58	$0.00
Number exercisable	3,744	1,904	–	4,839

The following table sets forth certain information regarding those options vested at June 30, 2007, those expected to vest subsequent to June 30, 2007 and the total expected to vest over the life of all options granted.

	Currently Vested	Additional Expected to Vest	Total Expected to Vest
Number of options at June 30, 2007	10,487	31,474	41,961
Weighted average exercise price	$ 1,950.16	$ 1,654.49	$ 1,728.39
Aggregate intrinsic value (in millions)	$ 2.2	$ 8.9	$ 11.1
Weighted average remaining contractual term	7.8 years	8.4 years	8.2 years

14. 401(k) Plan

Effective June 1, 1998, Vanguard adopted the Vanguard 401(k) Retirement Savings Plan (the "401(k) Plan"). The 401(k) Plan is a multiple employer defined contribution plan whereby employees who are age 21 or older are eligible to participate.

For purposes of determining vesting percentages in the 401(k) Plan, many employees received credit for years of service with their respective predecessor companies. The 401(k) Plan allows eligible employees to make contributions of 2% to 20% of their annual compensation. Employer matching contributions, which vary by employer, vest 20% after three years of service and continue vesting at 20% per year until fully vested. Vanguard's matching expense for the years ended June 30, 2005 (combined basis), 2006 and 2007 was approximately $8.2 million, $11.7 million and $13.8 million, respectively.

15. Leases

Vanguard leases real estate properties and equipment under operating leases having various expiration dates. Future minimum operating lease payments at June 30, 2007 are approximately as follows (in millions).

	Operating Leases
2008	$ 27.4
2009	23.2
2010	18.8
2011	14.0
2012	11.8
Thereafter	40.9
Total minimum lease payments	$ 136.1

For the predecessor period July 1, 2004 through September 22, 2004, the successor period September 23, 2004 through June 30, 2005, the combined year ended June 30, 2005 and the years ended June 30, 2006 and 2007, rent expense was approximately $5.1 million, $22.0 million, $27.1 million, $33.9 million and $37.4 million, respectively.

16. Contingencies and Healthcare Regulation

Contingencies

Vanguard is presently, and from time to time, subject to various claims and lawsuits arising in the normal course of business. In the opinion of management, the ultimate resolution of these matters will not have a material adverse effect on Vanguard's financial position or results of operations.

Reimbursement

Final determination of amounts earned under prospective payment and cost-reimbursement activities is subject to review by appropriate governmental authorities or their agents. In the opinion of Vanguard's management, adequate provision has been made for any adjustments that may result from such reviews.

Laws and regulations governing the Medicare and Medicaid and other federal healthcare programs are complex and subject to interpretation. Vanguard's management believes that it is in compliance with all applicable laws and regulations in all material respects and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing. While no such regulatory inquiries have been made, Vanguard's compliance with such laws and regulations is subject to future government review and interpretation. Non-compliance with such laws and regulations could result in significant regulatory action including fines, penalties, and exclusion from the Medicare, Medicaid and other federal healthcare programs.

Acquisitions

Vanguard has acquired and may continue to acquire businesses with prior operating histories. Acquired companies may have unknown or contingent liabilities, including liabilities for failure to comply with healthcare laws and regulations, such as billing and reimbursement, fraud and abuse and similar anti-referral laws. Although Vanguard institutes policies designed to conform practices to its standards following the completion of its acquisitions, there can be no assurance that it will not become liable for past activities of prior owners that may later be asserted to be improper by private plaintiffs or government agencies. Although Vanguard generally seeks to obtain indemnification from prospective sellers covering such matters, there can be no assurance that any such matter will be covered by indemnification, or if covered, that such indemnification will be adequate to cover potential losses and fines.

Employment-Related Agreements

Effective June 1, 1998, Vanguard executed employment agreements with three of its current senior executive officers. Vanguard executed an employment agreement with a fourth current senior executive officer on September 1, 1999. The employment agreements were amended on September 23, 2004 to extend the term of each employment agreement another 5 years and to provide that the Merger did not constitute a change of control, as defined in the agreements. The employment agreements will renew automatically for additional one-year periods, unless terminated by Vanguard or the executive officer. The employment agreements provide, among other things, for minimum salary levels, for participation in bonus plans, and for amounts to be paid as liquidated damages in the event of a change in control or termination by Vanguard without cause.

Vanguard has executed severance protection agreements ("severance agreements") between Vanguard and each of its other officers who do not have employment agreements. The severance agreements are automatically extended for successive one year terms at the discretion of Vanguard unless a change in control occurs, as defined in the severance agreement, at which time the severance agreement continues in effect for a period of not less than three years beyond the date of such event. Vanguard may be obligated to pay severance payments as set forth in the severance agreements in the event of a change in control and the termination of the executive's employment of Vanguard.

Guarantees

Physician Guarantees

Vanguard entered into physician relocation agreements and service agreements under which it guarantees minimum monthly income, revenues or collections to physicians during a specified period of time (typically 12 months to 24 months). In return for the minimum guarantee payment, the physicians are required to practice in the community or to provide emergency room or specialty program coverage at Vanguard's hospitals for a stated period of time (typically 3 to 5 years) or else return the payments to Vanguard. In January 2006, Vanguard adopted Financial Accounting Standards Board Staff Position No. FIN 45-3, *Application of FASB Interpretation No. 45 to Minimum Revenue Guarantees Granted to a Business or Its Owners* ("FSP 45-3"). FSP 45-3 requires that a liability

be recorded at fair value for all guarantees entered into on or after January 1, 2006. Vanguard determines this liability and an offsetting intangible asset by calculating an estimate of expected payments to be made over the guarantee period. Vanguard reduces the liability as it makes guarantee payments and amortizes the intangible asset over the term of the physicians' relocation or service agreements. As of June 30, 2007, Vanguard had a net intangible asset of $7.9 million and a remaining liability of $4.3 million related to these physician guarantees. The maximum amount of Vanguard's unpaid physician income guarantees under FSP 45-3 as of June 30, 2007 was approximately $10.4 million.

Other Guarantees

As part of its contract with AHCCCS, PHP is required to maintain a performance guarantee in the amount of $19.0 million, an amount determined based upon PHP's membership and capitation premiums received. As of June 30, 2007, Vanguard maintained this performance guarantee entirely in the form of surety bonds with independent third party insurers that expire on September 30, 2007. Vanguard is required to arrange for $2.9 million in letters of credit to collateralize its $19.0 million in surety bonds with the third party insurers. As of June 30, 2007, Vanguard provided a $0.6 million guarantee of the debt of a joint venture accounted for as an equity method investment and also from time to time enters into parent-subsidiary guarantee arrangements in the ordinary course of operating its business.

Variable Interest Entities

Vanguard is a party to three contractual agreements whereby it may be required to make monthly payments to the developers and managers of three medical office buildings located on its hospital campuses through minimum rent revenue guarantees. Vanguard entered into these agreements to provide an incentive to the developers to fund the construction of the medical office buildings and manage the buildings upon their completion in order to make physician office space available near its hospital campuses. One of the contracts commenced prior to the effective date of Financial Interpretation Number 46, *Variable Interest Entities*, (as amended by FIN 46R) and is scheduled to terminate in March 2016. Due to the significance of Vanguard's minimum rent revenue payments to the operations of the medical office building, Vanguard consolidated this entity for financial reporting purposes as of June 30, 2006 and 2007. The variable interest entity's debt is collateralized by the medical office building asset (cost value of $2.4 million) and not by any Vanguard assets. The second contract commenced in April 2005 for a period of 12 years. Vanguard deemed this contract a VIE in which Vanguard is not the primary beneficiary. The maximum annual amount Vanguard would pay under the contract assuming zero occupancy would be approximately $1.5 million. Vanguard expects to achieve the permanent burnoff provisions under the third contract during fiscal 2008 and deems the developer landlord to be the primary beneficiary. Vanguard currently expects to make no rental shortfall payments during fiscal 2008 under the second and third contracts given current and expected future occupancy levels.

17. Related Party Transactions

During fiscal 2005 (combined basis), Vanguard paid approximately $6,000 of the out-of-pocket expenses of MSCP related to their review of Vanguard's proposed transactions and reimbursement for travel and related expenses. MSCP maintained an equity interest in Vanguard of 17.3% as of June 30, 2007. Also, one of Vanguard's directors as of June 30, 2007, Eric T. Fry, and two previous directors, Howard I. Hoffen and Karen H. Bechtel, were managing directors of Morgan Stanley & Co. Incorporated during a portion of fiscal 2005. Until September 2004, Eric T. Fry was a managing director of Morgan Stanley Private Equity, while Howard I. Hoffen was Chairman and Chief Executive Officer of Morgan Stanley Private Equity. Morgan Stanley & Co. Incorporated, Morgan Stanley Private Equity and Morgan Stanley Senior Funding, Inc. are affiliates of MSCP.

Pursuant to the merger agreement, Vanguard entered into a transaction and monitoring fee agreement with Blackstone and Metalmark Subadvisor LLC ("Metalmark"). Under the terms of the agreement, Vanguard paid Blackstone a transaction and advisory fee on the Merger date equal to $20.0 million plus approximately $350,000 of out of pocket expenses for Blackstone's expertise in undertaking financial and structural analysis, due diligence investigations and other advice and negotiation assistance necessary to complete the Merger. This fee is included in goodwill as a direct acquisition cost. Funds affiliated with Blackstone held an equity interest in Vanguard of 66.0% as of June 30, 2007. Vanguard also agreed to pay Blackstone and Metalmark an annual monitoring fee of $4.0

million and $1.2 million, respectively, plus out of pocket expenses. The monitoring fee represents compensation to Blackstone and Metalmark for their advisory and consulting services with respect to financing transactions, strategic decisions, dispositions or acquisitions of assets and other Vanguard affairs from time to time. Blackstone also has the option under the agreement to elect at any time in anticipation of a change in control or initial public offering to require Vanguard to pay both Blackstone and Metalmark a lump sum monitoring fee, calculated as the net present value of future annual monitoring fees assuming a remaining ten-year payment period, in lieu of the remaining annual monitoring fee payments. If Blackstone chooses a lump sum payment, Metalmark is entitled to receive not less than 15% of the sum of the initial $20.0 million Blackstone transaction fee and the cumulative monitoring fees and lump sum monitoring fee paid to Blackstone less the cumulative aggregate monitoring fees paid to Metalmark to date. During fiscal 2005 (combined basis), Vanguard paid approximately $3,093,000 and $928,000 in monitoring fees to Blackstone and Metalmark, respectively. During both fiscal 2006 and 2007, Vanguard paid $4,000,000 and $1,200,000 in monitoring fees to Blackstone and Metalmark, respectively. Vanguard also incurred $2,569 of the out-of-pocket expenses for Metalmark's services under the monitoring agreement, which Vanguard paid in July 2006.

18. Segment Information

Vanguard's acute care hospitals and related healthcare businesses are similar in their activities and economic environments in which they operate (i.e. urban markets). Accordingly, Vanguard's reportable operating segments consist of 1) acute care hospitals and related healthcare businesses, collectively, and 2) health plans consisting of MacNeal Health Providers, a contracting entity for MacNeal Hospital and Weiss Memorial Hospital in the metropolitan Chicago area, Phoenix Health Plan, a Medicaid managed health plan operating in Arizona and Abrazo Advantage Health Plan, a Medicare and Medicaid dual eligible managed health plan operating in Arizona. The following tables provide financial information by business segment for the year ended June 30, 2005 (combined basis), the year ended June 30, 2006, the year ended June 30, 2007, the predecessor period July 1, 2004 through September 22, 2004 and the successor period September 23, 2004 through June 30, 2005. The measure of operating profit or loss presented in the following tables, income or loss from continuing operations before income taxes, is different than the measure used in previous years as a result of the discontinued operations as discussed in Note 5.

	For the Year Ended June 30, 2005 (combined basis)			
	Health Plans	Acute Care Services	Eliminations	Consolidated
		(In millions)		
Patient service revenues	$ –	$ 1,703.8	$ –	$ 1,703.8
Capitation premiums	333.5	–	–	333.5
Inter-segment revenues	–	36.6	(36.6)	–
Total revenues	333.5	1,740.4	(36.6)	2,037.3
Salaries and benefits (excludes stock compensation of $97.4 million)	12.5	799.3	–	811.8
Supplies	0.2	336.6	–	336.8
Medical claims expense	237.2	–	–	237.2
Provision for doubtful accounts	–	133.0	–	133.0
Other operating expenses – external	17.0	271.8	–	288.8
Operating expenses – inter-segment	36.6	–	(36.6)	–
Total operating expenses	303.5	1,540.7	(36.6)	1,807.6
Segment EBITDA(1)	30.0	199.7	–	229.7
Depreciation and amortization	3.7	72.0	–	75.7
Interest, net	(0.2)	82.5	–	82.3
Minority interests	–	(0.3)	–	(0.3)
Equity method income	–	(1.0)	–	(1.0)
Stock compensation	–	97.4	–	97.4
Debt extinguishment costs	–	62.2	–	62.2
Merger expenses	–	23.3	–	23.3
Monitoring fees	–	4.0	–	4.0
Loss on sale of assets	–	0.6	–	0.6
Income (loss) from continuing operations before income taxes	$ 26.5	$ (141.0)	$ –	$ (114.5)
Segment assets	$ 163.2	$ 2,308.5	$ –	$ 2,471.7
Capital expenditures	$ 1.5	$ 222.7	$ –	$ 224.2

(1) Segment EBITDA is defined as income before interest expense (net of interest income), income taxes, depreciation and amortization, minority interests, equity method income or loss, stock compensation, debt extinguishment costs, merger expenses, gain or loss on sale of assets, monitoring fees, impairment loss and discontinued operations. Management uses Segment EBITDA to measure performance for Vanguard's segments and to develop strategic objectives and operating plans for those segments. Segment EBITDA eliminates the uneven effect of non-cash depreciation of tangible assets and amortization of intangible assets, much of which results from acquisitions accounted for under the purchase method of accounting. Segment EBITDA also eliminates the effects of changes in interest rates which management believes relate to general trends in global capital markets, but are not necessarily indicative of the operating performance of Vanguard's segments. Management believes that Segment EBITDA provides useful information about the financial performance of Vanguard's segments to investors, lenders, financial analysts and rating agencies. Additionally, management believes that investors and lenders view Segment EBITDA as an important factor in making investment decisions and assessing the value of Vanguard. Segment EBITDA is not a substitute for net income, operating cash flows or other cash flow statement data determined in accordance with accounting principles generally accepted in the United States. Segment EBITDA, as presented, may not be comparable to similarly titled measures of other companies.

	For the Year Ended June 30, 2006			
	Health Plans	Acute Care Services	Eliminations	Consolidated
		(In millions)		
Patient service revenues	$ –	$ 2,043.6	$ –	$ 2,043.6
Premium revenues	375.0	–	–	375.0
Inter-segment revenues	–	40.0	(40.0)	–
Total revenues	375.0	2,083.6	(40.0)	2,418.6
Salaries and benefits (excludes stock compensation of $1.7 million)	13.6	976.1	–	989.7
Supplies	0.2	393.9	–	394.1
Medical claims expense	270.3	–	–	270.3
Provision for doubtful accounts	–	156.8	–	156.8
Other operating expenses – external	18.3	334.7	–	353.0
Operating expenses – inter-segment	40.0	–	(40.0)	–
Total operating expenses	342.4	1,861.5	(40.0)	2,163.9
Segment EBITDA(1)	32.6	222.1	–	254.7
Depreciation and amortization	4.3	96.0	–	100.3
Interest, net	(2.3)	106.1	–	103.8
Minority interests	–	2.6	–	2.6
Equity method income	–	(0.2)	–	(0.2)
Stock compensation	–	1.7	–	1.7
Debt extinguishment costs	–	0.1	–	0.1
Loss on sale of assets	–	1.5	–	1.5
Monitoring fees	–	5.2	–	5.2
Income from continuing operations before income taxes	$ 30.6	$ 9.1	$ –	$ 39.7
Segment assets	$ 161.9	$ 2,488.6	$ –	$ 2,650.5
Capital expenditures	$ 0.2	$ 275.3	$ –	$ 275.5

(1) Segment EBITDA is defined as income before interest expense (net of interest income), income taxes, depreciation and amortization, minority interests, equity method income or loss, stock compensation, debt extinguishment costs, merger expenses, gain or loss on sale of assets, monitoring fees, impairment loss and discontinued operations. Management uses Segment EBITDA to measure performance for Vanguard's segments and to develop strategic objectives and operating plans for those segments. Segment EBITDA eliminates the uneven effect of non-cash depreciation of tangible assets and amortization of intangible assets, much of which results from acquisitions accounted for under the purchase method of accounting. Segment EBITDA also eliminates the effects of changes in interest rates which management believes relate to general trends in global capital markets, but are not necessarily indicative of the operating performance of Vanguard's segments. Management believes that Segment EBITDA provides useful information about the financial performance of Vanguard's segments to investors, lenders, financial analysts and rating agencies. Additionally, management believes that investors and lenders view Segment EBITDA as an important factor in making investment decisions and assessing the value of Vanguard. Segment EBITDA is not a substitute for net income, operating cash flows or other cash flow statement data determined in accordance with accounting principles generally accepted in the United States. Segment EBITDA, as presented, may not be comparable to similarly titled measures of other companies.

	For the Year Ended June 30, 2007			
	Health Plans	Acute Care Services	Eliminations	Consolidated
		(In millions)		
Patient service revenues	$ –	$ 2,179.3	$ –	$ 2,179.3
Capitation premiums	401.4	–	–	401.4
Inter-segment revenues	–	34.2	(34.2)	–
Total revenues	401.4	2,213.5	(34.2)	2,580.7
Salaries and benefits (excludes stock compensation of $1.2 million)	14.7	1,052.0	–	1,066.7
Supplies	0.2	421.6	–	421.8
Medical claims expense	297.0	–	–	297.0
Provision for doubtful accounts	–	175.2	–	175.2
Other operating expenses – external	27.3	347.7	–	375.0
Operating expenses – inter-segment	34.2	–	(34.2)	–
Total operating expenses	373.4	1,996.5	(34.2)	2,335.7
Segment EBITDA(1)	28.0	217.0	–	245.0
Depreciation and amortization	4.3	114.3	–	118.6
Interest, net	(5.8)	129.6	–	123.8
Minority interests	–	2.6	–	2.6
Equity method income	–	(0.9)	–	(0.9)
Stock compensation	–	1.2	–	1.2
Gain on sale of assets	–	(4.1)	–	(4.1)
Impairment loss	–	123.8	–	123.8
Monitoring fees	–	5.2	–	5.2
Income (loss) from continuing operations before income taxes	$ 29.5	$ (154.7)	$ –	$ (125.2)
Segment assets	$ 197.3	$ 2,334.1	$ –	$ 2,531.4
Capital expenditures	$ 0.2	$ 164.1	$ –	$ 164.3

(1) Segment EBITDA is defined as income before interest expense (net of interest income), income taxes, depreciation and amortization, minority interests, equity method income or loss, stock compensation, debt extinguishment costs, merger expenses, gain or loss on sale of assets, monitoring fees, impairment loss and discontinued operations. Management uses Segment EBITDA to measure performance for Vanguard's segments and to develop strategic objectives and operating plans for those segments. Segment EBITDA eliminates the uneven effect of non-cash depreciation of tangible assets and amortization of intangible assets, much of which results from acquisitions accounted for under the purchase method of accounting. Segment EBITDA also eliminates the effects of changes in interest rates which management believes relate to general trends in global capital markets, but are not necessarily indicative of the operating performance of Vanguard's segments. Management believes that Segment EBITDA provides useful information about the financial performance of Vanguard's segments to investors, lenders, financial analysts and rating agencies. Additionally, management believes that investors and lenders view Segment EBITDA as an important factor in making investment decisions and assessing the value of Vanguard. Segment EBITDA is not a substitute for net income, operating cash flows or other cash flow statement data determined in accordance with accounting principles generally accepted in the United States. Segment EBITDA, as presented, may not be comparable to similarly titled measures of other companies.

	For the Predecessor period July 1, 2004 through September 22, 2004			
	Health Plans	Acute Care Services	Eliminations	Consolidated
		(In millions)		
Patient service revenues	$ –	$ 325.6	$ –	$ 325.6
Premium revenues	72.3	–	–	72.3
Inter-segment revenues	–	6.4	(6.4)	–
Total revenues	72.3	332.0	(6.4)	397.9
Operating expenses – external	61.2	294.1	–	355.3
Operating expenses – inter-segment	6.4	–	(6.4)	–
Total operating expenses	67.6	294.1	(6.4)	355.3
Segment EBITDA(1)	4.7	37.9	–	42.6
Depreciation and amortization	0.6	15.4	–	16.0
Interest, net	0.2	8.8	–	9.0
Minority interests	–	(0.5)	–	(0.5)
Equity method income	–	(0.2)	–	(0.2)
Stock compensation	–	96.7	–	96.7
Debt extinguishment costs	–	62.2	–	62.2
Merger expenses	–	23.1	–	23.1
Loss on sale of assets	–	0.6	–	0.6
Income (loss) from continuing operations before income taxes	$ 3.9	$ (168.2)	$ –	$ (164.3)
Capital expenditures	$ 0.7	$ 26.4	$ –	$ 27.1

(1) Segment EBITDA is defined as income before interest expense (net of interest income), income taxes, depreciation and amortization, minority interests, equity method income or loss, stock compensation, debt extinguishment costs, merger expenses, gain or loss on sale of assets, monitoring fees, impairment loss and discontinued operations. Management uses Segment EBITDA to measure performance for Vanguard's segments and to develop strategic objectives and operating plans for those segments. Segment EBITDA eliminates the uneven effect of non-cash depreciation of tangible assets and amortization of intangible assets, much of which results from acquisitions accounted for under the purchase method of accounting. Segment EBITDA also eliminates the effects of changes in interest rates which management believes relate to general trends in global capital markets, but are not necessarily indicative of the operating performance of Vanguard's segments. Management believes that Segment EBITDA provides useful information about the financial performance of Vanguard's segments to investors, lenders, financial analysts and rating agencies. Additionally, management believes that investors and lenders view Segment EBITDA as an important factor in making investment decisions and assessing the value of Vanguard. Segment EBITDA is not a substitute for net income, operating cash flows or other cash flow statement data determined in accordance with accounting principles generally accepted in the United States. Segment EBITDA, as presented, may not be comparable to similarly titled measures of other companies.

	For the Successor period September 23, 2004 through June 30, 2005			
	Health Plans	Acute Care Services	Eliminations	Consolidated
		(In millions)		
Patient service revenues	$ –	$ 1,378.2	$ –	$ 1,378.2
Premium revenues	261.2	–	–	261.2
Inter-segment revenues	–	30.2	(30.2)	–
Total revenues	261.2	1,408.4	(30.2)	1,639.4
Operating expenses – external	205.7	1,246.6	–	1,452.3
Operating expenses – inter-segment	30.2	–	(30.2)	–
Total operating expenses	235.9	1,246.6	(30.2)	1,452.3
Segment EBITDA(1)	25.3	161.8	–	187.1
Depreciation and amortization	3.1	56.6	–	59.7
Interest, net	(0.4)	73.7	–	73.3
Minority interests	–	0.2	–	0.2
Equity method income	–	(0.8)	–	(0.8)
Stock compensation	–	0.7	–	0.7
Merger expenses	–	0.2	–	0.2
Monitoring fees	–	4.0	–	4.0
Income from continuing operations before income taxes	$ 22.6	$ 27.2	$ –	$ 49.8
Capital expenditures	$ 0.8	$ 196.3	$ –	$ 197.1

(1) Segment EBITDA is defined as income before interest expense (net of interest income), income taxes, depreciation and amortization, minority interests, equity method income or loss, stock compensation, debt extinguishment costs, merger expenses, gain or loss on sale of assets, monitoring fees, impairment loss and discontinued operations. Management uses Segment EBITDA to measure performance for Vanguard's segments and to develop strategic objectives and operating plans for those segments. Segment EBITDA eliminates the uneven effect of non-cash depreciation of tangible assets and amortization of intangible assets, much of which results from acquisitions accounted for under the purchase method of accounting. Segment EBITDA also eliminates the effects of changes in interest rates which management believes relate to general trends in global capital markets, but are not necessarily indicative of the operating performance of Vanguard's segments. Management believes that Segment EBITDA provides useful information about the financial performance of Vanguard's segments to investors, lenders, financial analysts and rating agencies. Additionally, management believes that investors and lenders view Segment EBITDA as an important factor in making investment decisions and assessing the value of Vanguard. Segment EBITDA is not a substitute for net income, operating cash flows or other cash flow statement data determined in accordance with accounting principles generally accepted in the United States. Segment EBITDA, as presented, may not be comparable to similarly titled measures of other companies.

19. Unaudited Quarterly Operating Results

The following table presents summarized unaudited quarterly results of operations for the fiscal years ended June 30, 2006 and 2007. Management believes that all necessary adjustments have been included in the amounts stated below for a fair presentation of the results of operations for the periods presented when read in conjunction with Vanguard's consolidated financial statements for the fiscal years ended June 30, 2006 and 2007. Results of operations for a particular quarter are not necessarily indicative of results of operations for an annual period and are not predictive of future periods (in millions).

	September 30, 2005	December 31, 2005	March 31, 2006	June 30, 2006
Total revenues	$ 590.6	$ 584.4	$ 621.8	$ 621.8
Net income (loss)	$ 7.3	$ 3.6	$ 15.6	$ (13.6)

	September 30, 2006	December 31, 2006	March 31, 2007	June 30, 2007
Total revenues	$ 618.3	$ 638.4	$ 672.9	$ 651.1
Net income (loss)	$ (7.7)	$ (118.7)	$ 3.3	$ (9.6)

Total revenues disclosed above differ from the amounts disclosed in our previously filed fiscal 2007 Quarterly Reports on Form 10-Q due to the reclassification of PMH total revenues to discontinued operations as presented below (in millions).

	September 30, 2005	December 31, 2005	March 31, 2006
As previously reported	$ 605.6	$ 597.9	$ 637.1
Reclassification of PMH revenues	15.0	13.5	15.3
As disclosed above	$ 590.6	$ 584.4	$ 621.8

	September 30, 2006	December 31, 2006	March 31, 2007
As previously reported	$ 634.9	$ 652.9	$ 684.5
Reclassification of PMH revenues	16.6	14.5	11.6
As disclosed above	$ 618.3	$ 638.4	$ 672.9

Item 9. Changes in and Disagreements With Accountants on Accounting and Financial Disclosure.

None.

Item 9A. Controls and Procedures.

Evaluation of Disclosure Control and Procedures

As of the end of the period covered by this report, our management conducted an evaluation, with the participation of our chief executive officer and chief financial officer, of the effectiveness of our disclosure controls and procedures (as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934 (the "Exchange Act")). Based on this evaluation, our chief executive officer and chief financial officer have concluded that our disclosure controls and procedures are effective to ensure that information required to be disclosed by us in the reports that we file or submit under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in Securities and Exchange Commission's rules and forms and that such information is accumulated and communicated to management, including our chief executive officer and chief financial officer, as appropriate to allow timely decisions regarding required disclosure.

Changes in Internal Control Over Financial Reporting

There was no change in our internal control over financial reporting during our fiscal quarter ended June 30, 2007 that materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

Item 9B. Other Information.

None.

PART III

Item 10. Directors, Executive Officers and Corporate Governance.

The table below presents information with respect to the members of our board of directors and our executive officers and their ages as of September 15, 2007.

Name	Age	Position
Charles N. Martin, Jr.	64	Chairman of the Board & Chief Executive Officer; Director
Kent H. Wallace	52	President & Chief Operating Officer
Keith B. Pitts	50	Vice Chairman
Joseph D. Moore	60	Executive Vice President, Chief Financial Officer & Treasurer
Ronald P. Soltman	61	Executive Vice President, General Counsel & Secretary
Dan F. Ausman	52	Senior Vice President-Operations
Reginald M. Ballantyne III	63	Senior Vice President-Market Strategy & Government Affairs
Bruce F. Chafin	51	Senior Vice President-Compliance & Ethics
Karen Flinn	46	Senior Vice President-Physician & Ambulatory Services
James Johnston	63	Senior Vice President-Human Resources
Joseph J. Mullany	43	Senior Vice President-Operations
Harold H. Pilgrim III	46	Senior Vice President-Operations
Phillip W. Roe	46	Senior Vice President, Controller & Chief Accounting Officer
James H. Spalding	48	Senior Vice President, Assistant General Counsel & Assistant Secretary
Alan G. Thomas	53	Senior Vice President-Operations Finance
Thomas M. Ways	57	Senior Vice President-Managed Care
Deanna L. Wise	38	Senior Vice President & Chief Information Officer
Michael A. Dal Bello	36	Director
James A. Quella	57	Director
Neil P. Simpkins	41	Director

Charles N. Martin, Jr. has served as Chairman of the board of directors and Chief Executive Officer of Vanguard since July 1997. Until May 31, 2001, he was also Vanguard's President. From January 1992 until January 1997, Mr. Martin was Chairman, President and Chief Executive Officer of OrNda HealthCorp ("OrNda"), a hospital management company. Prior thereto Mr. Martin was President and Chief Operating Officer of HealthTrust, Inc., a hospital management company, from September 1987 until October 1991. Mr. Martin is also a director of several privately held companies.

Kent H. Wallace has served as Vanguard's President & Chief Operating Officer since September 2005. Prior thereto he was a Senior Vice President - Operations of Vanguard from February 2003 until September 2005. Prior thereto from July 2001 to December 2002 he was Regional Vice President of Province Healthcare Company of Brentwood, Tennessee, an owner and operator of 20 non-urban, acute care hospitals in 13 states of the United States. During this time Mr. Wallace had managerial responsibility for seven of these hospitals. From June 1999 until June 2001 Mr. Wallace was President and Chief Executive Officer of Custom Curb, Inc. of Chattanooga, Tennessee, a family owned company which manufactured roof accessories. Prior thereto from January 1997 until May 1999 Mr. Wallace was a Vice President - Acquisitions-and Development of Tenet Healthcare Corporation of Dallas, Texas, a hospital management company ("Tenet").

Keith B. Pitts has been Vanguard's Vice Chairman since May 2001, was a director of Vanguard from August 1999 until September 2004, and was an Executive Vice President of Vanguard from August 1999 until May 2001. Prior thereto, from November 1997 until June 1999, he was the Chairman and Chief Executive Officer of Mariner Post-Acute Network, Inc. and its predecessor, Paragon Health Network, Inc., which is a nursing home management company. Prior thereto from August 1992 until January 1997, Mr. Pitts served as Executive Vice President and Chief Financial Officer of OrNda.

Joseph D. Moore has served as Vanguard's Executive Vice President, Chief Financial Officer and Treasurer since July 1997 and was a director of Vanguard from July 1997 until September 2004. From February 1994 to April 1997, he was Senior Vice President - Development of Columbia/HCA Healthcare Corporation ("Columbia"), a hospital management company. Mr. Moore first joined Hospital Corporation of America (a predecessor of Columbia) in April 1970, rising to Senior Vice President - Finance and Development in January 1993.

Ronald P. Soltman has been Vanguard's Executive Vice President, General Counsel and Secretary since July 1997 and was a director of Vanguard from July 1997 until September 2004. From April 1994 until January 1997, he was Senior Vice President, General Counsel and Secretary of OrNda. From February 1994 until March 1994, he was Vice President and Assistant General Counsel of Columbia. From 1984 until February 1994, he was Vice President and Assistant General Counsel of Hospital Corporation of America.

Dan F. Ausman has served as a Senior Vice President - Operations of Vanguard since February 2006. Prior thereto from May 2005 to February 2006 he was Vice President - Operations of Vanguard. From 1998 to April 2005 Mr. Ausman was the President & Chief Executive Officer of Irvine Regional Hospital and Medical Center, a 176-bed acute care hospital in Irvine, CA which is owned by an affiliate of Tenet.

Reginald M. Ballantyne III, joined Vanguard in May 2001 and has served as Senior Vice President - Market Strategy & Government Affairs of Vanguard since January 2002. From 1984 to 2001, he served as President of PMH Health Resources, Inc., an Arizona based multi-unit healthcare system. Prior to 1984, Mr. Ballantyne served as President of Phoenix Memorial Hospital in Phoenix, Arizona. Mr. Ballantyne served as Chairman of the American Hospital Association ("AHA") in 1997 and as Speaker of the AHA House of Delegates in 1998. He is a Fellow of the American College of Healthcare Executives ("ACHE") and a recipient of the ACHE Gold Medal Award for Management Excellence. Mr. Ballantyne also served as a member of the national Board of Commissioners for the Joint Commission on Accreditation of Healthcare Organizations and as Chairman of the AHA Committee of Commissioners from 1992 until 1995. Mr. Ballantyne previously served as a director of Superior Consultant Holdings Corporation and is currently a director of several privately held companies.

Bruce F. Chafin has served as Senior Vice President - Compliance & Ethics of Vanguard since July 1997. Prior thereto, from April 1995 to January 1997, he served as Vice President - Compliance & Ethics of OrNda.

Karen Flinn has served as Senior Vice President - Physician & Ambulatory Services of Vanguard since September 11, 2007. Prior thereto from May 1999 until July 2007 she was Vice President - Physician Integration/Managed Care of Triad Hospitals, Inc., an investor owned hospital management company headquartered in Plano, Texas. Prior thereto from May 1996 until May 1999 she was Vice President - Physician Integration/Managed Care of the Central and Pacific Group of Columbia.

James Johnston has served as Senior Vice President - Human Resources of Vanguard since July 1997. Prior thereto from November 1995 to January 1997, he served as Senior Vice President - Human Resources of OrNda.

Joseph J. Mullany has served as a Senior Vice President - Operations of Vanguard since September 2005. Prior thereto from October 2002 to August 2005 he was a Regional Vice President of Essent Healthcare, Inc. of Nashville, TN, an investor-owned hospital management company, responsible for its New England Division. Prior thereto from October 1998 to October 2002 Mr. Mullany was a Division Vice President of Health Management Associates, Inc. of Naples, Florida, an investor-owned hospital management company, responsible for its Mississippi Division.

Harold H. Pilgrim III has served as a Senior Vice President - Operations of Vanguard since September 2005. Prior thereto from February 2003 to September 2005 he was Vice President - Business Development of Vanguard, responsible for development for Vanguard's Texas operations. Prior thereto from November 2001 to January 2003 Mr. Pilgrim was Vanguard's Vice President - Investor Relations, and during that period he was also involved in Vanguard's acquisitions and development activities. From January 1, 2001 to October 2001 Mr. Pilgrim was Chief Development Officer for Velocity Health Capital, Inc., a Nashville, TN - based investment banking firm focused on the health care and bio-sciences industries.

Phillip W. Roe has been Senior Vice President, Controller and Chief Accounting Officer of Vanguard since July 1997. Prior thereto he was Senior Vice President, Controller and Chief Accounting Officer of OrNda from September 1996 until January 1997. Prior thereto, from October 1994 until September 1996, Mr. Roe was Vice President, Controller and Chief Accounting Officer of OrNda.

James H. Spalding has served as Senior Vice President, Assistant General Counsel and Assistant Secretary of Vanguard since November 1998. Prior thereto he was Vice President, Assistant General Counsel and Assistant Secretary of Vanguard from July 1997 until November 1998. Prior thereto from April 1994 until January 1997, he served as Vice President, Assistant General Counsel and Assistant Secretary of OrNda.

Alan G. Thomas has been Senior Vice President - Operations Finance of Vanguard since July 1997. Prior thereto, Mr. Thomas was Senior Vice President - Hospital Financial Operations of OrNda from April 1995 until January 1997. Prior thereto he was Vice President - Reimbursement and Revenue Enhancement of OrNda from June 1994 until April 1995.

Thomas M. Ways has served as Senior Vice President - Managed Care of Vanguard since March 1998. Prior thereto from February 1997 to February 1998, he was Chief Executive Officer of MSO/Physician Practice Development for the Southern California Region of Tenet. Prior thereto from August 1994 to January 1997, he was Vice President - Physician Integration of OrNda.

Deanna L. Wise has served as Senior Vice President and Chief Information Officer of Vanguard since November 2006. Prior thereto from August 2004 to October 2006 she was the Chief Information Officer of Vanguard's operating region managing its Phoenix-area healthcare facilities. From November 2002 until August 2004 she was chief information officer of the Maricopa Integrated Health System in Phoenix, Arizona, which was a county integrated health care system including an acute care hospital, health clinics and health plans. Prior thereto, from October 1997 to November 2002 she was the director of applications of Ascension Health –Central Indiana Health System in Indianapolis, Indiana, a regional healthcare management organization supervising the operations of twelve acute care hospitals.

Michael A. Dal Bello became a member of Vanguard's board of directors on September 23, 2004. Mr. Dal Bello has been a Principal in the Private Equity Group of Blackstone since December 2005 and from 2002 until December 2005, he was an Associate in this Group. While at Blackstone, Mr. Dal Bello has been actively involved in Blackstone's healthcare investment activities. Prior to joining Blackstone, Mr. Dal Bello received an M.B.A. from Harvard Business School in 2002. Mr. Dal Bello worked at Hellman & Friedman LLC from 1998 to 2000 and prior thereto at Bain & Company. He currently serves on the board of representatives or directors of Team Finance LLC, Biomet, Inc., Catalent Pharma Solutions, Inc. and Sithe Global.

James A. Quella became a member of Vanguard's board of directors on September 11, 2007. Mr. Quella is a Senior Managing Director and Senior Operating Partner in the Private Equity Group at Blackstone. Prior to joining Blackstone in 2004, Mr. Quella was a Managing Director and Senior Operating Partner with DLJ Merchant Banking Partners-CSFB Private Equity from June 2000 to February 2004. Prior to that, Mr. Quella worked at Mercer Management Consulting and Strategic Planning Associates, its predecessor firm, from September 1981 to January 2000 where he served as a Senior Consultant to chief executive officers and senior management teams, and was Co-Vice Chairman with shared responsibility for overall management of the firm. Mr. Quella currently serves as a director of Allied Waste Industries, Inc., Graham Packaging Holdings Company, The Nielsen Company and Michaels Stores, Inc.

Neil P. Simpkins became a member of Vanguard's board of directors on September 23, 2004. Mr. Simpkins has served as a Senior Managing Director in the Private Equity Group of Blackstone since December 1999. From 1993 until the time he joined Blackstone, Mr. Simpkins was a Principal at Bain Capital. Prior to joining Bain Capital, Mr. Simpkins was a consultant at Bain & Company in London and the Asia Pacific region. He currently serves as Chairman of the board of directors of TRW Automotive Holdings Corp. and is a member of the board of representatives of Team Finance LLC.

Composition of the Board of Directors

General

As of the date of this report, the board of directors of Vanguard consists of four members, three of whom were nominated by Blackstone and one of whom is our chief executive officer (and, if our chief executive officer is not Charles N. Martin, Jr., such other person designated by senior management (the "Manager Representative")). MSCP has the right to nominate one other director to the Vanguard board and in September 2004 MSCP nominated Eric T. Fry who was a member of our board of directors until July 31, 2007. We expect MSCP to nominate a director for election to our board prior to our next scheduled board of directors meeting in November 2007. Blackstone has the right to increase the size of Vanguard's board from five to nine members, with two additional directors to be designated by Blackstone and two additional directors to be independent persons identified by our chief executive officer and acceptable to Blackstone. MSCP and, subject to the conditions above, senior management, will each continue to be entitled to nominate and elect one director unless and until the respective group ceases to own at least 50.0% of the Class A membership units in VHS Holdings LLC ("Holdings") owned on September 23, 2004. Holdings acquired Vanguard pursuant to a merger (the "Merger") on September 23, 2004. See "Item 1. Business – The Merger".

Committees

Our board of directors currently does not have any standing committees, including an audit committee. Our entire board of directors is acting as our audit committee to oversee our accounting and financial reporting processes and the audits of our financial statements, as allowed under the Securities Exchange Act of 1934 for issuers without securities listed on a national securities exchange or on an automated national quotation system. Additionally, because our securities are not so listed, our board of directors is not required to have on it a person who qualifies under the rules of the Securities and Exchange Commission as an "audit committee financial expert" or as having accounting or financial management expertise under the similar rules of the national securities exchanges. While our board of directors has not designated any of its members as an audit committee financial expert, we believe that each of the current board members is fully qualified to address any accounting, financial reporting or audit issues that may come before it.

Code of Ethics

We have adopted a Code of Business Conduct and Ethics for all of our employees, a copy of which has been posted on our Internet website at www.vanguardhealth.com/CodeofBusinessConductandEthics.pdf. Our Code of Business Conduct and Ethics is a "code of ethics", as defined in Item 406(b) of Regulation S-K of the Securities and Exchange Commission. Please note that our Internet website address is provided as an inactive textual reference only. We will make any legally required disclosures regarding amendments to, or waivers of, provisions of our code of ethics on our Internet website.

Item 11. Executive Compensation.

COMPENSATION DISCUSSION AND ANALYSIS

Overview

This section discusses the principles underlying our executive compensation policies and decisions. It provides qualitative information regarding the manner in which compensation is earned by our executive officers and places in context the data presented in the tables that follow. In addition, in this section, we address the compensation paid or awarded during fiscal year 2007 to: Charles N. Martin, Jr., our chief executive officer (principal executive officer); Joseph D. Moore, our chief financial officer (principal financial officer); and three other executive officers who were our three other most highly compensated executive officers in fiscal year 2007, Keith B. Pitts, our Vice Chairman; Kent H. Wallace, our president and chief operating officer; and Joseph J. Mullany, one of our Senior Vice Presidents-Operations. We refer to these five executive officers as our "named executive officers."

On September 23, 2004, we were acquired in the Merger by private equity investment funds associated with Blackstone Group who invested $494.4 million in our equity for a 66% equity interest, with private equity funds associated with our former equity sponsor, MSCP, retaining a 17.3% equity interest in us by reinvesting $130 million in our equity and with 13 of our 16 current executive officers retaining a 11.8% equity interest in us by reinvesting $88.4 million in us (such $88.4 million exclusive of amounts invested by our executive officers in Holdings' Class B, C and D units, as discussed below). As a result of the Merger, we are privately held and controlled by private equity funds associated with Blackstone and MSCP (the "Sponsors") with a board of directors made up of four representatives of the Sponsors and our Chief Executive Officer. As discussed in more detail below, various aspects of named executive officer compensation were negotiated and determined at the time of the Merger.

As a privately-owned company with a relatively small board of directors, our entire board of directors acts as our Compensation Committee (hereinafter referred to either as the "Committee" or the "board of directors"). Our executive compensation program is overseen and administered by the Compensation Committee. The Compensation Committee operates somewhat informally without a written charter and has responsibility for discharging the responsibilities of the board of directors relating to the compensation of our executive officers and related duties. Management presents cash, equity and benefits compensation recommendations to the Compensation Committee for its consideration and approval. The Compensation Committee reviews these proposals and makes all final compensation decisions for executive officers by exercising its discretion in accepting, modifying or rejecting any management recommendations.

Philosophy of Executive Compensation Programs

Our overall executive compensation objective is to provide a comprehensive plan designed to focus on our strategic business initiatives, financial performance objectives and the creation and maintenance of equity value. The following are the principal objectives in the design of our executive compensation programs:

- Attract, retain, and motivate superior management talent critical to our long-term success with compensation that is competitive within the marketplace;
- Maintain a reasonable balance among base salary, annual incentive payments and long-term equity-based incentive compensation and other benefits;
- Ensure compensation levels reflect the internal value and future potential of each executive within the Company and the achievement of outstanding individual results;
- Link executive compensation to the creation and maintenance of long-term equity value;
- Promote equity ownership by executives in order to align their interests with the interests of our equity holders, and
- Ensure that incentive compensation is linked to the achievement of specific financial and strategic objectives, which are established in advance and approved by the Committee.

To meet these objectives, our compensation program balances short-term and long-term performance goals and mixes fixed and at-risk compensation that is directly related to stockholder value and overall performance.

During our fiscal year ended June 30, 2007, the Committee did not retain the services of any external compensation consultant. Our Chief Executive Officer, Charles N. Martin, Jr., as a member of the board of directors, is also a member of the Committee and participates in discussions and deliberations of the Committee. Other named executive officers also attend the Committee meetings and participate only as and if required by the Committee. Any discussion by the Committee regarding compensation for Mr. Martin or other named executive officers is conducted by the Committee in executive session without such persons in attendance.

The Committee believes that compensation to its executive officers should be aligned closely with our short-term and long-term financial performance goals. As a result, a portion of executive compensation is "at risk" and is tied to the attainment of previously established financial goals. However, the Committee also believes that it

is prudent to provide competitive base salaries and benefits to attract and retain superior talent in order to achieve our strategic objectives.

Elements of Our Executive Compensation Program

In fiscal year 2007, the principal elements of our compensation for our executive officers, including our named executive officers were:

- Base Salary;
- Annual cash incentive opportunities;
- Long-term equity based incentives; and
- Benefits and executive perquisites.

Detail regarding each of these elements is discussed below.

Base Salaries

Annual base salaries reflect the compensation for an executive's ongoing contribution to the operating performance of his or her functional area of responsibility with us. We believe that base salaries must be competitive based upon the scope of responsibilities and market compensation of similar executives. We utilize as a tool the database provided by Salary.com's Job Analyzer. Job Analyzer includes data about 2,900 standard jobs using data from 7,500 organizations representing all industries of all types and sizes, both public and private companies. Other factors such as internal equity and comparability are also considered when establishing a base salary for a given executive. The Committee utilizes the experience, market knowledge and insight of its members in evaluating the competitiveness of current salary levels. Our Human Resources Department is also a resource for such additional information as needed.

Generally, base salaries of all executive officers, including the named executive officers, are adjusted effective January 1 of each year based upon the Committee's assessment of each executive's performance and our overall budgetary guidelines. Upon the recommendation of management, none of the named executive officers were given base salary increases as of January 1, 2007, except for Mr. Mullany whose base salary was increased by 13.3% to $425,000 as of such date (such salary increase largely reflecting Mr. Mullany obtaining operational responsibility for our Chicago facilities during the last fiscal year to add to his earlier responsibilities for our Massachusetts facilities). In addition, the Committee may adjust base salaries at other times during the year in connection with promotions, increased responsibilities or to maintain competitiveness within the market. The salary for each named executive officer for our fiscal year ended June 30, 2007 is reported in the Summary Compensation Table below.

Annual Incentive Compensation

Annual incentive awards are available to the named executive officers, as well as to Vanguard's other executive officers, under the Vanguard Health Systems, Inc. 2001 Annual Incentive Plan (the "Annual Incentive Plan"). The Annual Incentive Plan is designed to reward management for the achievement of annual financial targets and other operational goals, which are linked to the creation of long-term equity value.

Each year under the Annual Incentive Plan the Committee establishes specific earnings-related or operations-related goals for all of its executive officers, including the named executive officers, for the fiscal year. The executive officers are eligible to receive a cash award or awards based primarily on the extent to which the Company meets its pre-established earnings and/or cash flow and/or other operations-related goals. The Committee determines one or more target awards for each executive officer, designates a Company performance level or levels required to earn each target award, determines a threshold performance level at which the minimum awards are earned and determines a performance level that results in a maximum award to be paid. Target awards may vary among executives based on competitive market practices for comparable positions, their decision-making authority

and their ability to affect financial and operational performance. Awards for executives may be increased or decreased by the Committee on a discretionary basis. In addition, the Committee has the discretion to adjust the annual Adjusted EBITDA targets during the year in the event of acquisitions and divestitures, restructured or discontinued operations, or other extraordinary or unusual issues occurring during the year. The Committee will evaluate the allocation factors within the Annual Incentive Plan on an annual basis and has the flexibility to adjust the structure including allocation percentages as needed in order to better align the incentives under the Annual Incentive Plan.

For fiscal year 2007, Annual Incentive Plan awards for most executive officers (including four of the named executive officers, Messrs. Martin, Moore, Pitts, and Wallace) were 50% based on the Company achieving a certain consolidated Adjusted EBITDA target and 50% upon achieving a certain consolidated free cash flow target. Award maximum levels for these executive officers ranged from 30% to 50% of their base salaries for meeting the Adjusted EBITDA target and 30% to 50% of their base salaries for meeting the free cash flow target. Award maximum levels for Mr. Martin were 50% of his base salary for meeting the Adjusted EBITDA target and 50% of his base salary for meeting the free cash flow target. Award maximum levels for Messrs. Pitts and Wallace were 45% of their respective base salaries for meeting the Adjusted EBITDA target and 45% of their respective base salaries for meeting the free cash flow target. Award maximum levels for Mr. Moore were 35% of his base salary for meeting the Adjusted EBITDA target and 35% of his base salary for meeting the free cash flow target.

For officers responsible only for the operations of our various regions (including one name executive officer, Mr. Mullany), their Annual Incentive Plan awards were 50% based upon regional Adjusted EBITDA targets and 50% based upon their hospitals achieving certain specified quality and employee, patient and physician satisfaction goals, with their award targets ranging from 70% to 138% of their base salaries depending on the Adjusted EBITDA levels actually obtained by their operating regions as well as their attainment of the quality and satisfaction goals.

We do not intend to publicly disclose our specific performance targets for fiscal year 2007 as they reflect competitive, sensitive information regarding our budget. However, we consider our budget a reach and we deliberately set aggressive individual goals where applicable. Thus, while designed to be attainable, target performance levels for fiscal year 2007 required strong performance and execution which in our view provided an annual incentive firmly aligned with stockholder interests.

Our named executive officers in this annual report for fiscal year 2007 did not earn any awards with respect to financial performance targets under the Annual Incentive Plan for fiscal year 2007, other than Mr. Mullany who earned an award in the amount of $251,260 as a result of exceeding his minimum Adjusted EBITDA target for his Massachusetts facilities and meeting some but not all of his hospital quality and employee, patient and satisfaction targets. This award to Mr. Mullany was approved by the Committee and paid to him in September 2007. The Committee has historically attempted to maintain consistency year over year with respect to the difficulty of achieving the target performance levels under our Annual Incentive Plan.

Long Term Incentive Compensation

The Committee provides equity incentives to executive officers and other key employees in order to directly align their interests with the long term interests of the other equity holders who are principally the Sponsors.

Holdings LLC Units Plan

Holdings acquired Vanguard in the Merger on September 23, 2004. The following contains a summary of the material terms of the Holdings LLC Units Plan, which we refer to as the 2004 Unit Plan, pursuant to which Holdings granted the right to purchase units to members of our management on September 23, 2004 in connection with consummation of the Merger. Charles N. Martin, Jr., Kent H. Wallace, Keith B. Pitts and Joseph D. Moore, who are four of our named executive officers, and certain other members of our management have been granted the right to purchase units under the 2004 Units Plan.

General

The 2004 Unit Plan permits the grant of the right to purchase Class A Units, Class B Units, Class C Units and Class D Units to employees of Holdings or its affiliates. A maximum of 117,067 Class A Units, 41,945 Class B Units, 41,945 Class C Units and 35,952 Class D Units may be subject to awards under the 2004 Unit Plan. Units covered by awards that expire, terminate or lapse will again be available for option or grant under the 2004 Unit Plan. On September 23, 2004, certain members of management purchased all 117,067 Class A Units for an aggregate purchase price of $117,067,000 and all 41,945 Class B units, all 41,945 Class C Units and all 35,952 of the Class D Units for an aggregate purchase price of $5.7 million.

Administration

The 2004 Unit Plan is administered by a committee of Holdings' board of representatives or, in the board of representatives' discretion, the board of representatives. The committee has the sole discretion to determine the employees to whom awards may be granted under the 2004 Unit Plan, the number and/or class of Units to be covered by an award, the purchase price, if any, of such awards, determine the terms and conditions of any award and determine under what circumstances awards may be settled or cancelled. The committee is authorized to interpret the 2004 Unit Plan, to establish, amend and rescind any rules and regulations relating to the 2004 Unit Plan, and to make any other determinations that it deems necessary or desirable for the administration of the plan. The committee may correct any defect or supply any omission or reconcile any inconsistency in the 2004 Unit Plan in the manner and to the extent the committee deems necessary or desirable.

Adjustments Upon Certain Events

In the event of any changes in the Units by reason of any reorganization, recapitalization, merger, unit exchange or any other similar transaction, the board of representatives, in its sole discretion, may adjust (1) the number or kind of Units or other securities that may be issued or reserved for issuance pursuant to the 2004 Unit Plan or pursuant to any outstanding awards or (2) any other affected terms of such awards.

Amendment and Termination

The Holdings board of representatives may amend or terminate the 2004 Unit Plan at any time, provided that no amendment or termination is permitted that would diminish any rights of a management member pursuant to a previously granted award without his or her consent, subject to the committee's authority to adjust awards upon certain events as described in the previous paragraph. No awards may be made under the 2004 Unit Plan after the tenth anniversary of the effective date of the plan.

Holdings LLC Units Held by Certain of our Managers

The units of Holdings consist of Class A units, Class B units, Class C units and Class D units. As of September 15, 2007, approximately 59.2% of Holdings' Class A Units were held by Blackstone, approximately 20.8% were held by MSCP, approximately 15.4% were held by certain members of our management and approximately 4.6% were held by other investors. The Class B units, Class C units and Class D units are held exclusively by members of our senior management and all such units were purchased on September 23, 2004.

Of our named executive officers, Charles N. Martin, Jr. owns 40,000 class A units, 8,913 class B units, 8,913 class C units and 7,640 class D units; Kent H. Wallace owns 850 class A units, 2,622 class B units, 2,622 class C units and 2,247 class D units; Keith B. Pitts owns 11,000 class A units, 5,243 class B units, 5,243 class C units and 4,494 class D units; Joseph D. Moore owns 10,450 class A units, 3,146 class B units, 3,146 class C units and 2,696 class D units; and Joseph J. Mullany owns no such units. As of September 1, 2007, none of the class C units are vested, but 40% of the Class B and D units are vested; and an additional 20% of such class B and D units will vest on September 23, 2007. See the vesting provisions in respect of the class A, B, C and D units in the discussion immediately below.

Terms of the Holdings' Class A Units, Class B Units, Class C Units and Class D Units

The following is a summary of certain terms of the Holdings' Class A units, Class B units, Class C units and Class D units and certain rights and restrictions applicable to those units.

Class A units have economic characteristics that are similar to those of shares of common stock in a private corporation. Subject to applicable law, only the holders of Class A units are entitled to vote on any matter. Class A units are fully vested. The Class B units, Class C units and Class D units are subject to the vesting provisions described below.

Class B units vest in five equal annual installments on the first five anniversaries of the date of purchase, subject to an employee's continued service with Holdings and its affiliates. However, the Class B units will vest earlier upon a change of control of Holdings. In the event of an employee's termination of employment with Vanguard, other than due to termination by Vanguard for "cause" or by the employee without "good reason", the employee shall be deemed vested in any Class B unit that would otherwise have vested in the calendar year in which such termination of employment occurs. No employee who holds Class B units will receive any distributions until the holders of the Class A units receive the aggregate amount invested for their Class A units. Following return of the aggregate amount invested for the Class A units, the holders of Class B units will be entitled to receive the amount of their investment in the Class B units and, once all the aggregate investment amount invested for all of the units has been returned to their holders, the vested Class B units will share in any distributions pro rata with the Class A units and vested Class C units.

Class C units vest on the eighth anniversary of the date of purchase, subject to the employee's continued service with Holdings and its affiliates. However, the Class C units will vest earlier upon the occurrence of a sale by Blackstone of at least 25.0% of its Class A Units at a price per Class A unit exceeding two and one-half times the price per Class A Unit invested by Blackstone in connection with the Merger. No employee who holds Class C units will receive any distributions until the holders of the Class A units receive the aggregate amount invested for their Class A units. Following return of the aggregate amount invested for the Class A units, the holders of Class C units will be entitled to receive the amount of their investment in the Class C units and, once all the aggregate investment amount invested for all of the units has been returned to their holders, the vested Class C units will share in any distributions pro rata with the Class A units and vested Class B units.

Class D units vest in five equal annual installments on the fifth anniversary of the date of purchase, subject to an employee's continued service with Holdings and its affiliates. However, the Class D units will vest earlier upon a change of control of Holdings. In the event of an employee's termination of employment with Vanguard, other than due to termination by Vanguard for "cause" or by the employee without "good reason", the employee shall be deemed vested in any Class D unit that would otherwise have vested in the calendar year in which such termination of employment occurs. No employee who holds Class D units will receive any distributions until the holders of the Class A units receive the aggregate amount invested for their Class A units. Following return of the aggregate amount invested for the Class A units, the holders of Class D units will be entitled to receive the amount of their investment in the Class D units and, once all the aggregate investment amount invested for all of the units has been returned to their holders and the holders of the Class A units have received an amount representing a 300% return on their aggregate investment along with pro rata distributions to the vested Class B and Class C units, the vested Class D units will share in any distributions pro rata with the Class A units, the vested Class B units and the vested Class C units.

Certain Rights and Restrictions Applicable to the Units Held by Our Managers

The units held by members of our management are not transferable for a limited period of time except in certain circumstances. In addition, the units (other then Class A units) may be repurchased by Holdings, and in certain cases, Blackstone, in the event that the employees cease to be employed by us. Blackstone has the ability to force the employees to sell their units along with Blackstone if Blackstone decides to sell its units.

The employees that hold units are entitled to participate in certain sales by Blackstone. In addition, in the event that Holdings were to make a public offering of its equity securities, the employees would have limited rights to participate in subsequent registered public offerings.

Our 2004 Stock Incentive Plan

General

Since all Units have been granted under the 2004 Unit Plan, we intend for our option program pursuant to our 2004 Stock Incentive Plan to be the primary vehicle currently for offering long-term incentives and rewarding our executive officers, managers and key employees. Because of the direct relationship between the value of an option and the value of our stock, we believe that granting options is the best method of motivating our executive officers to manage our Company in a manner that is consistent with our interests and our stockholders' interests. We also regard our option program as a key retention tool.

We adopted the 2004 Stock Incentive Plan upon consummation of the Merger which permits the grant of non-qualified stock options, incentive stock options, stock appreciation rights, restricted stock and other stock-based awards to our employees or our affiliates' employees. The awards available under the 2004 Stock Incentive Plan, together with Holdings' equity incentive units, represent 20.0% of our fully-diluted equity at the closing of the Merger. Shares covered by awards that expire, terminate or lapse are again available for option or grant under the 2004 Stock Incentive Plan. The total number of shares of our common stock which may be issued under the 2004 Stock Incentive Plan is 101,117. All of our previous option plans were terminated upon consummation of the Merger on September 23, 2004.

Administration

The 2004 Stock Incentive Plan is administered by a committee of the board of directors or, in the sole discretion of the board of directors, the board of directors. The committee has the sole discretion to determine the employees, representatives and consultants to whom awards may be granted under the 2004 Stock Incentive Plan and the manner in which such awards will vest. Options, stock appreciation rights, restricted stock and other stock-based awards will be granted by the committee to employees, representatives and consultants in such numbers and at such times during the term of the 2004 Stock Incentive Plan as the committee shall determine. The committee is authorized to interpret the 2004 Stock Incentive Plan, to establish, amend and rescind any rules and regulations relating to the 2004 Stock Incentive Plan, and to make any other determinations that it deems necessary or desirable for the administration of the plan. The committee may correct any defect or supply any omission or reconcile any inconsistency in the 2004 Stock Incentive Plan in the manner and to the extent the committee deems necessary or desirable.

Stock Options and Stock Appreciation Rights

Options granted under the 2004 Stock Incentive Plan are vested and exercisable at such times and upon such terms and conditions as may be determined by the committee, but in no event will an option be exercisable more than 10 years after it is granted. Under the 2004 Stock Incentive Plan, the exercise price per share for any option awarded is determined by the committee, but may not be less than 100% of the fair market value of a share on the day the option is granted with respect to incentive stock options.

Stock option grants under the 2004 Stock Incentive Plan are generally made at the commencement of employment and occasionally following a significant change in job responsibilities or on a periodic basis to meet other special retention or performance objectives. All stock options granted by our board of directors to date under the 2004 Stock Incentive Plan have been granted at or above the fair market value of our common stock at the grant date based upon the most recent appraisal of our common stock. We have not back-dated any option awards.

As a privately-owned company, there has been no market for our common stock. Accordingly, in fiscal year 2007, we had no program, plan or practice pertaining to the timing of stock option grants to executive officers, coinciding with the release of material non-public information.

An option may be exercised by paying the exercise price in cash or its equivalent, and/or, to the extent permitted by the committee, shares, a combination of cash and shares or, if there is a public market for the shares, through the delivery of irrevocable instruments to a broker to sell the shares obtained upon the exercise of the option and to deliver to us an amount equal to the exercise price.

The committee may grant stock appreciation rights independent of or in conjunction with an option. The exercise price of a stock appreciation right is an amount determined by the committee. Generally, each stock appreciation right entitles a participant upon exercise to an amount equal to (i) the excess of (1) the fair market value on the exercise date of one share over (2) the exercise price, times (ii) the number of shares covered by the stock appreciation right. Payment will be made in shares or in cash or partly in shares and partly in cash (any shares valued at fair market value), as determined by the committee.

As of June 30, 2007, options to purchase 65,574 shares of our common stock (the "New Options") were outstanding under the 2004 Stock Incentive Plan. The New Options were granted in part as "time options," and in part as "performance options" which vest and become exercisable ratably on a yearly basis on each of the first five anniversaries following the date of grant (or earlier upon a change of control). 35% of the options granted were time options with an exercise price equal to the fair market price per share at the time of grant (a range of $1,000 to $1,167.50 per share). 30% of the options granted were performance options with an exercise price of $3,000 per share. 35% of the options granted were "liquidity options" with an exercise price equal to the fair market price per share at the time of grant (a range of $1,000 to $1,167.50 per share) that become fully vested and exercisable upon the completion of any of certain designated business events, and in any event by the eighth anniversary of the date of grant. Any common stock for which such options are exercised are governed by a stockholders agreement, which is described below under "Item 13. Certain Relationships and Related Transactions - Stockholders Agreement."

Of our named executive officers, Messrs. Martin, Moore and Pitts have been granted no New Options as of September 1, 2007, Mr. Mullany has been granted 5,000 New Options and Mr. Wallace has been granted 7,000 New Options. During fiscal year 2007 the Committee granted no New Options to any of the named executive officers.

Other Stock-Based Awards

The committee, in its sole discretion, may grant restricted stock, stock awards, stock appreciation rights, unrestricted stock and other awards that are valued in whole or in part by reference to, or are otherwise based on the fair market value of our shares. Such other stock-based awards shall be in such form, and dependent on such conditions, as the committee shall determine, including, without limitation, the right to receive, or vest with respect to, one or more shares (or the equivalent cash value of such shares) upon the completion of a specified period of service, the occurrence of an event and/or the attainment of performance objectives.

Adjustments Upon Certain Events

In the event of any stock dividend or split, reorganization, recapitalization, merger, share exchange or any other similar transaction, the committee, in its sole discretion, may adjust (i) the number or kind of shares or other securities that may be issued or reserved for issuance pursuant to the 2004 Stock Incentive Plan or pursuant to any outstanding awards, (ii) the option price or exercise price and/or (iii) any other affected terms of such awards. In the event of a change of control, the committee may, in its sole discretion, provide for the (i) termination of an award upon the consummation of the change of control, but only if such award has vested and been paid out or the participant has been permitted to exercise the option in full for a period of not less than 30 days prior to the change of control, (ii) acceleration of all or any portion of an award, (iii) payment of a cash amount in exchange for the cancellation of an award, which, in the case of options and stock appreciation rights, may equal the excess, if any, of the fair market value of the shares subject to such options or stock appreciation rights over the aggregate option price or grant price of such option or stock appreciation rights, and/or (iv) issuance of substitute awards that will substantially preserve the otherwise applicable terms of any affected awards previously granted hereunder.

Amendment and Termination

The committee may amend or terminate the 2004 Stock Incentive Plan at any time, provided that no amendment or termination shall diminish any rights of a participant pursuant to a previously granted award without his or her consent, subject to the committee's authority to adjust awards upon certain events (described under "Adjustments Upon Certain Events" above). No awards may be made under the 2004 Stock Incentive Plan after the tenth anniversary of the effective date of the plan.

Benefits and Executive Perquisites

The Committee believes that attracting and retaining superior management talent requires an executive compensation program that is competitive in all respects with the programs provided at similar companies. In addition to salaries, incentive bonus and equity awards, competitive executive compensation programs include retirement and welfare benefits and reasonable executive perquisites.

Retirement Benefits

Substantially all of the salaried employees, including our named executive officers, participate in our 401(k) savings plan. Employees are permitted to defer a portion of their income under the 401(k) plan. At the discretion of our board of directors, we may make a matching contribution of either (1) up to 50%, subject to annual limits established under the Internal Revenue Code, of the first 6% of employees' contributions under this 401(k) plan as determined each year or (2) in respect of a few of our employees who came to us with plans in place larger than this match, a match of 100% of the first 5% of employees' contributions under this 401(k) plan. Our board of directors authorized such maximum discretionary amounts as a match on employees' 401(k) Plan contributions for fiscal year 2007, including the named executive officers. Employee and our matching contributions are fully vested immediately. Participants may receive distribution of their 401(k) accounts any time after they cease service with us.

We maintain no defined benefit plans.

Other Benefits

All executive officers, including the named executive officers, are eligible for other benefits including: medical, dental, life insurance, and short term disability. The executives participate in these plans on the same basis, terms, and conditions as other administrative employees. In addition, we provide long-term disability insurance coverage on behalf of the named executive officers at an amount equal to 60% of current base salary (up to $10,000 per month). The named executive officers also participate in our vacation, holiday and sick program which provides paid leave during the year at various amounts based upon the executive's position and length of service.

Perquisites

Our executive officers may have limited use of our corporate plane for personal purposes as well as very modest other usual and customary perquisites. All of such perquisites are reflected in the All Other Compensation column of the Summary Compensation Table and the accompanying footnotes.

Our Employment Agreements with Certain Named Executive Officers

On June 1, 1998, we entered into written employment agreements with our Chief Executive Officer and Chief Financial Officer (Messrs. Martin and Moore, respectively), which were amended and restated on September 23, 2004, to extend the term of the employment agreements for five years, and to provide that the Merger did not constitute a change in control under the agreements. On September 1, 1999, we entered into a written employment agreement with Keith B. Pitts to be our Executive Vice President for a term expiring on September 1, 2004. Effective May 31, 2001, Mr. Pitts was promoted to the position of Vice Chairman, and on September 23, 2004, his employment agreement was amended and restated to extend the term of the employment agreement for five years, and to provide that the Merger did not constitute a change in control under the agreement. Messrs. Martin, Moore and Pitts are three of our named executive officers.

The term of each employment agreement will renew automatically for additional one-year periods, unless any such agreement is terminated by us or by the officer by delivering notice of termination no later than 90 days before the end of any such renewal term. The base salaries of Messrs. Martin, Moore and Pitts under such written employment agreements are, during calendar year 2007, $1,050,291, $583,495 and $641,844, respectively, which were their same base salaries in calendar year 2006. Pursuant to these agreements the officers are eligible to participate in an annual bonus plan giving each of them an opportunity to earn an annual bonus in such amount as our board of directors should determine, as well as pension, medical and other customary employee benefits. The terms of these agreements state that if the officer terminates his employment for Good Reason (as defined in the

agreements) or if we terminate the officer's employment without Cause (as defined in the agreements), he will receive within a specified time after the termination a payment of up to three times the sum of (i) his annual salary plus (ii) the average of the bonuses given to him in the two years immediately preceding his termination.

Our Severance Protection Agreements

We provide our officers at the Vice President level and above (other than Messrs. Martin, Moore and Pitts and Ronald P. Soltman (our General Counsel), who each have a written employment agreement containing severance provisions) with severance protection agreements granting them severance payments in amounts of 200% to 300% of annual salary and bonus. Generally, severance payments are due under these agreements if a change in control (as defined in the agreements) should occur and employment of the officer is terminated during the term of the agreement by us (or our successor) without Cause (as defined in the agreements) or by the executive for Good Reason (as defined in the agreement). In addition, these agreements state that in the event of a Potential Change in Control (defined as the time at which an agreement which would result in a change in control is signed, an acquisition attempt relating to us is publicly announced or there is an increase in the number of shares owned by one of our 10% shareholders by 5% or more), the executives have an obligation to remain in our employ until the earliest of (1) six months after the Potential Change in Control; (2) a change in control; (3) a termination of employment by us; or (4) a termination of employment by the employee for Good Reason (treating Potential Change in Control as a change in control for the purposes of determining whether the executive had a Good Reason) or due to death, disability or retirement. On September 23, 2004, all the outstanding severance protection agreements were amended and restated to provide that the Merger did not constitute a change in control under the agreements, and that we would not terminate the agreements prior to the third anniversary of the closing of the Merger.

Two of our named executive officers, Messrs. Wallace and Mullany, have severance protection agreements granting them severance payments in amounts equal to 300% and 250% of salary and bonus, respectively.

Stock Ownership

We do not have a formal policy requiring stock ownership by management. Our senior managers, including Messrs. Martin, Moore, Pitts and Wallace, however, have committed significant personal capital to our Company in connection with the consummation of the Merger. See the beneficial ownership chart below under Item 12, "Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters". Our stock is not publicly traded and is subject to a stockholder agreement that limits a stockholder's ability to transfer his or her shares. See "Holdings Limited Liability Company Agreement" and "Stockholders Agreement" under Item 13, "Certain Relationships and Related Transactions, and Director Independence."

Impact of Tax and Accounting Rules

The forms of our executive compensation are largely dictated by our capital structure and have not been designed to achieve any particular accounting treatment. We do take tax considerations into account, both to avoid tax disadvantages, and obtain tax advantages where reasonably possible consistent with our compensation goals. (Tax advantages for our executives benefit us by reducing the overall compensation we must pay to provide the same after-tax income to our executives.) Thus our severance pay plans are designed or are being reviewed to take account of and avoid "parachute" excise taxes under Section 280G of the Internal Revenue Code. Since we currently have no publicly traded common stock, we are not currently subject to the $1,000,000 limitation on deductions for certain executive compensation under Section 162(m) of the Internal Revenue Code, though that rule will be considered if our common stock becomes publicly traded. Incentives paid to executives under our annual incentive plan are taxable at the time paid to our executives.

The expenses associated with the stock options issued by us to our executive officers and other key employees are reflected in our consolidated financial statements. In the first quarter of the fiscal year ended June 30, 2007, we began accounting for these stock-based payments in accordance with the requirements of SFAS 123(R), which requires all share-based payments to employees, including grants of employee stock options, to be recognized as expense in the consolidated financial statements based on their fair values. For further discussion see "ITEM 8, Note 2-Summary of Critical and Significant Accounting Policies" under the heading "Stock-Based Compensation."

We previously accounted for these awards under the provisions of SFAS 123, which allowed us to estimate the fair value of options using the minimum value method.

Recovery of Certain Awards

We do not have a formal policy for recovery of annual incentives paid on the basis of financial results which are subsequently restated. Under the Sarbanes-Oxley Act, our chief executive officer and chief financial officer must forfeit incentive compensation paid on the basis of financial statements for which they were responsible and which have to be restated. In that event we would expect to recover such bonuses and incentive compensation. If and when the situation arises in other events, we would consider our course of action in light of the particular facts and circumstances, including the culpability of the individuals involved.

Compensation Committee Report

The Committee has reviewed and discussed the Compensation Discussion and Analysis with management. Based upon the review and discussions, the Committee directed that the Compensation Discussion and Analysis be included in this annual report on Form 10-K.

Compensation Committee:

Michael DalBello
Charles N. Martin, Jr.
James A. Quella
Neil P. Simpkins

Summary Compensation Table

The following table sets forth, for the fiscal year ended June 30, 2007, the compensation earned by the Chief Executive Officer and Chief Financial Officer and the three other most highly compensated executive officers of the registrant, Vanguard, at the end of Vanguard's last fiscal year ended June 30, 2007. We refer to these persons as our named executive officers.

Name and Principal Position	Year	Salary ($)	Non-Equity Incentive Plan Compensation ($)	All Other Compensation ($)	Total ($)
Charles N. Martin, Jr. Chairman of the Board & Chief Executive Officer	2007	1,050,291	–	10,164(a)	1,060,455
Joseph D. Moore Executive Vice President, Chief Financial Officer & Treasurer	2007	583,495	–	3,564(a)	587,059
Keith B. Pitts Vice Chairman	2007	641,844	–	7,410(a)	649,254
Kent H. Wallace President & Chief Operating Officer	2007	600,000	–	230,212(a)	830,212
Joseph J. Mullany Senior Vice President-Operations	2007	400,000	251,260(b)	72,847(a)	725,847

(a) The amounts disclosed under All Other Compensation in the Summary Compensation Table represent for the named executive officers in fiscal 2007 (i) the following amounts of our matching contributions made under our 401(k) Plan: Mr. Martin: $6,600; Mr. Moore: $0; Mr. Pitts: $6,600; Mr. Wallace: $6,600; and Mr. Mullany: $6,600; and (ii) the following amounts of insurance premiums paid by Vanguard with respect to group term life insurance: Mr. Martin: $3,564; Mr. Moore: $3,564; Mr. Pitts: $810; Mr. Wallace: $1,242; and Mr. Mullany: $30. The amounts in this column also include for Mr. Wallace only $222,370 in fiscal 2007 which represents our payment to him of $221,740 to reimburse him for certain relocation expenses in connection with his move to our Nashville, Tennessee headquarters from San Antonio, Texas after his election as our President & Chief Operating Officer (such $221,740 made up of $142,360 in costs of carrying his former residence while up for sale, $5,373 in relocation costs to Nashville, TN and $74,007 in income and other related personal taxes on our reimbursement to him of such relocation and former residence costs) and $630 to reimburse him for club dues. The amounts in this column also include for Mr. Mullany only in fiscal 2007 a $4,500 monthly housing allowance in connection with his relocation of his residence to Massachusetts from his residence in Tennessee after he joined us in September 2005 and $12,217 in temporary living and other relocation expenses (including reimbursement of his income and other related personal taxes on such housing allowance and on our reimbursement to him of such relocation expenses). No amounts for perquisites and other personal benefits, or property, have been included in this column for Messrs. Martin, Moore and Pitts because the aggregate value thereof for each of these named executive officers was below the $10,000 reporting threshold established by the Securities and Exchange Commission for this column.

(b) The Compensation Committee has determined the amount of the Annual Incentive Plan compensation that will be paid to Mr. Mullany for fiscal year 2007. This amount was paid on or about September 14, 2007. All other named executive officers received no annual incentive plan compensation for the fiscal year ended June 30, 2007.

Grants of Plan-Based Awards in Fiscal Year 2007

		Estimated Future Payouts Under Non-Equity Incentive Plan Awards (a)		
Name	Grant Date	Threshold ($)	Target ($)	Maximum ($)
Charles N. Martin, Jr.	9/12/06	-0-	1,052,291	--
Joseph D. Moore	9/12/06	-0-	408,446	--
Keith B. Pitts	9/12/06	-0-	577,660	--
Kent H. Wallace	9/12/06	-0-	540,000	--
Joseph J. Mullany	9/12/06	-0-	297,500	459,000

(a) No cash incentive amounts were actually paid to the named executive officers under the Annual Incentive Plan with respect to fiscal year 2007, as noted in footnote (b) of the Summary Compensation Table, because our actual financial performance was below the minimum thresholds, except for Mr. Mullany who earned $251,260 under the Plan. See the "Compensation Discussion and Analysis, Annual Incentive Compensation," for a detailed description of the Annual Incentive Plan. No equity-based awards were granted to the named executive officers during 2007.

Outstanding Equity Awards at Fiscal 2007 Year-End

The following table summarizes the outstanding equity awards held by each named executive officer at June 30, 2007. The table reflects options to purchase common stock of Vanguard which were granted under the Vanguard Health Systems, Inc. 2004 Stock Incentive Plan.

Name	Number of Securities Underlying Unexercised Options (#) Exercisable(a)	Number of Securities Underlying Unexercised Options (#) Unexercisable(b)	Option Exercise Price ($)(c)	Option Expiration Date
Charles N. Martin, Jr.	–	–	–	–
Joseph D. Moore	–	–	–	–
Keith B. Pitts	–	–	–	–
Kent H. Wallace	172(d)	686(d)	1,150.37	11/3/15
	–(e)	858(e)	1,150.37	11/3/15
	148(d)	588(d)	3,000.00	11/3/15
	319(f)	1,273(f)	1,150.37	11/28/15
	–(g)	1,592(g)	1,150.37	11/28/15
	273(f)	1,091(f)	3,000.00	11/28/15
Joseph J. Mullany	350(h)	1,400(h)	1,000.00	9/19/15
	–(i)	1,750(i)	1,000.00	9/19/15
	300(h)	1,200(h)	3,000.00	9/19/15

(a) This column represents the number of stock options that had vested as of June 30, 2007.

(b) This column represents the number of stock options that had not vested as of June 30, 2007.

(c) The exercise price for the options is equal to the grant date fair market value of a share of Vanguard common stock as determined by the Compensation Committee.

(d) 20% of the options represented by this option grant vest and become exercisable on each of the first five anniversaries of the November 3, 2005 grant date of these options. 20% of this option grant was vested as of June 30, 2007.

(e) 100% of the options represented by this option grant vest and become exercisable on the eighth anniversary of the November 3, 2005 grant date of these options.

(f) 20% of the options represented by this option grant vest and become exercisable on each of the first five anniversaries of the November 28, 2005 grant date of these options. 20% of this option grant was vested as of June 30, 2007.

(g) 100% of the options represented by this option grant vest and become exercisable on the eighth anniversary of the November 28, 2005 grant date of these options.

(h) 20% of the options represented by this option grant vest and become exercisable on each of the first five anniversaries of the September 19, 2005 grant date of these options. 20% of this option grant was vested as of June 30, 2007.

(i) 100% of the options represented by this option grant vest and become exercisable on the eighth anniversary of the September 19, 2005 grant date of these options.

Option Exercises and Stock Vested

No named executive officer exercised any stock options of Vanguard during fiscal 2007 nor were any restricted stock awards vested during fiscal 2007. Vanguard has made no restricted stock awards of its common stock since the Merger.

Pension Benefits

Vanguard maintains a 401(k) plan as previously discussed in the Compensation Discussion and Analysis. Vanguard maintains no defined benefit plans.

Nonqualified Deferred Compensation

None of the named executive officers receive nonqualified deferred compensation benefits.

Employment and Severance Protection Agreements

As discussed above, we have entered into definitive employment or severance protection agreements with each of the named executive officers. The terms of these agreements are described above under Compensation Discussion and Analysis.

Potential Payments Upon Termination or Change of Control

The following table describes the potential payments and benefits under our compensation and benefit plans and arrangements to which the named executive officers would be entitled upon a termination of their employment under their employment agreement, if they have an employment agreement, or if they do not have an employment agreement, under their severance protection agreement. In accordance with SEC disclosure rules, dollar amounts below assume a termination of employment on June 29, 2007 (the last business day of our last completed fiscal year).

Current	Cash Severance Payment ($)	Continuation of Medical/Welfare Benefits (present value) ($)	Total Termination Benefits ($)
Charles N. Martin, Jr.			
·Voluntary retirement	0	0	0
·Involuntary termination	5,776,602	8,539	5,785,141
·Involuntary or Good Reason termination after change in control	5,776,602	8,539	5,785,141
Joseph D. Moore			
·Voluntary retirement	0	0	0
·Involuntary termination	2,771,600	15,669	2,787,269
·Involuntary or Good Reason termination after change in control	2,771,600	15,669	2,787,269
Keith B. Pitts			
·Voluntary retirement	0	0	0
·Involuntary termination	3,369,685	22,879	3,392,564
·Involuntary or Good Reason termination after change in control	3,369,685	22,879	3,392,564
Kent H. Wallace			
·Voluntary retirement	0	0	0
·Involuntary termination	0	0	0
·Involuntary or Good Reason termination after change in control	3,960,000	21,722	3,981,722
Joseph J. Mullany			
·Voluntary retirement	0	0	0
·Involuntary termination	0	0	0
·Involuntary or Good Reason termination after change in control	2,103,750	22,479	2,126,229

Accrued Pay and Regular Retirement Benefits. The amounts shown in the table above do not include payments and benefits to the extent they are provided on a non-discriminatory basis to salaried employees generally upon termination of employment. These include:

- Accrued salary and vacation pay and earned but unpaid bonus.
- Distributions of plan balances under our 401(k) plan.

Death and Disability. A termination of employment due to death or disability does not entitle the named executive officers to any payments or benefits that are not available to salaried employees generally.

Involuntary Termination and Change-in-Control Severance Pay Program. As described above under "— Our Employment Agreements," three of the named executive officers (Messrs. Martin, Moore and Pitts) are entitled to severance pay in the event that their employment is terminated by us without Cause or if the named executive

officer terminates the agreement as a result of our breach of his employment agreement. Additionally, they are entitled to severance pay under their employment agreements in the event they terminate the agreements after a change in control if their termination is for Good Reason.

As described above under "—Our Severance Protection Agreements", the other two of our named executive officers (Messrs. Wallace and Mullany) are entitled to severance pay in the event that their employment is terminated by us after a change of control without Cause. Additionally, they may terminate their agreements and be entitled to severance pay after a change in control if their termination is for Good Reason.

Under our executive severance pay program, no payments due in respect of a change of control are "single trigger", that is, payments of severance due to the named executive officers merely upon a change of control. All of our change of control payments are "double trigger", due to the executive only subsequent to a change of control and after a termination of employment has occurred.

Under their employment agreements, Messrs. Martin, Moore and Pitts owe the following obligations to us:

- Not to disclose our confidential business information;
- Not to solicit for employment any of our employees for a period expiring two years after the termination of their employment; and
- Not to accept employment with or consult with, or have any ownership interest in, any hospital or hospital management entity for a period expiring two years after the termination of their employment, except there shall be not such prohibitions if (1) we terminate the executive under his employment agreement or (2) the executive terminates his agreement for Good Reason or because we have breached his agreement.

The amounts shown in the table are for such involuntary or Good Reason terminations for the named executive officers and are based on the following assumptions and provisions in the employment or severance agreements, as the case may be.

- *Covered terminations following a Change in Control.* Eligible terminations for Messrs. Martin, Moore and Pitts include an involuntary termination for reasons other than Cause both before and following a change of control , or a voluntary resignation by the executive as a result of Good Reason following a change in control. Eligible terminations for Messrs. Wallace and Mullany include an involuntary termination for reasons other than Cause following a change of control, or a voluntary resignation as a result of Good Reason following a change of control.

- *Definitions of Cause and Good Reason*

A termination of a named executive officer by us is for Cause if it is for any of the following reasons:

(a) the conviction of the executive of a criminal act classified as a felony;

(b) the willful failure by the executive to substantially perform the executive's duties with us (other than any such failure resulting from the executive's incapacity due to physical or mental illness); or

(c) the willful engaging by the executive in conduct which is materially injurious to us monetarily or otherwise.

A termination by the executive officer is for Good Reason if it results from, among other things, after a change of control has occurred, one of the following events:

(a) any change in the executive's title, authorities, responsibilities (including reporting responsibilities) which, in the executive's reasonable judgment, represents an adverse change from his status, title, position or responsibilities (including reporting responsibilities) which were in effect immediately prior to the change in control;

(b) a reduction by us in the executive's annual base salary;

(c) the relocation of the executive's office at which he is to perform his duties, to a location more than thirty (30) miles from the location at which the executive performed his duties prior to the Change in Control; or

(d) any material breach by us of any provision of his employment or severance protection agreement, as the case may be.

• *Cash severance payments; Timing.* Represents, for each of Messrs. Martin, Moore and Pitts, (1) if it relates to an involuntary termination without Cause by us prior to a change of control, a payment of 3 times (if the termination is prior to September 23, 2007) or 2 times (if the termination is on or after September 23, 2007) the named executive officer's base salary and average annual incentive actually paid during the last two years plus an additional amount equal to such officer's pro rata annual target incentive for the year of termination and (2) if it relates to an involuntary termination without cause by us or a Good Reason termination by the executive after a change of control, payment of 3 times the named executive officer's base salary and average annual incentive actually paid during the last two years plus an additional amount equal to such officer's pro rata annual target incentive for the year of termination. Represents, for each of Messrs. Wallace and Mullany, if it relates to either an involuntary termination without cause by us or a Good Reason termination by the executive after a change of control, payment of 3 times for Mr. Wallace and 2.5 times for Mr. Mullany, such named executive officer's base salary and target incentive plus an additional amount equal to such executive's pro rata annual incentive for the year of termination. All of these severance payments are "lump sum" payments by us to the named executive officers due within 5 days of termination of employment, except that the amounts of severance described above payable to Messrs. Martin, Moore and Pitts in respect of a termination of their employment prior to a change of control are payable monthly in equal monthly installments starting with the month after employment terminates and ending with the month that their 5-year employment agreements terminate (which is September 2009).

• *Continuation of health, welfare and other benefits.* Represents the value of coverage for 18 months following a covered termination equivalent to our current active employee medical, dental, life, long-term disability insurances and other covered benefits.

Director Compensation

Historically, we have paid no compensation to members of our board of directors for their service. We do, however, reimburse them for travel expenses and other out-of-pocket costs incurred in connection with attendance at meetings of the boards. Members of these boards are not eligible to receive options pursuant to our option plans, as described in Item 11 under the caption "Our 2004 Stock Incentive Plan." As an independent company, we expect at some time in the future to establish directors' compensation practices that will be aligned with creating and sustaining stockholder value. No additional remuneration will be paid to officers or employees of ours who also serve as directors.

Compensation Committee Interlocks and Insider Participation

During fiscal 2007, we had no compensation committee of our board of directors. Charles N. Martin, Jr., one of the named executive officers, participated in deliberations of our board of directors concerning executive officer compensation during fiscal 2007.

Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters.

As of September 15, 2007, VHS Holdings LLC ("Holdings") directly owned 624,550 of the outstanding shares of the common stock of Vanguard (representing a 83.3% ownership interest), certain investment funds affiliated with Blackstone directly owned 125,000 of the outstanding shares of the common stock of Vanguard (representing a 16.7% ownership interest) and no other person or entity had a direct beneficial ownership interest in the common stock of Vanguard, except for certain key employees who held an aggregate of 10,592 exercisable options into 10,592 shares of the common stock of Vanguard as of such date. However, ignoring only the direct ownership of Holdings in the common stock of Vanguard, the following table sets forth information with respect to the direct or indirect beneficial ownership of the common stock of Vanguard as of September 15, 2007 by (1) each person (other than Holdings) known to own beneficially more than 5.0% of the common stock of Vanguard, (2) each named executive officer, (3) each of our directors and (4) all executive officers and directors as a group. The indirect beneficial ownership of the common stock of Vanguard reflects the direct beneficial ownership of all Class A units and all vested Class B and D units of Holdings. None of the shares listed in the table are pledged as security pursuant to any pledge arrangement or agreement. Additionally, there are no arrangements with respect to the share, the operation of which may result in a change in control of Vanguard.

Notwithstanding the beneficial ownership of the common stock of Vanguard presented below, the limited liability company agreement of Holdings governs the holders' exercise of their voting rights with respect to election of Vanguard's directors and certain other material events. See "Item 13. Certain Relationships and Related Transactions - Holdings Limited Liability Company Agreement."

Name of Beneficial Owner	Beneficial Ownership	Ownership Percentage
Blackstone Funds(1)	494,930	66.0%
MSCP Funds(2)	130,000	17.3%
Charles N. Martin Jr.(3)	49,932	6.6%
Joseph D. Moore(4)	13,956	1.9%
Keith B. Pitts(5)	16,843	2.2%
Joseph J. Mullany(6)	1,300	*
Kent H. Wallace(7)	5,004	*
James A. Quella(1)	494,930	66.0%
Neil P. Simpkins (1)	494,930	66.0%
Michael A. Dal Bello	—(8)	—(8)
All directors and executive officers as a group (20 persons) (9)	752,404	95.4%

* Less than 1% of shares of common stock outstanding (excluding, in the case of all directors and executive officers as a group, shares beneficially owned by Blackstone and by the MSCP Funds).

(1) Includes common stock interests directly and indirectly owned by each of Blackstone FCH Capital Partners IV L.P., Blackstone FCH Capital Partners IV-A L.P., Blackstone FCH Capital Partners IV-B L.P., Blackstone Capital Partners IV-A L.P., Blackstone Family Investment Partnership IV-A L.P., Blackstone Health Commitment Partners L.P. and Blackstone Health Commitment Partners-A L.P. (the "Blackstone Funds"), for which Blackstone Management Associates IV L.L.C. ("BMA") is the general partner having voting and investment power over the membership interests in Holdings and the shares in Vanguard held or controlled by each of the Blackstone Funds. Messrs. Quella and Simpkins are members of BMA, but disclaim any beneficial ownership of the membership interests or the shares beneficially owned by BMA. Messrs. Peter G. Peterson and Stephen A. Schwarzman are the founding members of BMA and as such may be deemed to share beneficial ownership of the membership interests or shares held or controlled by the Blackstone Funds. Each of BMA and Messrs. Peterson and Schwarzman disclaims beneficial ownership of such membership interests and shares. The address of BMA and the Blackstone Funds is c/o The Blackstone Group L.P., 345 Park Avenue, New York, New York 10154

(2) The MSCP Funds consist of Morgan Stanley Capital Partners III, L.P., MSCP III 892 Investors, L.P., Morgan Stanley Capital Investors, L.P., Morgan Stanley Dean Witter Capital Partners IV, L.P., MSDW IV 892 Investors, L.P., and Morgan Stanley Dean Witter Capital Investors IV, L.P. The address of each such entity is c/o Metalmark Capital LLC, 1177 Avenue of the Americas, New York, New York 10036.

(3) Includes 5,348 B units and 4,584 D units in Holdings which are vested or vest within 60 days of September 15, 2007.

(4) Includes 1,888 B units and 1,618 D units in Holdings which are vested or vest within 60 days of September 15, 2007.

(5) Includes 3,146 B units and 2,697 D units in Holdings which are vested or vest within 60 days of September 15, 2007.

(6) Includes 1,300 options in Vanguard which are vested or vest within 60 days of September 15, 2007.

(7) Includes 1,231 options in Vanguard and 1,574 B units and 1,349 D units in Holdings which are vested or vest within 60 days of September 15, 2007.

(8) Mr. Dal Bello is an employee of Blackstone, but does not have investment or voting control over the shares beneficially owned by Blackstone.

(9) Includes 5,457 options in Vanguard and 18,095 B units and 15,509 D units in Holdings which have vested or vest within 60 days of September 15, 2007.

Equity Compensation Plan Information

The following table gives information about our common stock that may be issued upon the exercise of options, warrants and rights under all of Vanguard's existing equity compensation plans as of June 30, 2007.

	Equity Compensation Plan Information		
Plan Category	Number of securities to be issued upon exercise of outstanding options, warrants and rights (a)	Weighted-average exercise price of outstanding options, warrants and rights (b)	Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a)) (c)
Equity compensation plans approved by security holders	65,574 (1)	$1,661.39	35,207 (1)
Equity compensation plans not approved by security holders	0	$ 0	0
Total	65,574	$1,661.39	35,207

(1) The material features of the equity compensation plan under which these options were issued are set forth in this report under "Item 11. Executive Compensation – Our 2004 Stock Incentive Plan."

Item 13. Certain Relationships and Related Transactions, and Director Independence.

Holdings Limited Liability Company Agreement

In the Merger, Blackstone invested, and MSCP, Baptist and the Rollover Management Investors re-invested, in our company by subscribing for and purchasing Class A membership units in Holdings. In addition, at the closing of the Merger, the board of representatives of Holdings issued to certain Rollover Management Investors Class B, C and D membership units in Holdings as part of a new equity incentive program.

Under the limited liability company agreement of Holdings, the board of representatives of Holdings consists of the same five individuals who constitute the sole members of our board of directors. At Blackstone's election, the size of the board of representatives may be increased to nine members, with two additional representatives to be designated by Blackstone and two additional representatives to be independent representatives identified by our chief executive officer and acceptable to Blackstone. If at any time our chief executive officer is not Charles N. Martin, Jr., the Rollover Management Investors shall have the right to designate one representative to the board (the "Manager Representative") so long as the Rollover Management Investors continue to own not less than 50% of the Class A units held by them immediately after the completion of the Merger. MSCP will continue to be entitled to nominate and elect one representative so long as MSCP continues to own not less than 50% of the Class A units it held immediately after the completion of the Merger.

The limited liability company agreement of Holdings also has provisions relating to restrictions on transfer of securities, rights of first refusal, tag-along, drag-along, preemptive rights and affiliate transactions. At the completion of the Merger, the Company issued Class B, C and D warrants to Holdings, exercisable for the proportional percentage of equity represented by the related classes of membership units in Holdings. With respect to the Class B, C and D units only, the limited liability company agreement also has call provisions applicable in the event of certain termination events relating to a Rollover Management Investor's employment.

Stockholders Agreement

Recipients of options to purchase the Company's common stock are required to enter into a stockholders agreement governing such grantees' rights and obligations with respect to the common stock underlying such options. The provisions of the stockholders agreement are, with limited exceptions, similar to those set forth in the

limited liability company agreement of Holdings, including certain restrictions on transfer of shares of common stock, rights of first refusal, call rights, tag-along rights and drag-along rights. The transfer restrictions apply until the earlier of the fifth anniversary of the date the stockholder becomes a party to the stockholders agreement, or a change in control of the Company. The right of first refusal provision gives the Company a right of first refusal at any time after the fifth anniversary of the date the stockholder became a party to the stockholders agreement and prior to the earlier of a change in control of the Company or a registered public offering of our common stock meeting certain specified criteria. The call provisions provide rights with respect to the shares of our common stock held by the stockholder, whether or not such shares were acquired upon the exercise of a New Option, except for shares received upon conversion of or in redemption for Class A membership units in Holdings pursuant to the limited liability company agreement of Holdings. Such call rights are applicable in the event of certain termination events relating to the grantee's employment with the Company.

Transaction and Monitoring Fee Agreement

In connection with the Merger, Vanguard entered into a transaction and monitoring fee agreement with affiliates of Blackstone and Metalmark pursuant to which these affiliates provide certain structuring, advisory and management services to us. Under this agreement, Vanguard paid to Blackstone Management Partners IV L.L.C. ("BMP") upon the closing of the Merger a transaction fee of $20.0 million. In consideration for ongoing consulting and management advisory services, Vanguard is required to pay to BMP an annual fee of $4.0 million. In consideration for on-going consulting and management services Vanguard is required to pay to Metalmark Subadvisor LLC ("Metalmark SA"), an affiliate of Metalmark, an annual fee of $1.2 million for the first five years and thereafter an annual fee of $600,000. In the event or in anticipation of a change of control or initial public offering, BMP may elect at any time to have Vanguard pay to BMP and Metalmark SA lump sum cash payments equal to the present value (using a discount rate equal to the yield to maturity on the date of notice of such event of the class of outstanding U.S. government bonds having a final maturity closest to the tenth anniversary of such written notice) of all then-current and future fees payable to each of BMP and Metalmark SA under the agreement (assuming that the agreement terminates on the tenth anniversary of the closing of the Merger). In the event that BMP receives any additional fees in connection with an acquisition or disposition involving Vanguard, Metalmark SA will receive an additional fee equal to 15.0% of such fees paid to BMP or, if both parties provide equity financing in connection with the transaction, Metalmark SA will receive a portion of the aggregate fees payable by Vanguard, if any, based upon the amount of equity financing provided by Metalmark SA. The transaction and monitoring fee agreement also requires Vanguard to pay or reimburse BMP and Metalmark SA for reasonable out-of-pocket expenses in connection with, and indemnify them for liabilities arising from, the engagement of BMP and Metalmark SA of independent professionals pursuant to and the performance by BMP and Metalmark SA of the services contemplated by the transaction and monitoring fee agreement. The transaction and monitoring fee agreement will remain in effect with respect to each of BMP and Metalmark SA until the earliest of (1) BMP and Metalmark SA, as the case may be, beneficially owning less than 5.0% of Vanguard's common equity on a fully diluted basis, (2) the completion of a lump-sum payout as described above or (3) termination of the agreement upon the mutual consent of BMP and/or Metalmark SA, as the case may be, and Vanguard. Upon termination of Metalmark SA as a party to the agreement, Metalmark SA will be entitled to the excess, if any, of 15.0% of the aggregate amount of fees paid to date to BMP under the agreement minus any monitoring fees already paid to Metalmark SA.

Under the transaction and monitoring fee agreement during fiscal year 2007, Vanguard paid to BMP the annual $4.0 million fee referred to above. BMP is an affiliate of the Blackstone Funds which own 66.0% of the equity of Vanguard. Three of our four directors, Messrs. Dal Bello, Quella and Simpkins, are employed by affiliates of BMP.

Under the transaction and monitoring fee agreement during fiscal year 2007, Vanguard paid to Metalmark SA the annual $1.2 million fee referred to above. Vanguard also incurred $2,569 of the out-of-pocket expenses of Metalmark SA in connection with performing services for us under the agreement, which Vanguard paid to Metalmark in July 2006. Metalmark SA is an affiliate of Metalmark Capital LLC which manages the MSCP Funds and the MSCP Funds own 17.3% of the equity of Vanguard.

Registration Rights Agreement

In connection with the Merger, the Company entered into a registration rights agreement with Blackstone, MSCP and other investors and the Rollover Management Investors, pursuant to which Blackstone and MSCP are entitled to certain demand registration rights and pursuant to which Blackstone, MSCP and other investors and the Rollover Management Investors are entitled to certain piggyback registration rights.

Policy on Transactions with Related Persons

The Vanguard board of directors recognizes the fact that transactions with related persons present a heightened risk of conflicts of interests and/or improper valuation (or the perception thereof). In February 2007, the board of directors adopted a written policy reflecting existing practices to be followed in connection with any transaction between the Company and a "related person."

Any transaction with the Company in which a director, executive officer or beneficial holder of more than 5% of the total equity of the Company, or any immediate family member of the foregoing (each, a "related person") has a direct or indirect material interest, and where the amount involved exceeds $120,000, must be specifically disclosed by the Company in its public filings. Any such transaction would be subject to the Company's written policy respecting the review, approval or ratification of related person transactions.

Under this policy:

- the Company or any of its subsidiaries may employ a related person in the ordinary course of business consistent with the Company's policies and practices with respect to the employment of non-related persons in similar positions; and

- any other related person transaction that would be required to be publicly disclosed must be approved or ratified by the board of directors, a committee thereof or if it is impractical to defer consideration of the matter until a board or committee meeting, by a non-management director who is not involved in the transaction.

If the transaction involves a related person who is a director or an immediate family member of a director, that director may not participate in the deliberations or vote. In approving or ratifying a transaction under this policy, the board of directors, the committee or director considering the matter must determine that the transaction is fair to the Company and may take into account, among other factors deemed appropriate, whether the transaction is on terms not less favorable than terms generally available to an unaffiliated third-party under the same or similar circumstances and the extent of the related person's interest in the transaction.

During fiscal year 2007, there were no transactions between the Company and a related person requiring approval under this policy.

Director Independence

The board of directors has not made a determination as to whether each director is "independent" because all of the members of our board have either been appointed by our equity sponsors, except for Charles N. Martin, Jr. who is our full time employed chief executive officer. The Company has no securities listed for trading on a national securities exchange or in an automated inter-dealer quotation system of a national securities association, which has requirements that a majority of its board of directors be independent. The Company does not believe any of its directors would be considered independent under the New York Stock Exchange's definition of independence.

Item 14. Principal Accounting Fees and Services.

Fees Paid to the Independent Auditor

The following table presents fees for professional services rendered by Ernst & Young LLP for the audit of Vanguard's annual financial statements for 2006 and 2007, and fees billed for audit-related services, tax services and all other services rendered by Ernst & Young LLP for 2006 and 2007.

	2006	2007
Audit fees[1]	$ 771,187	$ 834,133
Audit-related fees	–	–
Audit and audit-related fees	771,187	834,133
Tax fees[2]	78,954	34,316
All other fees[3]	1,128,488	1,870,901
Total fees[4]	$ 1,978,629	$ 2,739,350

(1) Audit fees for 2006 and 2007 include fees for the audit of the annual consolidated financial statements, reviews of the condensed consolidated financial statements included Vanguard's quarterly reports and statutory audits.

(2) Tax fees for 2006 and 2007 consisted principally of fees for tax advisory services.

(3) All other fees for 2006 and 2007 consisted of assistance in filing Medicare and Medicaid appeals and reopening requests for cost reports that had been settled by the fiscal intermediary; assistance in identification of Medicaid eligible days for inclusion in the Medicare cost reports for Medicare disproportionate share reimbursement and assistance on accounting issues in the ownership of medical office buildings.

(4) Ernst & Young LLP full time, permanent employees performed all of the professional services described in this chart.

Pre-Approval Policies and Procedures

In February 2004, our board of directors first adopted an audit and non-audit services pre-approval policy and in November 2004 and May 2006 the board amended and restated this policy. This policy sets forth the Board's procedures and conditions pursuant to which services proposed to be performed by the Company's regular independent auditor (and those other independent auditors for whom pre-approvals are legally necessary) are presented to the Board for pre-approval. Normally, the policy would have been approved by the audit committee and ratified by the board of directors, but in February 2004, November 2004 and May 2006 we had no audit committee and, as a result, the full board of directors has the responsibility for all matters that are usually the responsibility of the audit committee.

The policy provides that the board of directors shall pre-approve audit services, audit-related services, tax services and those other services that it believes to be routine and recurring services that do not impair the independence of the auditor. Under the policy, our Chief Accounting Officer is responsible for determining whether services provided by the independent auditor are included as part of those services already pre-approved or whether separate approval from the board of directors is required. All services performed for us by Ernst & Young LLP, our independent registered public accounting firm, subsequent to the adoption of the policy have been pre-approved by the board of directors. The board of directors has concluded that the audit-related services, tax services and other non-audit services provided by Ernst & Young LLP in fiscal year 2007 were compatible with the maintenance of the firm's independence in the conduct of its auditing functions. In addition, to safeguard the continued independence of the independent auditors, the policy prevents our independent auditors from providing services to us that are prohibited under Section 10A(g) of the Securities Exchange Act of 1934, as amended.

PART IV

Item 15. Exhibits and Financial Statement Schedules.

(a) List of documents filed as part of this report.

(1) Financial Statements. The accompanying index to financial statements on page 76 of this report is provided in response to this item.

(2) Financial Statement Schedules. All schedules are omitted because the required information is either not present, not present in material amounts or presented within the consolidated financial statements.

(3) Exhibits. The exhibits filed as part of this report are listed in the Exhibit Index which is located at the end of this report.

(b) Exhibits.
See Item 15(a)(3) of this report.

(c) Financial Statement Schedules.
See Item 15(a)(2) of this report.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

VANGUARD HEALTH SYSTEMS, INC. — Date

By: /s/ Charles N. Martin, Jr. — September 19, 2007
Charles N. Martin, Jr.
Chairman of the Board & Chief Executive Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/s/ Charles N. Martin, Jr. Charles N. Martin, Jr.	Chairman of the Board & Chief Executive Officer; Director (Principal Executive Officer)	September 19, 2007
/s/ Joseph D. Moore Joseph D. Moore	Executive Vice President, Chief Financial Officer & Treasurer (Principal Financial Officer)	September 19, 2007
/s/ Phillip W. Roe Phillip W. Roe	Senior Vice President, Controller & Chief Accounting Officer (Principal Accounting Officer)	September 19, 2007
/s/ Michael A. Dal Bello Michael A. Dal Bello	Director	September 19, 2007
/s/ James A. Quella James A. Quella	Director	September 19, 2007
/s/ Neil P. Simpkins Neil P. Simpkins	Director	September 19, 2007

Supplemental Information to be Furnished With Reports Filed Pursuant to Section 15(d) of the Act by Registrants Which Have Not Registered Securities Pursuant to Section 12 of the Act.

No annual report or proxy material has been sent to security holders.

EXHIBIT INDEX

Exhibit No.	Description
2.1	Agreement and Plan of Merger, dated as of July 23, 2004, among VHS Holdings LLC, Health Systems Acquisition Corp. and Vanguard Health Systems, Inc.(1)
2.2	First Amendment to the Agreement and Plan of Merger, dated as of September 23, 2004, among VHS Holdings LLC, Health Systems Acquisition Corp. and Vanguard Health Systems, Inc.(1)
2.3	Indemnification Agreement, dated as of July 23, 2004, among VHS Holdings LLC, Vanguard Health Systems, Inc., and the stockholders and holders of options set forth therein(1)(3)
3.1	Amended and Restated Certificate of Incorporation of Vanguard Health Systems, Inc.(1)
3.2	By-Laws of Vanguard Health Systems, Inc.(12)
4.1	Indenture, relating to the 9% Senior Subordinated Notes, dated as of September 23, 2004, among Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the Guarantors party thereto and the Trustee(1)
4.2	First Supplemental Indenture, dated as of November 5, 2004, among Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the Guarantors party thereto and the Trustee(1)
4.3	Indenture, relating to the 11 1/4% Senior Discount Notes, dated as of September 23, 2004, among Vanguard Health Holding Company I, LLC, Vanguard Holding Company I, Inc, Vanguard Health Systems, Inc. and the Trustee(1)
4.4	Registration Rights Agreement relating to the 9% Senior Subordinated Notes, dated as of September 23, 2004, among Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the Guarantors party thereto, Citigroup Global Markets Inc., Banc of America Securities LLC, Bear Stearns & Co., Inc., J.P. Morgan Securities Inc., Merrill Lynch, Pierce, Fenner & Smith Incorporated, Wachovia Capital Markets, LLC and ABN AMRO Incorporated(1)
4.5	Registration Rights Agreement, relating to the 11 1/4% Senior Discount Notes, dated as of September 23, 2004, among Vanguard Health Holding Company I, LLC, Vanguard Holding Company I, Inc., Vanguard Health Systems, Inc., Citigroup Global Markets Inc., Banc of America Securities LLC, Bear Stearns & Co., Inc., J.P. Morgan Securities Inc., Merrill Lynch, Pierce, Fenner & Smith Incorporated, Wachovia Capital Markets, LLC and ABN AMRO Incorporated(1)
4.6	Registration Rights Agreement, concerning Vanguard Health Systems, Inc., dated as of September 23, 2004(1)
4.7	Second Supplemental Indenture, dated as of March 28, 2005, among Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the Guarantors party thereto and the Trustee (10)
4.8	Third Supplemental Indenture, dated as of July 13, 2006, among Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the Guarantors party thereto and the Trustee (18)
4.9	Fourth Supplemental Indenture, dated as of June 25, 2007, among Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the Guarantors party thereto and the Trustee

4.10	Fifth Supplemental Indenture, dated as of July 1, 2007, among Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the Guarantors party thereto and the Trustee
10.1	Credit Agreement, dated as of September 23, 2004, among Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., Vanguard Health Holding Company I, LLC, the lenders party thereto, Bank of America, N.A. as administrative agent, Citicorp North America, Inc., as syndication agent, the other agents named therein, and Banc of America Securities LLC and Citigroup Global Markets Inc., as joint lead arrangers and book runners(1)
10.2	Security Agreement, dated as of September 23, 2004, made by each assignor party thereto in favor of Bank of America, N.A., as collateral agent(1)
10.3	Vanguard Guaranty, dated as of September 23, 2004, made by and among Vanguard Health Systems, Inc. in favor of Bank of America, N.A., as administrative agent(1)
10.4	Subsidiaries Guaranty, dated as of September 23, 2004, made by and among each of the guarantors party thereto in favor of Bank of America, N.A., as administrative agent(1)
10.5	Pledge Agreement, dated as of September 23, 2004, among each of the pledgors party thereto and Bank of America, N.A., as collateral agent(1)
10.6	Transaction and Monitoring Fee Agreement, dated as of September 23, 2004, among Vanguard Health Systems, Inc., Blackstone Management Partners IV L.L.C., and Metalmark Management LLC(1)
10.7	Amended and Restated Limited Liability Company Operating Agreement of VHS Holdings LLC, dated as of September 23, 2004(1)
10.8	Vanguard Health Systems, Inc. 2004 Stock Incentive Plan(1)(3)
10.9	VHS Holdings LLC 2004 Unit Plan(1)(3)
10.10	Vanguard Health Systems, Inc. 2001 Annual Incentive Plan(2)(3)
10.11	Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Charles N. Martin, Jr., dated as of September 23, 2004(1)(3)
10.12	Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and William Lawrence Hough, dated as of September 23, 2004(1)(3)
10.13	Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Joseph D. Moore, dated as of September 23, 2004(1)(3)
10.14	Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Ronald P. Soltman, dated as of September 23, 2004(1)(3)
10.15	Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Keith B. Pitts, dated as of September 23, 2004(1)(3)
10.16	Amended and Restated Severance Protection Agreement between Vanguard Health Systems, Inc. and Kent H. Wallace, dated as of September 23, 2004(1)(3)
10.17	Form of Amended and Restated Severance Protection Agreement of Vanguard Health Systems, Inc. (1)(3)

10.18 Arizona Health Care Cost Containment System Administration Contract No. YH04-0001-06 with VHS Phoenix Health Plan, awarded May 1, 2003(4)

10.19 Solicitation Amendments numbers One, Two, Three and Four and Contract Amendment No. 01 dated May 1, 2003, to Arizona Health Care Cost Containment System Administration Contract No. YH04-0001-06 with VHS Phoenix Health Plan(4)

10.20 Contract Amendments Numbered 02, 03, 04 and 05, each effective October 1, 2003, to the Arizona Health Care Cost Containment System Administration Contract No. YH04-0001-06 with VHS Phoenix Health Plan(5)

10.21 Contract Amendment Number 06, executed on November 10, 2003, but effective as of October 1, 2003, to the Arizona Health Care Cost Containment System Administration Contract No. YH04-0001-06 between VHS Phoenix Health Plan and the Arizona Health Care Cost Containment System(6)

10.22 Contract Amendment Number 07, executed on April 28, 2004, but effective as of April 1, 2004, to the Arizona Health Care Cost Containment System Administration Contract No. YH04-0001-06 between VHS Phoenix Health Plan and the Arizona Health Care Cost Containment System(1)

10.23 Contract Amendment Number 08, executed on September 16, 2004, but effective as of October 1, 2004, to the Arizona Health Care Cost Containment System Administration Contract No. YH04-0001-06 between VHS Phoenix Health Plan and the Arizona Health Care Cost Containment System(1)

10.24 Contract Amendment Number 09, executed on November 4, 2004, but effective as of October 1, 2004, to the Arizona Health Care Cost Containment System Administration Contract No. YH04-0001-06 between VHS Phoenix Health Plan and the Arizona Health Care Cost Containment System(1)

10.25 Purchase and Sale Agreement, dated as of October 8, 2002, by and among Baptist Health System, VHS San Antonio Partners, L.P. and Vanguard Health Systems, Inc.(7)

10.26 Amended and Restated Agreement Between the Shareholders of VHS Acquisition Subsidiary Number 5, Inc. executed on September 8, 2004, but effective as of September 1, 2004(1)

10.27 Certificate of Designations, Preferences and Rights of Series A Preferred Stock of VHS Acquisition Subsidiary Number 5, Inc., dated as of September 8, 2004(1)

10.28 License Agreement between Baptist Health System and VHS San Antonio Partners, L.P. dated as of January 1, 2003(8)

10.29 Letter of Understanding dated September 12, 2003, between Vanguard Health Systems, Inc. and Dale S. St. Arnold(3)(4)

10.30 Asset Sale Agreement, dated as of October 11, 2004, among Tenet MetroWest Healthcare System, Limited Partnership, Saint Vincent Hospital, L.L.C., OHM Services, Inc. and VHS Acquisition Subsidiary Number 7, Inc.(1)

10.31 Guaranty of Performance by Vanguard Health Systems, Inc., dated as of October 11, 2004(1)

10.32 Form of Performance Option Under 2004 Stock Incentive Plan(1)(3)

10.33 Form of Time Option Under 2004 Stock Incentive Plan(1)(3)

10.34 Form of Liquidity Event Option Under 2004 Stock Incentive Plan(1)(3)

10.35 Stockholders Agreement Concerning Vanguard Health Systems, Inc., dated as of November 4, 2004, by and among Vanguard Health Systems, Inc., VHS Holdings LLC, Blackstone FCH Capital Partners IV L.P. and its affiliates identified on the signature pages thereto and the employees identified on the signature pages thereto(1)

10.36 Amendment No. 1 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Charles N. Martin, Jr., dated as of December 1, 2004(1)(3)

10.37 Amendment No. 1 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and William Lawrence Hough, dated as of December 1, 2004(1)(3)

10.38 Amendment No. 1 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Joseph D. Moore, dated as of December 1, 2004(1)(3)

10.39 Amendment No. 1 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Ronald P. Soltman, dated as of December 1, 2004(1)(3)

10.40 Amendment No. 1 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Keith B. Pitts, dated as of December 1, 2004(1)(3)

10.41 Restatement dated October 22, 2004, but effective as of October 1, 2004, of Arizona Health Care Cost Containment System Administration ("AHCCCS") Contract No. YH04-0001-06 with VHS Phoenix Health Plan, to reflect Solicitation Amendments One through Four and Contract Amendments Numbers 01 through 09 (unofficial and never executed, but prepared by AHCCCS and distributed to VHS Phoenix Health Plan for ease of contract administration)(1)

10.42 Amendment No. 1 to Asset Sale Agreement, dated as of December 23, 2004, among Tenet MetroWest Healthcare System, Limited Partnership, Saint Vincent Hospital, L.L.C., OHM Services, Inc. and VHS Acquisition Subsidiary Number 7, Inc.(9)

10.43 First Amendment of VHS Holdings LLC 2004 Unit Plan(3)(12)

10.44 First Amendment to Credit Agreement, dated as of August 15, 2005, among Vanguard Health Holding Company I, LLC, Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the lenders party to the Credit Agreement referred to therein, and Bank of America, N.A. as administrative agent(11)

10.45 Amended and Restated Severance Protection Agreement, dated as of September 23, 2004, between Vanguard Health Systems, Inc. and Kent H. Wallace(3)(13)

10.46 Amendment No. 1 to Amended and Restated Severance Protection Agreement, dated as of September 30, 2005, between Vanguard Health Systems, Inc. and Kent H. Wallace(3)(13)

10.47 First Amendment to Credit Agreement, dated as of August 15, 2005, among Vanguard Health Holding Company I, LLC, Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the lenders party to the Credit Agreement referred to therein, and Bank of America, N.A. as administrative agent(14)

10.48 Contract Amendment Number 10, executed on September 7, 2005, but effective as of October 1, 2005, to the Arizona Health Care Cost Containment System Administration Contract No. YH04-0001-06 between VHS Phoenix Health Plan and the Arizona Health Care Cost Containment System(15)

10.49 Contract Amendment Number 11, executed on September 7, 2005, but effective as of September 1, 2005, to the Arizona Health Care Cost Containment System Administration Contract No.

YH04-0001-06 between VHS Phoenix Health Plan and the Arizona Health Care Cost Containment System(15)

10.50 Amendment No. 2 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Charles N. Martin, Jr., dated as of December 1, 2005(3)(16)

10.51 Amendment No. 2 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Joseph D. Moore , dated as of December 1, 2005(3)(16)

10.52 Amendment No. 2 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Ronald P. Soltman, dated as of December 1, 2005(3)(16)

10.53 Amendment No. 2 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Keith B. Pitts, dated as of December 1, 2005(3)(16)

10.54 Amendment No. 1, dated as of November 3, 2005, to Amended and Restated Limited Liability Company Operating Agreement of VHS Holdings LLC(16)

10.55 Amendment Number 1 to the Vanguard Health Systems, Inc. 2004 Stock Incentive Plan, effective November 28, 2005(3)(16)

10.56 Contract Amendment Number 12, executed on December 21, 2005, but effective as of January 1, 2006, to the Arizona Health Care Cost Containment System Administration Contract No. YH04-0001-06 between VHS Phoenix Health Plan and the Arizona Health Care Cost Containment System(16)

10.57 Amendment Number 2 to the Vanguard Health Systems, Inc. 2004 Stock Incentive Plan, effective February 15, 2006(3)(17)

10.58 Amendment Number 3 to the Vanguard Health Systems, Inc. 2004 Stock Incentive Plan, effective April 15, 2006(3)(17)

10.59 Contract Amendment Number 13, executed on April 4, 2006, but effective as of October 1, 2005, to the Arizona Health Care Cost Containment System Administration Contract No. YH04-0001-06 between VHS Phoenix Health Plan and the Arizona Health Care Cost Containment System(17)

10.60 Contract Amendment Number 14, executed on April 26, 2006, but effective as of October 1, 2005, to the Arizona Health Care Cost Containment System Administration Contract No. YH04-0001-06 between VHS Phoenix Health Plan and the Arizona Health Care Cost Containment System(17)

10.61 Contract Amendment Number 15, executed on September 5, 2006, but effective as of October 1, 2006, to the Arizona Health Care Cost Containment System Administration Contract No. YH04-0001-06 between Phoenix Health Plan and the Arizona Health Care Cost Containment System (19)

10.62 Amendment Number 4 to the Vanguard Health Systems, Inc. 2004 Stock Incentive Plan, effective November 13, 2006(3)(20)

10.63 Contract Amendment Number 16, executed on April 27, 2007, but effective as of October 1, 2006, to the Arizona Health Care Cost Containment System Administration Contract No. YH04-0001-06 between Phoenix Health Plan and the Arizona Health Care Cost Containment System(21)

12.1 Computation of Ratio of Earnings to Fixed Charges

21.1 Subsidiaries of Vanguard Health Systems, Inc.

31.1	Certification of CEO pursuant to Rule 13a-14(a)/15d-14(a) as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
31.2	Certification of CFO pursuant to Rule 13a-14(a)/15d-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
32.1	Certification of CEO pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
32.2	Certification of CFO pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002

(1) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Registration Statement on Form S-4 (Registration No. 333-120436).

(2) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Registration Statement on Form S-1 (Registration No. 333-71934).

(3) Management compensatory plan or arrangement.

(4) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Annual Report on Form 10-K for the annual period ended June 30, 2003, File No. 333-71934.

(5) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended September 30, 2003, File No. 333-71934.

(6) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended December 31, 2003, File No. 333-71934.

(7) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Current Report on Form 8-K dated October 9, 2002, File No. 333-71934.

(8) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Current Report on Form 8-K dated January 14, 2003, File No. 333-71934.

(9) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Current Report on Form 8-K dated January 4, 2005, File No. 333-71934.

(10) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended March 31, 2005, File No. 333-71934.

(11) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Current Report on Form 8-K dated August 26, 2005, File No. 333-71934.

(12) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Annual Report on Form 10-K for the annual period ended June 30, 2005, File No. 333-71934.

(13) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Current Report on Form 8-K dated September 30, 2005, File No. 333-71934.

(14) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Current Report on Form 8-K dated September 27, 2005, File No. 333-71934.

(15) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended September 30, 2005, File No. 333-71934.

(16) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended December 31, 2005, File No. 333-71934.

(17) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended March 31, 2006, File No. 333-71934.

(18) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Annual Report on Form 10-K for the annual period ended June 30, 2006, File No. 333-71934.

(19) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Current Report on Form 8-K dated September 8, 2006, File No. 333-71934.

(20) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended December 31, 2006, File No. 333-71934.

(21) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended March 31, 2007, File No. 333-71934.

RESURRECTION HEALTH CARE CORPORATION AND AFFILIATES

HISTORICAL FINANCIAL STATEMENTS

RESURRECTION HEALTH CARE CORPORATION AND AFFILIATES

Consolidated Financial Statements and Schedules

June 30, 2009 and 2008

(With Independent Auditors' Report Thereon)

ATTACHMENT 75

KPMG LLP
303 East Wacker Drive
Chicago, IL 60601-5212

Independent Auditors' Report

Board of Directors
Resurrection Health Care Corporation:

We have audited the accompanying consolidated statements of financial position of Resurrection Health Care Corporation and Affiliates as of June 30, 2009 and 2008, and the related consolidated statements of operations, changes in net assets, and cash flows for the years then ended. These consolidated financial statements are the responsibility of Resurrection Health Care Corporation's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. Our audits included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Resurrection Health Care Corporation and Affiliates' internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of Resurrection Health Care Corporation and Affiliates as of June 30, 2009 and 2008, and the results of their operations, changes in net assets, and cash flows for the years then ended, in conformity with U.S. generally accepted accounting principles.

As discussed in note 2 to the consolidated financial statements, Resurrection Health Care Corporation and Affiliates adopted the provisions of the Financial Accounting Standards Board's Statement of Financial Accounting Standards No. 157, *Fair Value Measurements*, as of July 1, 2008.

KPMG

Our audits were made for the purpose of forming an opinion on the consolidated financial statements taken as a whole. The consolidating information in schedules 1 and 2 is presented for purposes of additional analysis of the 2009 consolidated financial statements rather than to present the financial position and results of operations of the individual organizations. The consolidating information has been subjected to the auditing procedures applied in the audit of the 2009 consolidated financial statements and, in our opinion, is fairly stated in all material respects in relation to the 2009 consolidated financial statements taken as a whole.

KPMG LLP

October 15, 2009

RESURRECTION HEALTH CARE CORPORATION AND AFFILIATES

Consolidated Statements of Financial Position

June 30, 2009 and 2008

(In thousands)

Assets		2009	2008
Current assets:			
Cash and cash equivalents	$	41,417	22,853
Assets whose use is limited or restricted – required for current liabilities		379,482	354,840
Patient and resident accounts receivable, net of allowance for uncollectible accounts of $99,501 in 2009 and $106,382 in 2008		195,408	214,989
Other receivables		16,593	23,411
Inventory of supplies		16,425	17,205
Estimated receivables under third-party reimbursement programs		1,396	526
Prepaid expenses and other current assets		27,611	28,572
Total current assets		678,332	662,396
Assets whose use is limited or restricted:			
By boards for reinvestment and self-insurance		297,342	458,985
Under bond indenture agreements – held by trustee		29,260	5,680
By donors – permanently restricted		14,319	14,492
		340,921	479,157
Land, buildings, and equipment, net		840,446	825,916
Deferred finance charges		9,653	9,877
Other assets		18,804	13,152
	$	1,888,156	1,990,498

See accompanying notes to consolidated financial statements.

Liabilities and Net Assets		2009	2008
Current liabilities:			
Current installments of long-term debt	$	379,482	352,078
Accounts payable and accrued expenses		89,591	96,599
Accrued payroll and fringe benefits		68,129	68,985
Estimated payables under third-party reimbursement programs		97,228	89,425
Deferred revenue and refundable deposits		42,099	44,583
Total current liabilities		676,529	651,670
Long-term debt, excluding current installments and unamortized bond discount		256,767	299,032
Accrued pension liability		245,673	152,106
Estimated self-insured professional and general liability claims		251,671	255,514
Asset retirement obligation		13,509	13,158
Total liabilities		1,444,149	1,371,480
Net assets:			
Unrestricted		416,932	586,307
Temporarily restricted		12,756	18,219
Permanently restricted		14,319	14,492
Total net assets		444,007	619,018
	$	1,888,156	1,990,498

RESURRECTION HEALTH CARE CORPORATION AND AFFILIATES

Consolidated Statements of Operations

Years ended June 30, 2009 and 2008

(In thousands)

	2009	2008
Net service revenue	$ 1,585,454	1,583,582
Other revenue:		
Auxiliary services	107,911	101,716
Net assets released from restrictions for operations	4,520	2,398
Total revenue	1,697,885	1,687,696
Expenses:		
Salaries and wages	652,707	645,307
Payroll taxes and fringe benefits	189,594	177,783
Physicians' fees	89,918	88,584
Supplies	206,276	203,849
Other	209,306	209,529
Purchased services	74,455	65,067
Insurance	44,761	47,556
Depreciation and amortization	90,346	86,468
Provision for uncollectible accounts receivable	125,403	164,157
Interest	23,141	31,464
Assessments and taxes	60,709	49,063
Total expenses, before impairment costs	1,766,616	1,768,827
Loss before impairment costs	(68,731)	(81,131)
Impairment costs	621	17,942
Loss from operations	(69,352)	(99,073)
Nonoperating gains (losses):		
Investment income (loss) and other, net	(42,282)	26,920
Unrestricted contributions	14	1,724
Loss on early extinguishment of long-term debt	—	(2,593)
Net nonoperating gains (losses)	(42,268)	26,051
Revenue and gains deficient of expenses and losses	(111,620)	(73,022)
Other changes in unrestricted net assets:		
Net assets released from restrictions for purchase of land, buildings, and equipment	6,442	4,647
Net reclassification of net assets based on donor intent	—	(91)
Recognition of change in pension funded status	(64,197)	(2,156)
Decrease in unrestricted net assets	$ (169,375)	(70,622)

See accompanying notes to consolidated financial statements.

RESURRECTION HEALTH CARE CORPORATION AND AFFILIATES

Consolidated Statements of Changes in Net Assets

Years ended June 30, 2009 and 2008

(In thousands)

	2009	2008
Unrestricted net assets:		
Revenue and gains deficient of expenses and losses	$ (111,620)	(73,022)
Net assets released from restrictions for purchase of land, buildings, and equipment	6,442	4,647
Net reclassification of net assets based on donor intent	—	(91)
Recognition of change in pension funded status	(64,197)	(2,156)
Decrease in unrestricted net assets	(169,375)	(70,622)
Temporarily restricted net assets:		
Pledges and contributions	4,777	7,735
Investment return	307	(528)
Net reclassification of net assets based on donor intent	415	91
Net assets released from restrictions for purchase of land, building, and equipment	(6,442)	(4,647)
Net assets released from restrictions for operations	(4,520)	(2,398)
Increase (decrease) in temporarily restricted net assets	(5,463)	253
Permanently restricted net assets:		
Net reclassification of net assets based on donor intent	(415)	—
Contributions	242	442
Increase (decrease) in permanently restricted net assets	(173)	442
Change in net assets	(175,011)	(69,927)
Net assets at beginning of year	619,018	688,945
Net assets at end of year	$ 444,007	619,018

See accompanying notes to consolidated financial statements.

RESURRECTION HEALTH CARE CORPORATION AND AFFILIATES

Consolidated Statements of Cash Flows

Years ended June 30, 2009 and 2008

(In thousands)

	2009	2008
Cash flows from operating activities:		
Change in net assets	$ (175,011)	(69,927)
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation and amortization	90,346	86,468
Provision for uncollectible accounts receivable	125,403	164,157
Loss on early extinguishment of long-term debt	—	2,593
Equity loss (gain) in joint ventures, net of cash distributions received	(175)	100
Impairment costs	621	17,942
Amortization of deferred occupancy and care revenue	(370)	(138)
Recognition of change in pension funded status	64,197	2,156
Change in net unrealized gains and losses on trading securities	62,514	28,908
Permanently restricted contributions	(242)	(442)
Changes in assets and liabilities:		
Patient and resident accounts receivable	(105,822)	(172,115)
Other receivables, inventory of supplies, prepaid expenses, and other current assets	4,407	81,666
Accounts payable and accrued expenses and other liabilities	(7,513)	(19,616)
Estimated payables under third-party reimbursement programs, net	6,933	(15,601)
Accrued pension liability	29,370	(6,926)
Estimated self-insured professional and general liability claims	(3,843)	6,012
Net cash provided by operating activities	90,815	105,237
Cash flows from investing activities:		
Acquisition of land, buildings, and equipment, net	(105,273)	(125,951)
Gross purchases of securities	(530,367)	(712,012)
Gross sales or maturities of securities	581,447	822,733
Capital contributions to joint ventures	(1,228)	(5,143)
Net change in other assets	(97)	5,260
Net cash used in investing activities	(55,518)	(15,113)
Cash flows from financing activities:		
Proceeds from the issuance of long-term debt	—	325,000
Repayments of long-term debt	(14,861)	(422,153)
Payments for deferred financing fees	—	(2,148)
Net refunds of entrance fees and membership deposits	(2,114)	(1,305)
Permanently restricted contributions	242	442
Net cash used in financing activities	(16,733)	(100,164)
Net increase (decrease) in cash and cash equivalents	18,564	(10,040)
Cash and cash equivalents at beginning of year	22,853	32,893
Cash and cash equivalents at end of year	$ 41,417	22,853
Supplemental disclosure of cash flow information:		
Cash paid for interest	$ 22,984	26,048

See accompanying notes to consolidated financial statements.

(1) Organization and Operations

Resurrection Health Care Corporation (RHC), a not-for-profit tax-exempt corporation, was incorporated for charitable, educational, and scientific purposes to support health and human services by providing management assistance and in all other relevant ways. The accompanying consolidated financial statements include the accounts of RHC and the following affiliates (collectively, RHC and Affiliates) for which it serves as the parent corporation through ownership, sole member powers, the authority to approve Board membership, or the holding of certain reserve powers:

- Resurrection Medical Center (RMC), a not-for-profit acute care hospital providing various inpatient and outpatient services and programs
- Saint Francis Hospital (SFH), a not-for-profit acute care hospital providing various inpatient and outpatient services and programs
- Our Lady of the Resurrection Medical Center (OLR), a not-for-profit acute care hospital providing various inpatient and outpatient services and programs
- Westlake Hospital (WH), a not-for-profit acute care hospital providing various inpatient and outpatient services and programs
- Saints Mary and Elizabeth Medical Center (SMEMC), not-for-profit acute care facilities providing various inpatient and outpatient services and programs
- Holy Family Medical Center (HFMC), a not-for-profit long-term acute care hospital providing various services and programs to patients in between acute care and skilled nursing
- Saint Joseph Hospital (SJH), a not-for-profit acute care hospital providing various inpatient and outpatient services and programs
- West Suburban Medical Center (WSMC), a not-for-profit acute care hospital providing various inpatient and outpatient services and programs
- Resurrection Senior Services (Senior Services), which provides various independent living and nursing services and programs and, which encompasses the following: Resurrection Nursing and Rehabilitation Center (RNRC), Resurrection Retirement Community (RRC), Resurrection Life Center (RLC), St. Francis Nursing and Rehabilitation Center (SFNR), Bethlehem Woods Retirement Community (BWRC), Casa San Carlo Retirement Community (CSCRC), St. Benedict Nursing and Rehabilitation Center (SBNRC), Villa Scalabrini Nursing and Rehabilitation Center (VSNRC), Maryhaven Nursing and Rehabilitation Center (MNRC), St. Andrew Life Center (SALC), Holy Family Nursing and Rehabilitation Center (HFNRC), Resurrection Nursing Home (RNH), and Mt. Loretto Nursing Home (MLNH)
- Resurrection Services (Services), which encompasses the following corporations and/or operating divisions: Resurrection Ambulatory Care Services (RACS), Resurrection Properties (RP), Resurrection Pharmacies, and Resurrection Medical Network
- Resurrection Behavioral Health (RBH), a not-for-profit corporation established to provide behavioral health services

- Resurrection Home Health Services (Home Care), a not-for-profit corporation established to provide home care services. Home Care also includes RHC's membership interest in Rainbow Hospice.
- Resurrection Development Foundation (Foundation), a not-for-profit corporation established to coordinate fund-raising activities that support the benevolent care and other programs at RHC and Affiliates
- Resurrection Health Care Preferred (RHCP), a systemwide managed care contracting organization that engages physicians in capitated risk contracts

The above listed entities are not-for-profit corporations as described in Section 501(c)(3) of the Internal Revenue Code (Code) and, with the exception of RHCP, are exempt from federal income taxes on related income pursuant to Section 501(a) of the Code.

On July 1, 2007, RHC and Affiliates adopted Financial Accounting Standards Board (FASB) Interpretation No. 48, *Accounting for Uncertainty in Income Taxes—an interpretation of FASB Statement No. 109* (FIN 48). The Interpretation addresses the determination of how tax benefits claimed or expected to be claimed on a tax return should be recorded in the consolidated financial statements. Under FIN 48, RHC and Affiliates must recognize the tax benefit from an uncertain tax position only if it is more likely than not that the tax position will be sustained on examination by the taxing authorities, based on the technical merits of the position. The tax benefits recognized in the consolidated financial statements from such a position are measured based on the largest benefit that has a greater than 50% likelihood of being realized upon ultimate settlement. FIN 48 also provides guidance on derecognition, classification, interest and penalties on income taxes, accounting in interim periods, and requires increased disclosures. At the date of adoption, and as of June 30, 2009 and 2008, RHC and Affiliates do not have a liability for unrecognized tax benefits. The adoption of FIN 48 had no impact on the consolidated financial statements of RHC and Affiliates.

(2) Summary of Significant Accounting Policies

Significant accounting policies of RHC and Affiliates are as follows:

- The preparation of financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosures of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates.
- Cash and cash equivalents include demand deposits and investments in highly liquid debt instruments with maturities of three months or less, excluding amounts classified as assets whose use is limited or restricted.
- Inventory of supplies is stated at lower of cost (first-in, first-out method) or market.
- On July 1, 2008, RHC and Affiliates adopted Statement of Financial Accounting Standards (SFAS) No. 157, *Fair Value Measurements*, for fair value measurements of financial assets and financial liabilities and for fair value measurements of nonfinancial items that are recognized or

disclosed at fair value in the consolidated financial statements on a recurring basis. SFAS No. 157 defines fair value as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. SFAS No. 157 also establishes a framework for measuring fair value and expands disclosures about fair value measurements. This pronouncement did not require any new fair value measurements and its adoption did not affect the results of operations or financial position of RHC and Affiliates. SFAS No. 157 establishes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value (note 7).

- Assets whose use is limited or restricted include: assets set aside by the boards of directors for debt repayment, reinvestment and self-insurance purposes, over which the boards retain control and may at their discretion use for other purposes, assets held by a trustee under bond indenture agreements, and funds restricted by donors.
- Except as otherwise noted, the carrying value of all financial instruments approximates their fair values.
- Land, buildings, and equipment are stated at cost, or if donated, at fair value at date of donation, net of allowances for depreciation and impairments. Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed on the straight-line method.
- Deferred finance charges, bond discount, and bond premium are amortized on the straight-line basis over the periods the related obligations are outstanding.
- Deferred revenue and refundable deposits represent various types of entrance and membership fees received from residents of senior living facilities. RRC resident membership deposits are fully refundable, net of applicable processing fees, to the resident upon termination of the lease agreement between RRC and the resident, with any interest earned on such deposits accruing to RRC. BWRC and CSCRC offer a variety of partially refundable entrance fees. These entrance payments are included with deferred revenue and refundable deposits in the accompanying consolidated statements of financial position. Total entrance payments subject to refund at June 30, 2009 and 2008 approximated $39,969 and $42,288, respectively.
- Unconditional promises to give cash or other assets are reported at fair value at the date the promise is received. All contributions are considered to be available for unrestricted use unless specifically restricted by donors. Contributions are reported as direct additions to temporarily restricted net assets if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or a purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the consolidated statements of operations as net assets released from restrictions. Gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.
- Temporarily restricted net assets are those assets whose use has been limited by donors to a specific time period or purpose. Temporarily restricted net assets principally represent amounts restricted for the purpose of acquiring long-lived assets or for specific operating purposes. During 2009 and 2008,

certain donors clarified their intentions for previously recorded gifts. Such reclassified amounts are reported as net reclassification of net assets based on donor intent in the accompanying consolidated statements of operations and changes in net assets.

- Permanently restricted net assets represent donor-restricted contributions, the principal amount of which may not be expended. Amounts reported as permanently restricted net assets represent the cumulative amount of contributions received for permanent endowment. Investment return currently earned on permanently restricted investments is reported as either nonoperating investment income or a direct addition to temporarily restricted net assets based on donor intentions.

  In August 2008, the FASB issued Staff Position No. 117-1 *Endowments of Not-for-Profit Organizations: Net Asset Classification of Funds Subject to An Enacted Version of the Uniform Prudent Management of Institutional Funds Act (UPMIFA), and Enhanced Disclosures for All Endowment Funds* (FSP 117-1). FSP 117-1 provides guidance on the net asset classification of donor restricted endowment funds for a not-for-profit organization and requires additional disclosure about endowment funds. RHC and Affiliates have adopted FSP 117-1 as of July 1, 2008.

  Effective June 30, 2009, the State of Illinois adopted UPMIFA, which establishes guidelines for the prudent spending and preservation of endowment funds through the establishment of a UPMIFA compliant endowment spending policy.

  RHC and Affiliates classify as permanently restricted net assets the original value of gifts donated to the permanent endowment. Investment returns in excess of approved spending are classified within temporarily restricted net assets until appropriated for expenditure by RHC and Affiliates.

  Endowment funds are commingled in a pooled investment portfolio administered by RHC (note 6). RHC relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized) and current yield (interest and dividends). RHC targets a diversified asset allocation that places a greater emphasis on fixed income investments to achieve its long-term return objectives within prudent risk constraints. Investment return is allocated to endowment fund assets on a basis proportional to its percentage of the investment portfolio. RHC endowment fund assets are maintained at a level equivalent to the balance of permanently restricted net assets.

- Net service revenue is reported at the estimated net realizable amounts from patients and residents, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Those adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined.

- The consolidated statements of operations include revenue and gains deficient of expenses and losses. Transactions deemed by management to be ongoing, major, or central to the provision of health and residential care services are reported as revenue and expenses. Transactions incidental to the provision of health and residential care services are reported as gains and losses. Changes in unrestricted net assets, which are excluded from revenue and gains deficient of expenses and losses, consistent with industry practice, include contributions of long-lived assets (including assets

acquired using contributions, which by donor restriction were to be used for the purposes of acquiring such assets) and recognition of changes in pension funded status.

- Investment income or loss (including realized gains and losses on investments, changes in unrealized gains and losses on trading securities, interest, and dividends) is included in revenue and gains deficient of expenses and losses unless the income or loss is restricted by donors, in which case the investment income is recorded directly to temporarily restricted net assets. Investment returns of temporarily restricted investments are recorded directly to temporarily restricted net assets in accordance with donor intent.
- RHC and Affiliates recognize liabilities when a legal obligation exists to perform an asset retirement obligation (ARO) in which the timing or method of settlement are conditional on a future event that may or may not be under the control of the entity. An ARO liability is recorded at its net present value with recognition of a related long-lived asset in a corresponding amount. The ARO liability is accreted through periodic charges to depreciation expense. RHC and Affiliates are legally liable to remove asbestos from existing buildings prior to future remodeling or demolishing of the existing buildings. The estimated asbestos removal cost at June 30, 2009 and 2008 was $13,509 and $13,158, respectively.
- RHC and Affiliates incur expenses for the provision of health and residential care services and related general and administrative activities.
- All significant intercompany balances and transactions have been eliminated in the preparation of the accompanying consolidated financial statements.
- In connection with the preparation of the consolidated financial statements and in accordance with the recently issued SFAS No. 165, *Subsequent Events*, RHC and Affiliates evaluated subsequent events after the consolidated balance sheet date of June 30, 2009 through October 15, 2009, which was the date the consolidated financial statements were available to be issued.
- Certain 2008 amounts have been reclassified to conform to the 2009 consolidated financial statement presentation, including the presentation as an operating expense of all interest-related costs on the Series 1999 and Series 2005 Revenue Bonds ($28,214 in 2008), which was previously reported as a reduction of nonoperating investment income in the 2008 consolidated statement of operations.

Other significant accounting policies are set forth in the consolidated financial statements and in the following notes.

(3) Third-Party Reimbursement Programs

RHC and Affiliates have agreements with third-party payors, which provide for reimbursement at amounts different from their established rates. Contractual adjustments under third-party reimbursement programs principally represent the difference between the billings at list price and the amounts reimbursed by Blue Cross and certain other contracted third-party payors; the difference between the billings at list price and the allocated cost of services provided to Medicare and Medicaid patients; and any differences between estimated third-party reimbursement settlements for prior years and subsequent final settlements. A summary of the reimbursement methodologies with major third-party payors follows:

(a) Medicare

RMC, OLR, SFH, WH, SMEMC, HFMC, SJH, and WSMC (collectively known as the Hospitals) and Senior Services are paid for inpatient acute care services, long-term care services, outpatient services, rehabilitation services, and home health services rendered to Medicare program beneficiaries under prospective reimbursement rates. These rates vary according to patient classification systems that are based on clinical, diagnostic, and other factors. The prospectively determined rates are not subject to retroactive adjustment. The Hospitals' classification of patients under the Medicare prospective payment systems and the appropriateness of the patients' admissions are subject to validation reviews.

For services rendered to Medicare beneficiaries for psychiatric services, rehabilitation services, and defined "pass-through" costs (i.e., medical education related costs), the Hospitals are reimbursed based upon cost reimbursement methodologies. The Hospitals are reimbursed at tentative rates with final settlement determined after submission of annual cost reports by the Hospitals and audits thereof by the Medicare fiscal intermediary. The Medicare cost reports have been audited and settled by the Medicare fiscal intermediary through 2007 for RMC, SFH, OLR, SMEMC, HFMC, SJH, WH, and WSMC.

(b) Medicaid

Under the State of Illinois' (the State) Medicaid reimbursement system, the Hospitals are paid for inpatient acute care services rendered to Medicaid program beneficiaries under prospectively determined rates-per-discharge. These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Senior Services are reimbursed based upon an all inclusive per-diem rate. SMEMC also receives incremental Medicaid reimbursement for specific Programs and services at the discretion of the State Medicaid program. Medicaid reimbursement methodologies and payment rates are subject to change based on the amount of funding available to the State Medicaid program and any such changes could have a significant effect on RHC and Affiliates' revenues.

During fiscal year 2007, the State approved an assessment program to assist in the financing of its Medicaid program through June 30, 2008. The program was renewed on December 4, 2008 for the State's fiscal years ended June 30, 2009 through June 30, 2013. Pursuant to this program, hospitals within the State are required to remit payment to the State of Illinois Medicaid program under an assessment formula approved by the Centers for Medicare & Medicaid Services (CMS). RHC and

Affiliates have included their 2009 and 2008 related assessments of $58,915 and $47,282, respectively, within assessments and taxes expense in the accompanying consolidated statements of operations. The assessment program also provides hospitals within the State with additional Medicaid reimbursement based on funding formulas also approved by CMS. RHC and Affiliates have included their additional 2009 and 2008 related reimbursement of $99,800 and $78,169, respectively, within net service revenue in the accompanying consolidated statements of operations.

(c) Blue Cross

The Hospitals also participate as providers of health care services under reimbursement agreements with Blue Cross. The provisions of these agreements stipulate that services will be reimbursed at a tentative reimbursement rate and that final reimbursement for these services is determined after the submission of annual cost reports by the Hospitals and reviews thereof by Blue Cross. The Blue Cross traditional indemnity reimbursement reports for 2008 and prior years have been reviewed by Blue Cross. The Blue Cross HMOI, PPO, and MCNP reimbursement reports have been reviewed by Blue Cross through 2008 for RMC, SFH, WH, SMEMC, and SJH and through 2007 for HFMC.

(d) Other

The Hospitals have also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for reimbursement under these agreements includes prospectively determined rates-per-discharge, discounts from established charges, and prospectively determined per diem rates.

A summary of gross and net service revenue for the years ended June 30, 2009 and 2008 follows:

		2009	2008
Service revenue:			
Nursing, dietary, and room service	$	869,759	860,491
Ancillary services		3,468,997	3,248,450
Long-term care services		154,294	142,333
Retirement communities		23,353	20,280
Ambulatory care services		19,602	20,398
Apothecary, durable medical equipment, home, health services, and other		28,923	28,640
Gross service revenue		4,564,928	4,320,592
Less provisions for estimated contractual adjustments under third-party reimbursement programs and other discounts and allowances		2,979,474	2,737,010
Net service revenue	$	1,585,454	1,583,582

A summary of RHC and Affiliates' Medicare, Medicaid, managed care, self-pay, and commercial utilization percentages based upon gross service revenue follows:

	2009	2008
Medicare	45%	46%
Medicaid	19	18
Managed care	26	26
Self-pay, commercial, and other	10	10

Accruals for settlements with third-party payors are made based on estimates of amounts to be received or paid under the terms of the respective contracts and related settlement principles and regulations of the federal Medicare program, the Illinois Medicaid program, and the Blue Cross Plan of Illinois. Included in 2009 and 2008 as additions to net service revenue is $11,356 and $8,389, respectively, related to changes in prior year third-party revenue estimates.

(4) Concentration of Credit Risk

RHC and Affiliates grant credit without collateral to their patients, most of who are local residents and are generally insured under third-party payor agreements. The mix of receivables from patients and third-party payors as of June 30, 2009 and 2008 was as follows:

	2009	2008
Medicare	33%	32%
Medicaid	21	21
Managed care	25	26
Self-pay	14	15
Commercial and other	7	6

(5) Charity Care

RHC and Affiliates provide necessary medical care to patients who meet certain criteria under their charity care policies without charge or at amounts less than their established rates. Because RHC and Affiliates do not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue. The following information presents the level of charity care provided during the years ended June 30, 2009 and 2008.

		2009	2008
Charges forgone for non-Medicare and non-Medicaid patients, based on established rates	$	52,919	49,843

(6) Investments

RHC and Affiliates report their investments at fair value and consider all investments to be trading securities. Investment securities are exposed to various risks such as interest rate, credit, and overall market volatility risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect the amounts reported in the accompanying consolidated statements of financial position. A summary of the composition of the RHC and Affiliates' investment portfolios at June 30, 2009 and 2008 follows:

		2009	2008
Cash and cash equivalents	$	59,127	24,974
Common stocks and mutual funds		114,504	151,882
U.S. Treasury securities		56,522	66,687
Corporate and municipal bonds and notes		308,240	380,647
U.S. government agency securities		182,010	209,807
	$	720,403	833,997

Investments are reported in the accompanying consolidated statements of financial position at June 30 as follows:

		2009	2008
Assets whose use is limited or restricted – required for current liabilities	$	379,482	354,840
Assets whose use is limited or restricted, less amounts required for current liabilities:			
By boards for reinvestment and self-insurance		297,342	458,985
Under bond indenture agreements – held by trustee		29,260	5,680
By donors – permanently restricted		14,319	14,492
	$	720,403	833,997

The composition of investment return on the RHC and Affiliates' investment portfolio for the years ended June 30, 2009 and 2008 is as follows:

		2009	2008
Interest and dividend income, net of fees and expenses	$	36,239	43,350
Net realized gains (losses) on sale of investments		(17,098)	8,969
Net change in unrealized gains and losses during the holding period		(62,514)	(28,908)
	$	(43,373)	23,411

Investment returns are included in the accompanying consolidated financial statements for the years ended June 30, 2009 and 2008 as follows:

	2009	2008
Nonoperating gains (losses) – investment income (loss) and other, net	$ (43,680)	23,939
Temporarily restricted investment return	307	(528)
	$ (43,373)	23,411

(7) Fair Value Measurements

(a) Fair Value of Financial Instruments

The following methods and assumptions were used by RHC and Affiliates in estimating the fair value of its financial instruments:

- The carrying amount reported in the consolidated statements of financial position for the following approximates fair value because of the short maturities of these instruments: cash and cash equivalents, accounts receivable, accounts payable and accrued expenses, and estimated receivables and payables under third-party reimbursement programs.
- Assets whose use is limited or restricted: common stocks and mutual funds, and U.S. Treasury securities are measured using quoted market prices at the reporting date multiplied by the quantity held. Corporate and municipal bonds and notes and U.S. government agency securities are estimated based on observable inputs as provided by national pricing services. The carrying value equals fair value.

(b) Fair Value of Financial Instruments

RHC and Affiliates adopted SFAS No. 157 on July 1, 2008 for fair value measurements of financial assets and financial liabilities and for fair value measurements of nonfinancial items that are recognized or disclosed at fair value in the consolidated financial statements on a recurring basis. SFAS No. 157 establishes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to measurements involving significant unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy are as follows:

- Level 1 inputs are quoted prices (unadjusted) in active markets for identical assets or liabilities that RHC and Affiliates have the ability to access at the measurement date.
- Level 2 are observable inputs other than Level 1 prices such as quoted prices for similar assets or liabilities, quoted prices in markets that are not active, or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities.

- Level 3 inputs are unobservable inputs for the asset or liability.

The level in the fair value hierarchy within which a fair value measurement in its entirety falls is based on the lowest level input that is significant to the fair value measurement in its entirety.

The following table presents assets that are measured at fair value on a recurring basis at June 30, 2009:

	June 30, 2009	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Assets:				
Cash and cash equivalents	$ 41,417	41,417	—	—
Assets whose use is limited or restricted	720,403	230,153	490,250	—
Total	$ 761,820	271,570	490,250	—

(8) Land, Buildings, and Equipment

A summary of land, buildings, and equipment at June 30, 2009 and 2008 follows:

	2009	2008
Land	$ 67,887	67,887
Land improvements	46,341	45,869
Buildings and building equipment	1,203,003	1,183,648
Departmental equipment	860,859	794,506
	2,178,090	2,091,910
Less accumulated depreciation	1,397,556	1,314,473
	780,534	777,437
Construction in progress	59,912	48,479
Land, buildings, and equipment, net	$ 840,446	825,916

Construction in progress at June 30, 2009 and 2008 consists primarily of costs associated with various projects including the construction of a bed tower at RMC. The remaining costs associated with these projects at June 30, 2009 are approximately $41,928, substantially all of which have been contractually committed. These projects are expected to be financed from operations.

Impairment Costs

RHC and Affiliates periodically evaluate land, buildings, and equipment to determine whether assets may have been impaired in accordance with SFAS No. 144, *Accounting for the Impairment or Disposal of Long-Lived Assets*. Such analyses require various valuation techniques using management assumptions, including estimates of future cash flows as well as third party appraisals of the assets. As a result, there is at least a reasonable possibility that recorded estimates of fair value and impairment will change by a material amount.

In 2008, RHC and Affiliates determined that the fair value of land, buildings, and equipment at one of their hospital facilities was less than the recorded historical costs, and recorded an impairment loss of $17,942. In 2009, a property no longer in use was deemed to be impaired and an impairment loss of $621 was recognized to write the asset down to estimated fair value.

(9) Long-Term Debt

A summary of long-term debt at June 30, 2009 and 2008 follows:

	2009	2008
Variable Rate Revenue Bonds (Series 2008A)	$ 49,185	50,000
Variable Rate Revenue Bonds (Series 2008B)	49,185	50,000
Variable Rate Revenue Bonds (Series 2005A)	26,130	26,130
Variable Rate Revenue Bonds (Series 2005B)	119,240	120,735
Variable Rate Revenue Bonds (Series 2005C)	119,775	121,055
Fixed Rate Revenue Bonds (Series 1999A)	108,200	112,500
Fixed Rate Revenue Bonds (Series 1999B)	108,200	112,500
Revenue Bonds (Series 1997B) (HFMC)	32,400	33,400
Term loan (HFMC)	7,060	7,471
Mortgage loans (RMNY)	12,528	12,772
Total long-term debt	631,903	646,563
Less:		
Current installments	379,482	352,078
Unamortized bond premium	(4,977)	(5,215)
Unamortized bond discount	631	668
Long-term debt, excluding current installments and unamortized bond discount and premium	$ 256,767	299,032

On August 1, 1999, RHC entered into a Master Trust Indenture under which RHC was the only Obligated Group member. RMC, OLR, WH, SFH, Services, Senior Services, Home Care, and the Foundation were named Unlimited Credit Group Participants required to permit RHC to perform all obligations and covenants under the Master Trust Indenture. The Master Trust Indenture was amended and restated as of May 1, 2005, pursuant to the issuance of the Series 2005 bonds and the reissuance of the Variable Rate Demand Bonds (Series 1999A and Series 1999B). RHC, RMC, OLR, WH, SFH, SJH, SMEMC, and

WSMC were named Obligated Group Members under the amended and restated Master Trust Indenture. Services, Senior Services, Home Care, and the Foundation were named Unlimited Credit Group Participants required to permit the Obligated Group to perform all obligations and covenants under the amended and restated Master Trust Indenture, and required to pay such amounts as are necessary to make all payments on the Series 1999 and Series 2005 obligations. On June 5, 2008, the Master Trust Indenture was amended and restated pursuant to the issuance of the Series 2008 bonds and the conversion of the Series 2005A and Series 2005B bonds. The purpose of the Master Trust Indenture is to provide a mechanism for the efficient and economical issuance of notes by individual members of the Obligated Group using the collective borrowing capacity and credit rating of the Obligated Group. The Master Trust Indenture requires the individual members of the Obligated Group to make principal and interest payments on notes issued for their benefit and to pay such amounts as are otherwise necessary to enable the Obligated Group to satisfy all obligations issued under the Master Trust Indenture.

On June 5, 2008, the Illinois Finance Authority issued Variable Rate Revenue Bonds, Series 2008A and Series 2008B (collectively referred to as the Series 2008 bonds), in the aggregate amount of $100,000 on behalf of RHC. The proceeds from the Series 2008 bond issuance were used to advance refund various outstanding debt. The transactions to advance refund and cash defease outstanding debt resulted in a loss of $2,593, which is included with nonoperating losses in the 2008 consolidated statement of operations. Principal on the bonds is due on May 15, 2029. Interest is payable monthly at variable rates. During 2009 and 2008, the effective interest rate on the Series 2008 bonds was 1.51% and 1.65%, respectively. The Series 2008 bonds were issued pursuant to two separate Bond Trust Indentures, each dated as of June 1, 2008. The Series 2008 bonds are secured by irrevocable transferable direct pay letters of credit issued by commercial banks, which expire on December 5, 2009. Subsequent to June 30, 2009, the letter of credit facility providers for the Series 2008 bonds notified RHC that they do no intend to renew the letters of credit securing the Series 2008 bonds. Holders of the Series 2008 bonds have a put option that allows them to redeem the bonds prior to maturity. The Obligated Group has an agreement with an underwriter to remarket any bonds redeemed through the exercise of put options. Principal on the bonds outstanding at June 30, 2009 has been included in current installments as the letters of credit expire on December 5, 2009.

On May 26, 2005, the Illinois Finance Authority issued Variable Rate Revenue Bonds, Series 2005A, Series 2005B, Series 2005C, and Series 2005D, and on June 16, 2005, the Illinois Finance Authority issued Variable Rate Revenue Bonds, Series 2005E (collectively referred to as the Series 2005 bonds), in the aggregate amount of $350,000 on behalf of RHC. Principal on the bonds is payable annually through 2035. Interest is payable monthly at variable rates. During 2009 and 2008, the effective interest rate on the Series 2005 bonds was 1.67% and 3.69%, respectively. The Series 2005 bonds were issued pursuant to five separate Bond Trust Indentures, each dated as of May 1, 2005. The Series 2005B and 2005C bonds are secured by direct pay letters of credit issued by commercial banks, which currently expire on February 26, 2010, in amounts equal to the principal amount of the bonds and accrued interest on such principal. The remaining Series 2005 bonds are unsecured. Holders of the Series 2005 bonds have a put option that allows them to redeem the bonds prior to maturity. The Obligated Group has an agreement with an underwriter to remarket any bonds redeemed through the exercise of put options. Principal on the Series 2005A bonds outstanding at June 30, 2009 has been included in current installments as the bonds were cash defeased on July 1, 2009. Principal on the Series 2005B and 2005C bonds outstanding at June 30, 2009 has been

included in current installments as the letters of credit expire on February 26, 2010. The Series 2005D and Series 2005E bonds with an outstanding principal balance of $72,370 were cash defeased in 2008.

On August 27, 1999, the Illinois Health Facility Authorities issued Variable Rate Demand Revenue Bonds, Series 1999A and Series 1999B, and Periodic Auction Reset Securities, Series 1999C (collectively referred to as the Series 1999 bonds), in the aggregate amount of $380,000 on behalf of RHC. Principal on the bonds is payable annually through 2029. Interest was payable monthly at PARS rates and variable rates. During 2008, the effective interest rate on the Series 1999 bonds was 5.16%. On June 5, 2008, RHC converted the outstanding Series 1999A and Series 1999B bonds of $225,000 from variable rate to fixed rate bonds through a bond reissuance. Principal on the Series 1999A and Series 1999B bonds is payable annually commencing on May 14, 2009 through 2029. Interest is payable semiannually at fixed rates varying between 4.00% and 5.50% depending on date of maturity. The Series 1999A and Series 1999B bonds were issued pursuant to amended and restated Bond Trust Indentures, each dated as of June 1, 2008. Payment of principal and interest on the Series 1999A and Series 1999B bonds when due is guaranteed under municipal bond insurance policies. The Series 1999C bonds with an outstanding principal balance of $100,000 were advance refunded in 2008.

On December 23, 1997, the Illinois Health Facilities Authority on behalf of HFMC issued its Revenue Bonds, Series 1997, in the principal amount of $41,000 pursuant to a loan agreement dated December 1, 1997 between the Illinois Health Facilities Authority and HFMC (Series 1997B). Interest is payable at rates varying between 4.25% and 5.00% in annual installments through 2027. Effective February 6, 2001, HFMC entered into a Reimbursement, Mortgage, and Security Agreement (RHC Reimbursement Agreement) with RHC. The RHC Reimbursement Agreement provides that RHC will guarantee payment to the Bond Insurer of all amounts paid by the Bond Insurer in connection with the Series 1997B bonds under either the Bond Insurance Policy or the Surety Bond, which are not reimbursed to the Bond Insurer by HFMC. In conjunction with the RHC Reimbursement Agreement, HFMC issued its Direct Note Obligation, Series 2001A (Series 2001A), in a principal amount equal to the amount owed under the RHC Reimbursement Agreement, if any. Series 2001A is secured by a mortgage of the land and healthcare facilities of HFMC's main campus located in Des Plaines, Illinois and HFMC's accounts receivable. All intercompany amounts related to the Series 2001A bonds have been eliminated in consolidation. RHC has not made or accrued any payment obligations pursuant to this guarantee.

In October 1999, HFMC entered into a 10-year term loan (Term Loan) in the amount of $10,275. Under the terms of the Term Loan, HFMC pays interest at a fixed rate of 7.75%. Principal installments are due annually in amounts ranging from $227 to $420 through October 2009 with a lump-sum payment of $6,951, due November 2009. The Term Loan is secured by HFMC's medical office building and applicable rental income.

RNH and MLNH have two mortgage loan agreements through the Dormitory Authority of the State of New York. Principal and interest on the first note are payable in fixed monthly amounts of $46 through July 2027. The note bears interest at a fixed annual rate of 7.25% and is secured by certain real estate. Principal and interest on the second note are payable in fixed monthly amounts of $53 through January 2033. The note bears interest at a fixed annual rate of 7.90% and is secured by certain assets of RNH and MLNH.

At June 30, 2009 and 2008, the fair value of RHC and Affiliates' total long-term debt was approximately $621,801 and $650,117, respectively. Fair value was estimated using quoted market prices based upon the Obligated Group's current borrowing rates for similar types of long-term debt securities.

Under Section 148(f) of the Code, an issuer of tax-exempt bonds is required to rebate to the Internal Revenue Service the excess of investment income earned on all nonpurpose investments made with the gross proceeds of tax-exempt bond issues over the amount, which would have been earned if such nonpurpose investments had been invested at a rate equal to the interest yield on the related bond issue. The estimated rebate liability of $1,340 at June 30, 2009 and 2008 related to the Series 2005 bonds is recorded within accounts payable and accrued expenses in the accompanying consolidated statements of financial position.

Scheduled principal repayments on long-term debt based on the variable rate revenue bonds being put back to the Obligated Group and a corresponding draw being made on the underlying credit facility, if available, are as follows for the ensuing five years:

	Amount
Year:	
2010	$ 379,482
2011	9,438
2012	9,918
2013	10,201
2014	10,691

Scheduled annual principal payments on long-term debt based on the scheduled redemptions according to the respective Bond Trust Indentures for the ensuing five years are as follows:

	Amount
Year:	
2010	$ 42,777
2011	10,188
2012	10,848
2013	11,347
2014	12,046

(10) Employees' Retirement Plans

RHC and Affiliates have two cash balance plans (defined benefit plans that operate like defined contribution plans) (Plan A and Plan B) that cover substantially all eligible employees of RHC and Affiliates. Each eligible participant has a benefit account balance, which accrues as a percentage of current year's pay and earns interest at a specified rate.

RHC and Affiliates record pension cost at an amount calculated by an independent consulting actuary. RHC and Affiliates recognize the cost related to employee service using the projected unit credit cost method. Gains and losses, calculated as the difference between estimated and actual amounts of plan assets and the projected benefit obligation, and prior service cost are amortized over the expected future service period.

The following table sets forth the consolidated funded status, assumptions, and amounts recognized in the accompanying consolidated financial statements as of and for the years ended June 30, 2009 and 2008 for Plans A and B:

		2009	2008
Change in benefit obligation:			
Benefit obligation at beginning of year	$	(275,226)	(276,724)
Service cost		(20,569)	(20,843)
Interest cost		(18,275)	(16,596)
Actuarial gain (loss)		(25,375)	16,418
Benefits paid		19,933	22,519
Benefit obligation at end of year	$	(319,512)	(275,226)
Change in plan assets:			
Fair value of plan assets at beginning of year	$	125,161	121,967
Actual return on plan assets		(16,264)	(4,837)
Adjustments for transfers		(461)	(450)
Employer contributions		—	31,000
Benefits paid		(19,933)	(22,519)
Fair value of plan assets at end of year	$	88,503	125,161
Funded status	$	(231,009)	(150,065)
Amount recognized in the accompanying consolidated statement of financial position consist of:			
Accrued pension liability	$	—	—
Accumulated charge to unrestricted net assets		—	—
Net amount recognized	$	—	—
Accumulated benefit obligation	$	—	—
Amounts recognized in the accompanying consolidated statements of financial position:			
Accrued pension liability	$	(231,009)	(150,065)
Accumulated charge to unrestricted net assets		93,011	42,532
Net amount recognized	$	(137,998)	(107,533)
Accumulated benefit obligation	$	(317,790)	(273,374)

(Continued)

		2009	2008
Components of net periodic benefit cost:			
Service cost	$	20,569	20,843
Expense load		461	450
Interest cost		18,275	16,596
Expected return on plan assets		(9,664)	(10,857)
Amortization of unrecognized net loss		1,473	1,507
Amortization of unrecognized prior service credit		(650)	(650)
Net periodic benefit cost	$	30,464	27,889
Other changes in plan assets and benefit obligation recognized in unrestricted net assets:			
Net actuarial gain (loss)	$	(51,397)	724
Reversal of amortization items:			
Net actuarial loss		1,473	1,507
Prior service credit		(650)	(650)
Total recognized in unrestricted net assets	$	(50,574)	1,581
Estimated future benefit payments:			
Fiscal year 2010	$	27,748	
Fiscal year 2011		25,072	
Fiscal year 2012		22,093	
Fiscal year 2013		21,308	
Fiscal years 2014 – 2017		124,389	
Expected contribution during fiscal year 2010	$	—	

The estimated net actuarial loss and prior service credit for Plans A and B that will be amortized from unrestricted net assets into net periodic benefit cost during the 2010 fiscal year are $5,579 and $404, respectively.

	2009	2008
Weighted average assumptions used to determine benefit obligations at June 30:		
Settlement (discount) rate	6.57%	6.93%
Weighted average rate of increase in future compensation levels	4.00	4.00
Weighted average assumptions used to determine net periodic benefit cost for years ended June 30:		
Discount rate	6.93%	6.26%
Expected return on plan assets	8.50	8.50
Rate of compensation increase	4.00	4.00

RHC's overall expected long-term rate of return on assets is 8.5%. The expected long-term rate of return is based on the portfolio as a whole and not on the sum of the returns on individual asset categories. The return is based exclusively on historical returns, without adjustments.

RHC's pension plan weighted average asset allocations at June 30, 2009 and 2008, by asset category, are as follows:

Asset category	Plan assets at June 30	
	2009	2008
Equities	55.8%	53.6%
Fixed income securities	39.2	43.0
Cash and cash equivalents	5.0	3.4

RHC has developed a plan investment policy, which is reviewed and approved by the RHC Finance Committee and the boards of directors. The policy established goals and objectives of the fund, asset allocations, asset classifications, and manager guidelines. The policy reflects a target of up to 60% for equity securities. Investments are managed by independent advisors who are monitored by management and the Finance Committee. RHC monitors the asset allocation and executes required recalibrations of the portfolio allocation on a regular basis in response to fluctuations in market conditions and the overall portfolio composition.

RHC and Affiliates also have a defined contribution money purchase plan (Defined Contribution Plan). RHC and Affiliates contribute 25% of contributions made by employees to their tax deferred account up to a maximum contribution percentage of 1% of the participant's qualified income. RHC and Affiliates' boards of directors have amended Plan A and the Defined Contribution Plan whereby the employer matching contribution of the Defined Contribution Plan is considered a component of Plan A. Accordingly, this employer matching component has been included as a component of the accrued pension liability of Plan A as determined by the professional consulting actuary.

The WSMC retirement program consists of the West Suburban Health Care Retirement Income Plan (Income Plan), a noncontributory defined benefit pension plan, and the West Suburban Health Care Retirement Savings Plan (Savings Plan), a defined contribution pension plan, for which WSMC's employees are eligible. Effective January 1, 2002, the board of directors of WSMC authorized the curtailment of the Income Plan. As a result of this action, participation in the Income Plan is limited to participants entering on or before January I, 2002, and no new benefits will accrue to participants subsequent to that date.

The Savings Plan became effective on January 1, 2002 and covers employees on the first day of employment after attaining the age of 21. Under the terms of the Savings Plan, employees may contribute up to 40.0% of eligible compensation subject to the Code's salary deferral limitations. WSMC makes matching payments equal to 50.0% of a participant's salary deferral contributions up to the first 3.0%. WSMC also contributes 1.5% of each eligible employee's compensation into the Savings Plan, regardless of whether or not the employee elects to make salary deferrals into the Savings Plan. Participants vest 100% in WSMC contributions after one year of service. WSMC funds the Savings Plan on a current basis.

Effective January 1, 2004, participants of the West Suburban Health Care Retirement Income Plan and the West Suburban Health Care Retirement Savings Plan became participants in the RHC and Affiliates cash balance plans.

A summary of the changes in the projected benefit obligation and plan assets and the resulting funded status of the Income Plan is as follows at June 30, 2009 and 2008 (measurement dates):

		2009	2008
Change in projected benefit obligation:			
Projected benefit obligation at beginning of period	$	(54,305)	(56,088)
Interest cost		(3,778)	(3,540)
Actuarial gain (loss)		(2,049)	3,262
Benefits paid		2,214	2,061
Projected benefit obligation at end of period	$	(57,918)	(54,305)
Change in plan assets:			
Fair value of plan assets at beginning of period	$	52,264	53,969
Actual return on plan assets		(7,856)	(2,404)
Employer contributions		1,060	2,760
Benefits paid		(2,214)	(2,061)
Fair value of plan assets at end of period	$	43,254	52,264
Funded status	$	(14,664)	(2,041)

		2009	2008
Accumulated benefit obligation	$	(57,918)	(54,305)
Amount recognized in the accompanying consolidated statements of financial position:			
Accrued pension liability	$	(14,664)	(2,041)
Accumulated charge to unrestricted net assets		23,523	9,900
Net amount recognized	$	8,859	7,859
Components of net periodic benefit cost:			
Interest cost	$	3,778	3,540
Expected return on plan assets		(4,391)	(4,679)
Amortization of unrecognized net loss		673	83
Net periodic benefit cost (income)	$	60	(1,056)
Other changes in plan assets and benefit obligation recognized in unrestricted net assets:			
Net actuarial loss	$	(14,296)	(3,820)
Reversal of amortization item:			
Net actuarial gain		673	83
Total recognized in unrestricted net assets	$	(13,623)	(3,737)
Estimated future benefit payments:			
Fiscal year 2010	$	2,914	
Fiscal year 2011		3,128	
Fiscal year 2012		3,302	
Fiscal year 2013		3,558	
Fiscal years 2014 – 2017		25,597	
Expected contributions during fiscal year 2010:			
Minimum required contribution	$	—	
Weighted average assumptions used to determine benefit obligations:			
Settlement (discount) rate		6.83%	7.13%
Weighted average assumptions used to determine net periodic benefit cost:			
Discount rate		7.13%	6.43%
Expected return on plan assets		8.50	8.50

The estimated net actuarial loss for the Income Plan that will be amortized from unrestricted net assets into net periodic benefit cost during the 2010 fiscal year is $2,691.

WSMC's overall expected long-term rate of return on assets is 8.5%. The expected long-term rate of return is based on the portfolio as a whole and not on the sum of the returns on individual asset categories. The return is based exclusively on historical returns, without adjustments.

WSMC's pension plan weighted average asset allocations at June 30, 2009 and 2008 by asset category are as follows:

Asset category	Plan assets at June 30 2009	2008
Equities	50.8%	57.2%
Fixed income securities	44.6	40.0
Cash and cash equivalents	4.6	2.8

WSMC has developed a plan investment policy, which is reviewed and approved by the RHC Finance Committee and the boards of directors. The policy established goals and objectives of the fund, asset allocations, asset classifications, and manager guidelines. The policy dictates a specific asset allocation between equity and fixed income securities. Investments are managed by independent advisors who are monitored by management and the Finance Committee. RHC monitors the asset allocation and executes required recalibrations of the portfolio allocation on a regular basis in response to fluctuations in market conditions and the overall portfolio composition.

(11) Self-Insurance

(a) Professional and General Liability

RHC and Affiliates are self-insured for professional and general liability claims up to specified limits arising from incidents occurring after dates of entry into the program, which vary by corporation. Excess insurance coverage was occurrence-based through various dates, at which time all corporations changed to claims made-based coverage. There are no assurances that RHC and Affiliates will be able to renew existing policies or procure coverage on similar terms in the future.

RHC and Affiliates are involved in litigation arising in the ordinary course of business. Claims alleging malpractice have been asserted against RHC and Affiliates and are currently in various stages of litigation. Provisions for professional and general liability claims include the ultimate cost of known claims and claims incurred but not reported as of the respective consolidated statement of financial position dates. It is the opinion of management that the estimated malpractice liabilities accrued at June 30, 2009 and 2008 are adequate to provide for the ultimate cost of potential losses resulting from pending or threatened litigation; however, such estimates may be more or less than the amounts ultimately paid when claims are resolved. Estimated malpractice claims have been discounted at rates of 3.5% and 4.0% at June 30, 2009 and 2008, respectively. The accrued liability estimated for self-insured professional and general liability claims amounted to $251,671 and $255,514 at June 30, 2009 and 2008, respectively. All self-insured malpractice and general claim liabilities are reported as long-term liabilities as the portion expected to be paid within one year is not readily determinable.

(b) Workers' Compensation

The Hospitals maintain self-insurance programs for workers' compensation coverage. These programs limit the self-insured retention to specific amounts on a per occurrence basis. Coverage

from commercial insurance carriers is maintained for claims in excess of the self-insured retention. Accrued workers' compensation claims amounted to $8,109 and $5,617 at June 30, 2009 and 2008, respectively. Management believes the estimated self-insured workers' compensation claims liability at June 30, 2009 and 2008 is adequate to cover the ultimate liability; however, such estimates may be more or less than the amounts ultimately paid when claims are resolved. The portion of workers' compensation claims expected to be paid beyond one year of the consolidated statements of financial position dates is not readily determinable, and therefore, the entire accrual is classified as a current liability included within accounts payable and accrued expenses in the accompanying consolidated statements of financial position.

(c) Health Care

RHC and Affiliates also maintain a program of self-insurance for employee health coverage. Stop-loss reinsurance coverage is maintained for claims in excess of stop-loss limits. Accrued self-insured employee health care claims amounted to $6,761 and $4,169 for 2009 and 2008, respectively, and are included with accounts payable and accrued expenses in the accompanying consolidated statements of financial position. It is the opinion of management that the estimated health care costs accrued at June 30, 2009 and 2008 are adequate to provide for the ultimate liability; however, final payouts as claims are paid may vary significantly from estimated claim liabilities.

(12) Joint Ventures

Investments in joint ventures include RHC and Affiliates' investment in various joint ventures, which were established to provide various health care services including laboratory, radiation, oncology, sleep lab, and a group purchasing function. RHC and Affiliates account for their investment in the joint ventures on the equity method of accounting. RHC and Affiliates have included their proportional share of the joint ventures' net income of $325 and $59 in 2009 and 2008, respectively, within investment income (loss) and other, net in the accompanying consolidated statements of operations. RHC and Affiliates received cash distributions from the joint ventures of $150 and $159 in 2009 and 2008, respectively. As of and for the years ended June 30, 2009 and 2008, respectively, the joint ventures had total assets of $49,663 and $44,798, members' equity of $25,369 and $24,154, revenue of $77,222 and $65,910, and net income of $1,313 and $1,260. The carrying value of RHC and Affiliates' investments in joint ventures of $10,622 and $8,613 at June 30, 2009 and 2008, respectively, is included with other assets in the accompanying consolidated statements of financial position.

(13) Contingencies

(a) Medicare Reimbursement

For the year ended June 30, 2009, RHC and Affiliates recognized approximately $572,178 of net service revenue from services provided to Medicare beneficiaries. Federal legislation has included provisions to reduce Medicare payments to health care providers as well as phase out cost based reimbursement mechanisms to prospective payment methodologies. Changes in Medicare and other payor reimbursement as a result of current health reform initiatives may have an adverse effect on RHC and Affiliates' net service revenues.

(b) Litigation

RHC and Affiliates are involved in litigation and regulatory investigations arising in the normal course of business. In consultation with legal counsel, management estimates that these matters will be resolved without material adverse effect on RHC and Affiliates' consolidated financial position or results from operations.

(c) Regulatory Investigations

The U.S. Department of Justice and other federal agencies routinely conduct regulatory investigations and compliance audits of health care providers. RHC and Affiliates are subject to these regulatory efforts. Management is currently unaware of any regulatory matters, which may have a material adverse effect on RHC and Affiliates' consolidated financial position or results of operations.

Schedule 1

RESURRECTION HEALTH CARE CORPORATION AND AFFILIATES

Consolidating Schedule – Financial Position Information

June 30, 2009

(In thousands)

Assets	Resurrection Health Care	Resurrection Medical Center	Saint Francis Hospital	Our Lady of the Resurrection Medical Center	Westlake Hospital	Saints Mary and Elizabeth Medical Center	Holy Family Medical Center	Saint Joseph Hospital
Current assets:								
Cash and cash equivalents	$ 306	26,664	1,736	109	1,202	2,615	—	170
Assets whose use is limited or restricted – required for current liabilities	139,857	150,000	36,705	—	—	—	—	—
Patient and resident accounts receivable, net of allowance for uncollectible accounts of $99,501	—	35,448	22,267	18,711	6,770	33,756	15,900	19,765
Other receivables	2,074	1,311	606	172	2,771	777	78	1,306
Inventory of supplies	—	2,079	1,279	555	586	3,834	1,172	3,628
Estimated receivables under third-party reimbursement programs	—	—	—	1,396	—	—	—	—
Prepaid expenses and other current assets	11,245	11,016	339	481	194	817	307	497
Due from affiliates	58,900	333,766	8,170	5,203	—	—	—	—
Total current assets	212,382	560,284	71,102	26,627	11,523	41,799	17,457	25,366
Assets whose use is limited or restricted:								
By boards for reinvestment and self-insurance	33,525	25,416	44,322	29,978	—	65,815	—	—
Under bond indenture agreements – held by trustee	28,062	—	—	—	—	—	1,198	—
By donors – permanently restricted	—	—	—	—	—	—	—	—
	61,587	25,416	44,322	29,978	—	65,815	1,198	—
Land, buildings, and equipment, net	191,508	21,660	77,876	33,033	22,261	98,706	31,994	77,910
Deferred finance charges	8,530	—	—	—	—	—	1,123	—
Other assets	31,077	6,427	—	—	—	282	—	—
	$ 505,084	613,787	193,300	89,638	33,784	206,602	51,772	103,276

(Continued)

ATTACHMENT 75

Schedule 1

RESURRECTION HEALTH CARE CORPORATION AND AFFILIATES

Consolidating Schedule – Financial Position Information

June 30, 2009

(In thousands)

Assets	West Suburban Medical Center	Resurrection Senior Services	Resurrection Services	Resurrection Behavioral Health	Resurrection Home Health Services	Resurrection Development Foundation	Resurrection Health Care Preferred	Eliminations	Consolidated
Current assets:									
Cash and cash equivalents	$ 185	5,683	920	454	74	670	629	—	41,417
Assets whose use is limited or restricted – required for current liabilities	2,920	50,000	—	—	—	—	—	—	379,482
Patient and resident accounts receivable, net of allowance for uncollectible accounts of $99,301	17,351	9,891	11,259	2,362	1,748	—	180	—	195,408
Other receivables	854	1,168	919	—	20	4,537	—	—	16,593
Inventory of supplies	1,513	485	1,294	—	—	—	—	—	16,425
Estimated receivables under third-party reimbursement programs	—	—	—	—	—	—	—	—	1,396
Prepaid expenses and other current assets	619	543	740	32	—	601	180	—	27,611
Due from affiliates	—	—	—	570	—	—	6,639	(413,248)	—
Total current assets	23,442	67,770	15,132	3,418	1,842	5,808	7,628	(413,248)	678,332
Assets whose use is limited or restricted:									
By boards for reinvestment and self-insurance	—	81,483	—	—	—	16,803	—	—	297,342
Under bond indenture agreements – held by trustee	—	—	—	—	—	—	—	—	29,260
By donors – permanently restricted	—	—	—	—	—	14,319	—	—	14,319
	—	81,483	—	—	—	31,122	—	—	340,921
Land, buildings, and equipment, net	57,526	120,001	104,380	3,129	244	176	42	—	840,446
Deferred finance charges	—	—	—	—	—	—	—	—	9,653
Other assets	1,077	302	5,656	—	2,007	—	—	(28,024)	18,804
	$ 82,045	269,556	125,168	6,547	4,093	37,106	7,670	(441,272)	1,888,156

(Continued)

ATTACHMENT 75

Schedule 1

RESURRECTION HEALTH CARE CORPORATION AND AFFILIATES

Consolidating Schedule – Financial Position Information

June 30, 2009

(In thousands)

Liabilities and Net Assets	Resurrection Health Care	Resurrection Medical Center	Saint Francis Hospital	Our Lady of the Resurrection Medical Center	Westlake Hospital	Saints Mary and Elizabeth Medical Center	Holy Family Medical Center	Saint Joseph Hospital
Current liabilities:								
Current installments of long-term debt	$ 371,115	—	—	—	—	—	8,110	—
Accounts payable and accrued expenses	14,632	27,656	3,035	1,416	1,113	4,596	2,035	3,420
Accrued payroll and fringe benefits	—	67,746	24	—	—	359	—	
Estimated payables under third-party reimbursement programs	—	18,355	8,271	5,809	5,250	6,797	13,710	28,507
Deferred revenue and refundable deposits	—	—	—	—	—	—	—	—
Due to affiliates	—	—	—	—	28,105	21,159	31,372	20,102
Total current liabilities	385,747	113,757	11,330	7,225	34,468	32,911	55,227	52,029
Long-term debt, excluding current installments and unamortized bond discount	213,777	—	—	—	28,026	—	30,717	—
Accrued pension liability	—	245,673	—	—	—	—	—	—
Estimated self-insured professional and general liability claims	—	53,869	42,285	13,413	23,714	39,421	6,038	18,074
Asset retirement obligation	13,509	—	—	—	—	—	—	—
Total liabilities	613,033	413,299	53,615	20,638	86,208	72,332	91,982	70,103
Net assets (deficit):								
Unrestricted	(108,386)	200,488	139,685	69,000	(52,424)	134,196	(40,210)	33,173
Temporarily restricted	437	—	—	—	—	74	—	—
Permanently restricted	—	—	—	—	—	—	—	—
Total net assets (deficit)	(107,949)	200,488	139,685	69,000	(52,424)	134,270	(40,210)	33,173
	$ 505,084	613,787	193,300	89,638	33,784	206,602	51,772	103,276

(Continued)

ATTACHMENT 75

Schedule 1

RESURRECTION HEALTH CARE CORPORATION AND AFFILIATES

Consolidating Schedule – Financial Position Information

June 30, 2009

(In thousands)

Liabilities and Net Assets	West Suburban Medical Center	Resurrection Senior Services	Resurrection Services	Resurrection Behavioral Health	Resurrection Home Health Services	Resurrection Development Foundation	Resurrection Health Care Preferred	Eliminations	Consolidated
Current liabilities:									
Current installments of long-term debt	$ —	257	—	—	—	—	—	—	379,482
Accounts payable and accrued expenses	5,190	5,894	9,491	363	35	200	10,515	—	89,591
Accrued payroll and fringe benefits	—	—	—	—	—	—	—	—	68,129
Estimated payables under third-party reimbursement programs	7,842	2,687	—	—	—	—	—	—	97,228
Deferred revenue and refundable deposits	—	41,968	—	131	—	—	—	—	42,099
Due to affiliates	98,507	60,816	132,049	5,996	12,890	2,252	—	(413,248)	—
Total current liabilities	111,539	111,622	141,540	6,490	12,925	2,452	10,515	(413,248)	676,529
Long-term debt, excluding current installments and unamortized bond discount	—	12,271	—	—	—	—	—	(28,024)	256,767
Accrued pension liability	—	—	—	—	—	—	—	—	245,673
Estimated self-insured professional and general liability claims	54,857	—	—	—	—	—	—	—	251,671
Asset retirement obligation	—	—	—	—	—	—	—	—	13,509
Total liabilities	166,396	123,893	141,540	6,490	12,925	2,452	10,515	(441,272)	1,444,149
Net assets (deficit):									
Unrestricted	(84,368)	145,663	(16,372)	57	(8,832)	8,107	(2,845)	—	416,932
Temporarily restricted	17	—	—	—	—	12,228	—	—	12,756
Permanently restricted	—	—	—	—	—	14,319	—	—	14,319
Total net assets (deficit)	(84,351)	145,663	(16,372)	57	(8,832)	34,654	(2,845)	—	444,007
	$ 82,045	269,556	125,168	6,547	4,093	37,106	7,670	(441,272)	1,888,156

See accompanying independent auditors' report.

ATTACHMENT 75

Schedule 2

RESURRECTION HEALTH CARE CORPORATION AND AFFILIATES

Consolidating Schedule – Operations and Changes in Unrestricted Net Assets Information

Year ended June 30, 2009

(In thousands)

	Resurrection Health Care	Resurrection Medical Center	Saint Francis Hospital	Our Lady of the Resurrection Medical Center	Westlake Hospital	Saints Mary and Elizabeth Medical Center	Holy Family Medical Center	Saint Joseph Hospital
Net service revenue	$ —	280,129	165,831	135,296	96,100	301,614	73,686	192,550
Other revenue:								
Auxiliary services	675	4,320	3,499	811	2,817	4,596	954	3,213
Services provided to affiliates	159,770	—	—	—	—	—	—	—
Net assets released from restrictions for operations	1,131	380	298	560	825	32	1	182
Total revenue	161,576	284,829	169,628	136,667	99,742	306,242	74,641	195,945
Expenses:								
Salaries and wages	82,807	97,924	50,310	45,688	39,152	91,664	29,165	66,108
Payroll taxes and fringe benefits	20,834	28,804	14,700	12,392	11,083	25,588	8,209	19,932
Physicians' fees	983	16,372	11,165	5,136	10,111	10,959	1,572	13,889
Supplies	273	51,827	19,682	16,659	11,598	33,288	7,279	23,153
Other	45,207	25,109	11,685	9,187	4,791	9,503	6,791	15,139
Management services	—	26,977	19,833	15,136	12,009	30,059	3,906	18,473
Purchased services	10,136	5,812	5,103	2,837	5,769	16,860	2,069	8,959
Insurance	105	8,206	12,419	3,087	(9,613)	3,130	(279)	1,319
Depreciation and amortization	16,631	6,260	10,538	5,112	4,231	9,699	4,381	8,194
Provision for uncollectible accounts receivable	—	10,760	18,769	21,732	6,903	32,890	1,227	6,979
Interest	20,072	—	—	—	—	—	1,678	—
Assessments and taxes	—	6,819	5,822	3,958	4,544	20,828	2,869	8,514
Total expenses, before impairment costs	197,048	284,870	180,026	140,924	100,578	284,468	68,867	190,659
Income (loss) before impairment costs	(35,472)	(41)	(10,398)	(4,257)	(836)	21,774	5,774	5,286
Impairment costs	—	—	—	—	—	—	—	—
Income (loss) from operations	(35,472)	(41)	(10,398)	(4,257)	(836)	21,774	5,774	5,286
Nonoperating gains (losses):								
Investment income (loss) and other, net	(55,366)	4,337	2,339	711	9	1,086	(739)	163
Unrestricted contributions	—	—	—	—	—	1	—	—
Net nonoperating gains (losses)	(55,366)	4,337	2,339	711	9	1,087	(739)	163
Revenue and gains in excess (deficient) of expenses and losses	(90,838)	4,296	(8,059)	(3,546)	(827)	22,861	5,035	5,449
Other changes in unrestricted net assets:								
Net assets released from restrictions for purchases of land, building, and equipment	1,183	49	122	—	2,388	184	347	324
Recognition of change in pension funded status	—	(64,197)	—	—	—	—	—	—
Increase (decrease) in unrestricted net assets	$ (89,655)	(59,852)	(7,937)	(3,546)	1,561	23,045	5,382	5,773

(Continued)

Schedule 2

RESURRECTION HEALTH CARE CORPORATION AND AFFILIATES

Consolidating Schedule – Operations and Changes in Unrestricted Net Assets Information

Year ended June 30, 2009

(In thousands)

	West Suburban Medical Center	Resurrection Senior Services	Resurrection Services	Resurrection Behavioral Health	Resurrection Home Health Services	Resurrection Development Foundation	Resurrection Health Care Preferred	Eliminations	Consolidated
Net service revenue	$ 164,376	129,634	32,888	—	13,350	—	—	—	1,585,454
Other revenue:									
Auxiliary services	8,607	1,976	23,303	18,008	40	—	48,131	(13,039)	107,911
Services provided to affiliates	—	8,339	—	—	—	—	—	(168,109)	—
Net assets released from restrictions for operations	176	393	318	223	1	—	—	—	4,520
Total revenue	173,159	140,342	56,509	18,231	13,391	—	48,131	(181,148)	1,697,885
Expenses:									
Salaries and wages	58,940	57,108	12,268	9,110	7,933	1,987	2,543	—	652,707
Payroll taxes and fringe benefits	16,550	20,746	4,793	3,142	1,867	372	582	—	189,594
Physicians' fees	10,314	353	6,803	2,038	—	—	223	—	89,918
Supplies	20,843	17,714	10,995	460	683	2	159	(8,339)	206,276
Other	14,689	17,312	16,758	2,033	665	550	44,369	(14,482)	209,306
Management services	13,746	7,903	1,203	897	2,438	44	69	(154,693)	—
Purchased services	9,669	2,538	6,275	1,532	105	271	154	(3,634)	74,455
Insurance	18,207	5,784	1,507	174	714	1	—	—	44,761
Depreciation and amortization	9,269	7,429	8,252	260	56	14	20	—	90,346
Provision for uncollectible accounts receivable	23,214	2,929	—	—	—	—	—	—	125,403
Interest	—	815	576	—	—	—	—	—	23,141
Assessments and taxes	5,560	1,795	—	—	—	—	—	—	60,709
Total expenses, before impairment costs	203,001	142,426	69,430	19,646	14,461	3,241	48,119	(181,148)	1,766,616
Income (loss) before impairment costs	(29,842)	(2,084)	(12,921)	(1,415)	(1,070)	(3,241)	12	—	(68,731)
Impairment costs	—	—	621	—	—	—	—	—	621
Income (loss) from operations	(29,842)	(2,084)	(13,542)	(1,415)	(1,070)	(3,241)	12	—	(69,352)
Nonoperating gains (losses):									
Investment income (loss) and other, net	611	3,483	965	—	(247)	355	11	—	(42,282)
Unrestricted contributions	—	—	—	—	—	13	—	—	14
Net nonoperating gains (losses)	611	3,483	965	—	(247)	368	11	—	(42,268)
Revenue and gains in excess (deficient) of expenses and losses	(29,231)	1,399	(12,577)	(1,415)	(1,317)	(2,873)	23	—	(111,620)
Other changes in unrestricted net assets:									
Net assets released from restrictions for purchases of land, building, and equipment	1,555	290	—	—	—	—	—	—	6,442
Recognition of change in pension funded status	—	—	—	—	—	—	—	—	(64,197)
Increase (decrease) in unrestricted net assets	$ (27,676)	1,689	(12,577)	(1,415)	(1,317)	(2,873)	23	—	(169,375)

See accompanying independent auditors' report.

ATTACHMENT 75

RESURRECTION HEALTH CARE AND AFFILIATES

Consolidated Financial Statements and Schedules

June 30, 2008 and 2007

(With Independent Auditors' Report Thereon)

ATTACHMENT 75

KPMG LLP
303 East Wacker Drive
Chicago, IL 60601-5212

Independent Auditors' Report

Boards of Directors
Resurrection Health Care and Affiliates:

We have audited the accompanying consolidated statements of financial position of Resurrection Health Care and affiliates as of June 30, 2008 and 2007, and the related consolidated statements of operations, changes in net assets, and cash flows for the years then ended. These consolidated financial statements are the responsibility of Resurrection Health Care and affiliates' management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. Our audits included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Resurrection Health Care and affiliates' internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of Resurrection Health Care and affiliates as of June 30, 2008 and 2007, and the results of their operations, changes in net assets, and cash flows for the years then ended, in conformity with U.S. generally accepted accounting principles.

As discussed in note 9 to the consolidated financial statements, Resurrection Health Care and affiliates adopted the provisions of Financial Accounting Standards Board (FASB) issued Statement of Financial Accounting Standards (SFAS) No. 158, *Employers' Accounting for Defined Benefit Pension and Other Postretirement Plans—an Amendment of FASB Statements No. 87, 88, 106, and 132(R)*, in 2007.

KPMG

Our audits were made for the purpose of forming an opinion on the consolidated financial statements taken as a whole. The consolidating information in schedules 1 and 2 is presented for purposes of additional analysis of the 2008 consolidated financial statements rather than to present the financial position and results of operations of the individual organizations. The consolidating information has been subjected to the auditing procedures applied in the audit of the 2008 consolidated financial statements and, in our opinion, is fairly stated in all material respects in relation to the 2008 consolidated financial statements taken as a whole.

KPMG LLP

December 15, 2008

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RESURRECTION HEALTH CARE AND AFFILIATES

Consolidated Statements of Financial Position

June 30, 2008 and 2007

(In thousands)

Assets		2008	2007
Current assets:			
Cash and cash equivalents	$	22,853	32,893
Assets whose use is limited or restricted – required for current liabilities		354,840	19,875
Patient and resident accounts receivable, net of allowance for uncollectible accounts of $106,382 in 2008 and $89,568 in 2007		214,989	207,031
Other receivables		23,411	102,040
Inventory of supplies		17,205	15,876
Estimated receivables under third-party reimbursement programs		526	—
Prepaid expenses and other current assets		28,572	32,938
Total current assets		662,396	410,653
Assets whose use is limited or restricted:			
By Boards for reinvestment and self-insurance		458,985	932,693
Under bond indenture agreements – held by trustee		5,680	7,008
By donors – permanently restricted		14,492	14,050
		479,157	953,751
Land, buildings, and equipment, net		825,916	804,375
Deferred finance charges		9,877	10,768
Other assets		13,152	13,369
	$	1,990,498	2,192,916

See accompanying notes to consolidated financial statements.

Liabilities and Net Assets	2008	2007
Current liabilities:		
Current installments of long-term debt	$ 352,078	15,520
Accounts payable and accrued expenses	96,599	119,890
Accrued payroll and fringe benefits	68,985	63,716
Estimated payables under third-party reimbursement programs	89,425	104,500
Deferred revenue and refundable deposits	44,583	46,026
Total current liabilities	651,670	349,652
Long-term debt, excluding current installments and unamortized bond discount	299,032	733,189
Accrued pension liability	152,106	156,876
Estimated self-insured professional and general liability claims	255,514	249,502
Asset retirement obligation	13,158	13,418
Other	—	1,334
Total liabilities	1,371,480	1,503,971
Net assets:		
Unrestricted	586,307	656,929
Temporarily restricted	18,219	17,966
Permanently restricted	14,492	14,050
Total net assets	619,018	688,945
	$ 1,990,498	2,192,916

RESURRECTION HEALTH CARE AND AFFILIATES

Consolidated Statements of Operations

Years ended June 30, 2008 and 2007

(In thousands)

	2008	2007
Net service revenue	$ 1,583,582	1,606,564
Other revenue:		
Auxiliary services	101,716	60,959
Net assets released from restrictions for operations	2,398	2,276
Total revenue	1,687,696	1,669,799
Expenses:		
Salaries and wages	645,307	615,627
Payroll taxes and fringe benefits	177,783	176,990
Physicians' fees	88,584	82,540
Supplies	203,849	199,814
Other	209,529	156,363
Purchased services	65,067	61,376
Insurance	47,556	37,497
Depreciation and amortization	86,468	81,210
Provision for uncollectible accounts receivable	164,157	154,963
Interest	3,250	3,404
Loss on early extinguishment of long-term debt	2,593	—
Assessments and taxes	49,063	95,938
Total expenses, before impairment costs	1,743,206	1,665,722
Income (loss) before impairment costs	(55,510)	4,077
Impairment costs	17,942	—
Income (loss) from operations	(73,452)	4,077
Nonoperating gains (losses):		
Investment income (loss) and other, net	(1,294)	36,856
Unrestricted contributions	1,724	1,429
Net nonoperating gains (losses)	430	38,285
Revenue and gains in excess (deficient) of expenses and losses	(73,022)	42,362
Other changes in unrestricted net assets:		
Net assets released from restrictions for purchase of land, buildings, and equipment	4,647	4,575
Net reclassification of net assets based on donor intent	(91)	—
Recognition of change in pension funded status	(2,156)	—
Change in net unrealized gains and losses on other than trading securities	—	21,902
Designation of investments as trading	—	(10,005)
Cumulative effect of changes in accounting principles	—	11,312
Increase (decrease) in unrestricted net assets	$ (70,622)	70,146

See accompanying notes to consolidated financial statements.

ATTACHMENT 75

RESURRECTION HEALTH CARE AND AFFILIATES

Consolidated Statements of Changes in Net Assets

Years ended June 30, 2008 and 2007

(In thousands)

	2008	2007
Unrestricted net assets:		
Revenue and gains in excess (deficient) of expenses and losses	$ (73,022)	42,362
Net assets released from restrictions for purchase of land, buildings, and equipment	4,647	4,575
Net reclassification of net assets based on donor intent	(91)	—
Recognition of change in pension funded status	(2,156)	—
Change in net unrealized gains and losses on other than trading securities	—	21,902
Designation of investments as trading	—	(10,005)
Cumulative effect of changes in accounting principles	—	11,312
Increase (decrease) in unrestricted net assets	(70,622)	70,146
Temporarily restricted net assets:		
Pledges and contributions	7,735	5,830
Investment income	176	319
Net realized and unrealized gains and losses on temporarily restricted net assets	(704)	759
Net reclassification of net assets based on donor intent	91	—
Net assets released from restrictions for purchase of land, building, and equipment	(4,647)	(4,575)
Net assets released from restrictions for operations	(2,398)	(2,276)
Increase in temporarily restricted net assets	253	57
Permanently restricted net assets:		
Contributions	442	2,538
Increase in permanently restricted net assets	442	2,538
Change in net assets	(69,927)	72,741
Net assets at beginning of year	688,945	616,204
Net assets at end of year	$ 619,018	688,945

See accompanying notes to consolidated financial statements.

RESURRECTION HEALTH CARE AND AFFILIATES

Consolidated Statements of Cash Flows

Years ended June 30, 2008 and 2007

(In thousands)

	2008	2007
Cash flows from operating activities:		
Change in net assets	$ (69,927)	72,741
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Cumulative effect of changes in accounting principles	—	(11,312)
Depreciation and amortization	86,468	81,210
Provision for uncollectible accounts receivable	164,157	154,963
Loss on early extinguishment of long-term debt	2,593	—
Impairment costs	17,942	—
Amortization of deferred occupancy and care revenue	(138)	(292)
Recognition of change in pension funded status	2,156	—
Change in net unrealized gains and losses on other than trading securities	—	(21,902)
Change in net unrealized gains and losses on trading securities	28,908	—
Designation of investments as trading	—	10,005
Permanently restricted contributions	(442)	(2,538)
Changes in assets and liabilities:		
Patient and resident accounts receivable	(172,115)	(156,897)
Other assets	81,883	(77,129)
Accounts payable and accrued expenses and other liabilities	(19,616)	30,947
Estimated payables under third-party reimbursement programs, net	(15,601)	(4,207)
Accrued pension liability	(6,926)	(16,117)
Estimated self-insured professional, general, and workers' compensation liability claims	6,012	7,193
Net cash provided by operating activities	105,354	66,665
Cash flows from investing activities:		
Acquisition of land, buildings, and equipment, net	(125,951)	(141,092)
Gross purchases of securities	(712,012)	(979,143)
Gross sales or maturities of securities	822,733	1,075,188
Net cash used in investing activities	(15,230)	(45,047)
Cash flows from financing activities:		
Proceeds from the issuance of long-term debt	325,000	—
Repayments of long-term debt	(422,153)	(14,953)
Payments for deferred financing fees	(2,148)	—
Net proceeds (refunds) of entrance fees and membership deposits	(1,305)	1,018
Permanently restricted contributions	442	2,538
Net cash used in financing activities	(100,164)	(11,397)
Net increase (decrease) in cash and cash equivalents	(10,040)	10,221
Cash and cash equivalents at beginning of year	32,893	22,672
Cash and cash equivalents at end of year	$ 22,853	32,893
Supplemental disclosure of cash flow information:		
Cash paid for interest, net of amounts capitalized	$ 26,048	23,525

See accompanying notes to consolidated financial statements.

ATTACHMENT 75

(1) Organization and Operations

Resurrection Health Care (RHC), a not-for-profit tax-exempt corporation, was incorporated for charitable, educational, and scientific purposes to support health and human services by providing management assistance and in all other relevant ways. The accompanying consolidated financial statements include the accounts of RHC and the following affiliates (collectively RHC and Affiliates) for which it serves as the parent corporation through ownership, sole member powers, the authority to approve Board membership, or the holding of certain reserve powers:

- Resurrection Medical Center (RMC), a not-for-profit acute care hospital providing various inpatient and outpatient services and programs.
- Saint Francis Hospital (SFH), a not-for-profit acute care hospital providing various inpatient and outpatient services and programs.
- Our Lady of the Resurrection Medical Center (OLR), a not-for-profit acute care hospital providing various inpatient and outpatient services and programs.
- Westlake Hospital (WH), a not-for-profit acute care hospital providing various inpatient and outpatient services and programs.
- Saints Mary and Elizabeth Medical Center (SMEMC), not-for-profit acute care facilities providing various inpatient and outpatient services and programs.
- Holy Family Medical Center (HFMC), a not-for-profit long-term acute care hospital providing various services and programs to patients in between acute care and skilled nursing.
- Saint Joseph Hospital (SJH), a not-for-profit acute care hospital providing various inpatient and outpatient services and programs.
- West Suburban Medical Center (WSMC), a not-for-profit acute care hospital providing various inpatient and outpatient services and programs.
- Resurrection Senior Services (Senior Services), which provides various independent living and nursing services and programs and, which encompasses the following: Resurrection Nursing and Rehabilitation Center (RNRC), Resurrection Retirement Community (RRC), Resurrection Life Center (RLC), St. Francis Nursing and Rehabilitation Center (SFNR), Bethlehem Woods Retirement Community (BWRC), Casa San Carlo Retirement Community (CSCRC), St. Benedict Nursing and Rehabilitation Center (SBNRC), Villa Scalabrini Nursing and Rehabilitation Center (VSNRC), Maryhaven Nursing and Rehabilitation Center (MNRC), St. Andrew Life Center (SALC), Holy Family Nursing and Rehabilitation Center (HFNRC), Resurrection Nursing Home (RNH), and Mt. Loretto Nursing Home (MLNH).
- Resurrection Services (Services), which encompasses the following corporations and/or operating divisions: Resurrection Ambulatory Care Services (RACS), Resurrection Properties (RP), Resurrection Pharmacies, and Resurrection Medical Network.
- Resurrection Behavioral Health (RBH), a not-for-profit corporation established to provide behavioral health services.

- Resurrection Home Health Services (Home Care), a not-for-profit corporation established to provide home care services. Home Care also includes RHC's membership interest in Rainbow Hospice.
- Resurrection Development Foundation (Foundation), a not-for-profit corporation established to coordinate fund-raising activities that support the benevolent care and other programs at RHC and Affiliates.
- Resurrection Health Care Preferred (RHCP), a systemwide managed care contracting organization that engages physicians in capitated risk contracts.

The above listed entities are not-for-profit corporations as described in Section 501(c)(3) of the Internal Revenue Code (Code) and, with the exception of RHCP, are exempt from federal income taxes on related income pursuant to Section 501(a) of the Code.

On July 1, 2007, RHC and Affiliates adopted Financial Accounting Standards Board (FASB) Interpretation No. 48, *Accounting for Uncertainty in Income Taxes – An Interpretation of FASB Statement No. 109* (FIN 48). The Interpretation addresses the determination of how tax benefits claimed or expected to be claimed on a tax return should be recorded in the consolidated financial statements. Under FIN 48, RHC and Affiliates must recognize the tax benefit from an uncertain tax position only if it is more likely than not that the tax position will be sustained on examination by the taxing authorities, based on the technical merits of the position. The tax benefits recognized in the consolidated financial statements from such a position are measured based on the largest benefit that has a greater than fifty percent likelihood of being realized upon ultimate settlement. FIN 48 also provides guidance on derecognition, classification, interest and penalties on income taxes, accounting in interim periods and requires increased disclosures. At the date of adoption, and as of June 30, 2008, RHC and Affiliates do not have a liability for unrecognized tax benefits. The adoption of FIN 48 had no impact on the consolidated financial statements of RHC and Affiliates.

(2) Summary of Significant Accounting Policies

Significant accounting policies of RHC and Affiliates are as follows:

- The preparation of financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosures of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates.
- Cash and cash equivalents include demand deposits and investments in highly liquid debt instruments with maturities of three months or less, excluding amounts classified as assets whose use is limited or restricted.
- Inventory of supplies is stated at lower of cost (first-in, first-out method) or market.
- Assets whose use is limited or restricted include: assets set aside by the boards of directors for reinvestment and self-insurance purposes, over which the boards retain control and may at their

discretion use for other purposes, assets held by a trustee under bond indenture agreements, and funds restricted by donors.

- Except as otherwise noted, the carrying value of all financial instruments approximates their fair values.
- Land, buildings, and equipment are stated at cost, or if donated, at fair value at date of donation, net of any allowances for impairment. Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed on the straight-line method.
- Deferred finance charges, bond discount, and bond premium are amortized on the straight-line basis over the period the related obligations are outstanding, which approximates the effective interest method.
- Deferred revenue and refundable deposits represent various types of entrance and membership fees. RRC resident membership deposits are fully refundable, net of applicable processing fees, to the resident upon termination of the lease agreement between RRC and the resident, with any interest earned on such deposits accruing to RRC. BWRC and CSCRC offer a variety of partially refundable entrance fees. These entrance payments are included with deferred revenue and refundable deposits in the accompanying consolidated statements of financial position. Total deferred entrance payments subject to refund at June 30, 2008 and 2007 approximated $42,288 and $43,593, respectively.
- Unconditional promises to give cash or other assets are reported at fair value at the date the promise is received. All contributions are considered to be available for unrestricted use unless specifically restricted by donors. Contributions are reported as direct additions to temporarily restricted net assets if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or a purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the consolidated statements of operations as net assets released from restrictions. Gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.
- Temporarily restricted net assets are those assets whose use has been limited by donors to a specific time period or purpose. Temporarily restricted net assets principally represent amounts restricted for the purpose of acquiring long-lived assets or for specific operating purposes.
- Permanently restricted net assets represent donor-restricted contributions, the principal amount of which may not be expended. Amounts reported as permanently restricted net assets represent the cumulative amount of contributions received, including investment return earned thereon, for an endowment fund. Investment return currently earned on permanently restricted investments is reported as nonoperating investment income.
- Net service revenue is reported at the estimated net realizable amounts from patients and residents, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Those adjustments are accrued on an

estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined.

- The consolidated statements of operations include revenue and gains in excess (deficient) of expenses and losses. Transactions deemed by management to be ongoing, major, or central to the provision of health and residential care services are reported as revenue and expenses. Transactions incidental to the provision of health and residential care services are reported as gains and losses. Changes in unrestricted net assets, which are excluded from revenue and gains in excess (deficient) of expenses and losses, consistent with industry practice, include changes in net unrealized gains and losses on investments other than trading securities, designation of investments as trading, contributions of long-lived assets (including assets acquired using contributions, which by donor restriction were to be used for the purposes of acquiring such assets), recognition of change in pension funded status, and cumulative effects of changes in accounting principles. During 2008, donors clarified their intentions for gifts previously recorded; accordingly, $91 has been reflected as a net reclassification of net assets based on donor intent in the accompanying consolidated financial statements.

- Investment income or loss (including realized gains and losses on investments, changes in unrealized gains and losses on trading securities, interest, and dividends) is included in revenue and gains in excess (deficient) of expenses and losses unless the income or loss is restricted by donors, in which case the investment income is recorded directly to temporarily or permanently restricted net assets. Unrealized gains and losses on investments are excluded from revenue and gains in excess (deficient) of expenses and losses unless the investments are classified by management as trading securities. Unrealized gains and losses of temporarily and permanently restricted investments are recorded directly to temporarily and permanently restricted net assets. Effective June 30, 2007, management redesignated all investments to be trading securities. As a result of such redesignation, the net unrealized gain on the investment portfolio of $10,005 at June 30, 2007 was reclassified from unrestricted net assets to investment income (loss) and other in the accompanying 2007 consolidated statement of operations. Other-than-temporary declines in investments are considered to be realized losses. All interest expense, letter of credit fees, and rebate expense (note 8) on the Series 1999 and Series 2005 Revenue Bonds ($28,214 in 2008 and $27,502 in 2007) are netted against nonoperating investment income in the accompanying consolidated statements of operations.

- RHC and Affiliates incur expenses for the provision of health and residential care services and related general and administrative activities.

- All significant intercompany balances and transactions have been eliminated in the preparation of the accompanying consolidated financial statements.

- Certain 2007 amounts have been reclassified to conform to the 2008 consolidated financial statement presentation.

Other significant accounting policies are set forth in the consolidated financial statements and in the following notes.

(3) Third-Party Reimbursement Programs

RHC and Affiliates have agreements with third-party payors, which provide for reimbursement at amounts different from their established rates. Contractual adjustments under third-party reimbursement programs principally represent the difference between the billings at list price and the amounts reimbursed by Blue Cross and certain other contracted third-party payors; the difference between the billings at list price and the allocated cost of services provided to Medicare and Medicaid patients; and any differences between estimated third-party reimbursement settlements for prior years and subsequent final settlements. A summary of the reimbursement methodologies with major third-party payors follows:

Medicare

RMC, OLR, SFH, WH, SMEMC, HFMC, SJH, and WSMC (collectively known as the Hospitals) and Senior Services are paid for inpatient acute care services, long-term care services, outpatient services, rehabilitation services, and home health services rendered to Medicare program beneficiaries under prospective reimbursement rates. These rates vary according to patient classification systems that are based on clinical, diagnostic, and other factors. The prospectively determined rates are not subject to retroactive adjustment. The Hospitals' classification of patients under the Medicare prospective payment systems and the appropriateness of the patients' admissions are subject to validation reviews.

For services rendered to Medicare beneficiaries for psychiatric services, rehabilitation services, and defined "pass-through" costs (i.e., medical education related costs), the Hospitals are reimbursed based upon cost reimbursement methodologies. The Hospitals are reimbursed at tentative rates with final settlement determined after submission of annual cost reports by the Hospitals and audits thereof by the Medicare fiscal intermediary. The Medicare cost reports have been audited and settled by the Medicare fiscal intermediary through 2006 for RMC, SFH, OLR, SMEMC, HFMC, SJH, and WSMC; and through 2007 for WH.

Medicaid

Under the State of Illinois' (the State) Medicaid reimbursement system, the Hospitals are paid for inpatient acute care services rendered to Medicaid program beneficiaries under prospectively determined rates-per-discharge. These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Senior Services are reimbursed based upon an all inclusive per-diem rate. SMEMC also receives incremental Medicaid reimbursement for specific Programs and services at the discretion of the State Medicaid program. Medicaid reimbursement methodologies and payment rates are subject to change based on the amount of funding available to the State Medicaid program and any such changes could have a significant effect on RHC and Affiliates' revenues.

During fiscal year 2007, the State approved an assessment program to assist in the financing of its Medicaid program through June 30, 2008. Pursuant to this program, hospitals within the State are required to remit payment to the State Medicaid program under an assessment formula approved by the Centers for Medicare & Medicaid Services (CMS). RHC and Affiliates have included their 2008 and 2007 related assessment of $47,282 and $94,564, respectively, in assessments and taxes in the

accompanying consolidated statements of operations. The assessment program also provides hospitals within the State with additional Medicaid reimbursement based on funding formulas also approved by CMS. RHC and Affiliates have included their additional 2008 and 2007 related reimbursement of $78,169 and $156,338, respectively, within net patient service revenue in the accompanying consolidated statements of operations. RHC and Affiliates have included their unpaid assessment of $47,282 within accounts payable and accrued expenses and their related reimbursement receivable of $78,169 within other receivables in the accompanying 2007 consolidated statement of financial position, as these amounts had not yet been paid as of June 30, 2007. All outstanding amounts under the program have been paid as of June 30, 2008. The State received CMS approval for extension of a new five-year Medicaid assessment program on December 4, 2008 for the State's fiscal years ending June 30, 2009 through June 30, 2013.

Blue Cross

The Hospitals also participate as providers of health care services under reimbursement agreements with Blue Cross. The provisions of these agreements stipulate that services will be reimbursed at a tentative reimbursement rate and that final reimbursement for these services is determined after the submission of annual cost reports by the Hospitals and reviews thereof by Blue Cross. The Blue Cross traditional indemnity reimbursement reports for 2007 and prior years have been reviewed by Blue Cross. The Blue Cross HMOI, PPO, and MCNP reimbursement reports have been reviewed by Blue Cross through 2006 for RMC, SFH, OLR, WH, SMEMC, HFMC, SJH, and WSMC.

Other

The Hospitals have also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for reimbursement under these agreements includes prospectively determined rates-per-discharge, discounts from established charges, and prospectively determined per diem rates.

A summary of gross and net service revenue for the years ended June 30, 2008 and 2007 follows:

		2008	2007
Service revenue:			
Nursing, dietary, and room service	$	860,491	836,628
Ancillary services		3,248,450	3,124,607
Long-term care services		142,333	133,867
Retirement communities		20,280	18,745
Ambulatory care services		20,398	15,224
Apothecary, durable medical equipment, home, health services, and other		28,640	29,648
Gross service revenue		4,320,592	4,158,719
Less provisions for estimated contractual adjustments under third-party reimbursement programs and other discounts and allowances		2,737,010	2,552,155
Net service revenue	$	1,583,582	1,606,564

A summary of RHC and Affiliates' Medicare, Medicaid, managed care, self-pay, and commercial utilization percentages based upon gross service revenue follows:

	2008	2007
Medicare	46%	47%
Medicaid	18	18
Managed care	26	24
Self-pay, commercial, and other	10	11

(4) Concentration of Credit Risk

RHC and Affiliates grant credit without collateral to their patients, most of who are local residents and are generally insured under third-party payor agreements. The mix of receivables from patients and third-party payors as of June 30, 2008 and 2007 was as follows:

	2008	2007
Medicare	32%	32%
Medicaid	21	24
Managed care	26	25
Self-pay	15	12
Commercial and other	6	7

(5) Charity Care

RHC and Affiliates provide necessary medical care to patients who meet certain criteria under their charity care policies without charge or at amounts less than their established rates. Because RHC and Affiliates do not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue. The following information presents the level of charity care provided during the years ended June 30, 2008 and 2007.

		2008	2007
Charges forgone for non-Medicare and non-Medicaid patients, based on established rates	$	49,843	72,184

(6) Investments

RHC and Affiliates report investments in equity securities with readily determinable fair values and all investments in debt securities at fair value. Fair value is determined primarily on the basis of quoted market prices. A summary of the composition of the RHC and Affiliates' investment portfolios at June 30, 2008 and 2007 follows:

		2008	2007
Cash and cash equivalents	$	24,974	45,687
Common stocks and mutual funds		151,882	149,393
U.S. treasury securities		66,687	100,030
Corporate and municipal bonds and notes		380,647	417,457
U.S. government agencies		209,807	261,059
	$	833,997	973,626

Investments are reported in the accompanying consolidated statements of financial position at June 30 as follows:

		2008	2007
Assets whose use is limited or restricted – required for current liabilities	$	354,840	19,875
Assets whose use is limited or restricted, less amounts required for current liabilities:			
By Boards for reinvestment and self-insurance		458,985	932,693
Under bond indenture agreements – held by trustee		5,680	7,008
By donors – permanently restricted		14,492	14,050
	$	833,997	973,626

(Continued)

The composition of investment return on the RHC and Affiliates' investment portfolio for the years ended June 30, 2008 and 2007 is as follows:

	2008	2007
Interest and dividend income, net of fees and expenses	$ 44,054	50,339
Net realized gains on sale of investments	8,969	3,168
Net change in unrealized gains and losses during the holding period	(29,612)	22,607
	$ 23,411	76,114

Prior to the June 30, 2007 designation of investments as trading, changes in net unrealized gains and losses during the holding period were attributable to other than trading securities, and accordingly, are excluded from the determination of revenue and gains in excess of expenses and losses. Investment returns are included in the accompanying consolidated financial statements for the years ended June 30, 2008 and 2007 as follows:

	2008	2007
Nonoperating gains – investment income and other	$ 53,023	52,857
Nonoperating losses – change in net unrealized gains and losses on trading securities	(28,908)	—
Other changes in unrestricted net assets – change in net unrealized gains and losses on other than trading securities	—	21,902
Net realized and unrealized gains and losses on temporarily restricted investments	(704)	759
Interest income offset against capitalized interest cost	—	596
	$ 23,411	76,114

(7) Land, Buildings, and Equipment

A summary of land, buildings, and equipment at June 30, 2008 and 2007 follows:

	2008	2007
Land	$ 67,887	68,792
Land improvements	45,869	45,760
Buildings and building equipment	1,183,648	1,104,728
Departmental equipment	794,506	766,527
	2,091,910	1,985,807
Less accumulated depreciation	1,314,473	1,230,323
	777,437	755,484
Construction in progress	48,479	48,891
Land, buildings, and equipment, net	$ 825,916	804,375

Construction in progress at June 30, 2008 and 2007 consists primarily of costs associated with various projects. The remaining costs associated with these projects at June 30, 2008 are approximately $96,421, substantially all of which have been contractually committed. These projects are expected to be completed in fiscal year 2010 and are expected to be financed from operations. For the years ended June 30, 2008 and 2007, RHC and Affiliates capitalized interest cost of $0 and $2,352, respectively, and offset such capitalized interest cost by $0 and $596, respectively, of interest income earned on unexpended project specific borrowed funds.

Impairment Costs

RHC and Affiliates periodically evaluate land, buildings, and equipment to determine whether assets may have been impaired in accordance with Statement of Financial Accounting Standards (SFAS) No. 144, *Accounting for the Impairment or Disposal of Long-Lived Assets*. Such analyses require various valuation techniques using management assumptions, including estimates of future cash flows as well as third party appraisals of the assets. As a result, there is at least a reasonable possibility that recorded estimates of fair value and impairment will change by a material amount.

In 2008, RHC and Affiliates determined that the fair value of land, buildings, and equipment at one of their hospital facilities was less than the recorded historical costs, and recorded a loss of $17,942 in impairment costs.

(8) Long-term Debt

A summary of long-term debt at June 30, 2008 and 2007 follows:

	2008	2007
Variable Rate Revenue Bonds (Series 2008A)	$ 50,000	—
Variable Rate Revenue Bonds (Series 2008B)	50,000	—
Variable Rate Revenue Bonds (Series 2005A)	26,130	26,130
Variable Rate Revenue Bonds (Series 2005B)	120,735	121,975
Variable Rate Revenue Bonds (Series 2005C)	121,055	122,110
Variable Rate Revenue Bonds (Series 2005D)	—	61,750
Variable Rate Revenue Bonds (Series 2005E)	—	10,620
Variable Rate Demand Revenue Bonds (Series 1999A)	—	116,100
Variable Rate Demand Revenue Bonds (Series 1999B)	—	116,100
Fixed Rate Revenue Bonds (Series 1999A)	112,500	—
Fixed Rate Revenue Bonds (Series 1999B)	112,500	—
Periodic Auction Reset Securities (PARS) (Series 1999C)	—	119,375
Revenue Bonds (Series 1997B) (HFMC)	33,400	34,355
Term loan (HFMC)	7,471	7,885
Mortgage loans (RMNY)	12,772	13,010
Total long-term debt	646,563	749,410
Less:		
Current installments	352,078	15,520
Unamortized bond premium	(5,215)	—
Unamortized bond discount	668	701
Long-term debt, excluding current installments and unamortized bond discount and premium	$ 299,032	733,189

On August 1, 1999, RHC entered into a Master Trust Indenture under which RHC was the only Obligated Group member. RMC, OLR, WH, SFH, Services, Senior Services, Home Care, and the Foundation were named Unlimited Credit Group Participants required to permit RHC to perform all obligations and covenants under the Master Trust Indenture. The Master Trust Indenture was amended and restated as of May 1, 2005, pursuant to the issuance of the Series 2005 bonds and the reissuance of the Variable Rate Demand Bonds (Series 1999A and Series 1999B). RHC, RMC, OLR, WH, SFH, SJH, SMEMC, and WSMC were named Obligated Group Members under the amended and restated Master Trust Indenture. Services, Senior Services, Home Care, and the Foundation were named Unlimited Credit Group Participants required to permit the Obligated Group to perform all obligations and covenants under the amended and restated Master Trust Indenture, and required to pay such amounts as are necessary to make all payments on the Series 1999 and Series 2005 obligations. On June 5, 2008, the Master Trust Indenture was amended and restated pursuant to the issuance of the Series 2008 bonds and the conversion of the Series 2005A and Series 2005B bonds. The purpose of the Master Trust Indenture is to provide a mechanism for the efficient and economical issuance of notes by individual members of the Obligated Group using the collective borrowing capacity and credit rating of the Obligated Group. The Master Trust

Indenture requires the individual members of the Obligated Group to make principal and interest payments on notes issued for their benefit and to pay such amounts as are otherwise necessary to enable the Obligated Group to satisfy all obligations issued under the Master Trust Indenture.

On June 5, 2008, the Illinois Finance Authority issued Variable Rate Revenue Bonds, Series 2008A and Series 2008B (collectively referred to as the Series 2008 bonds), in the aggregate amount of $100,000 on behalf of RHC. The proceeds from the Series 2008 bond issuance were used to advance refund various outstanding debt. The transactions to advance refund and cash defease outstanding debt resulted in a loss of $2,593, which is included with operating expenses in the 2008 consolidated statement of operations. Principal on the bonds is due on May 15, 2029. Interest is payable monthly at variable rates. During 2008, the effective interest rate on the Series 2008 bonds was 1.65%. The Series 2008 bonds were issued pursuant to two separate Bond Trust Indentures, each dated as of June 1, 2008. The Series 2008 bonds are secured by irrevocable transferable direct pay letters of credit issued by commercial banks, which currently expire on June 5, 2009. Holders of the Series 2008 bonds have a put option that allows them to redeem the bonds prior to maturity. The Obligated Group has an agreement with an underwriter to remarket any bonds redeemed through the exercise of put options. Principal on the bonds outstanding at June 30, 2008 has been included in current installments as the letters of credit expire on June 5, 2009.

On May 26, 2005, the Illinois Finance Authority issued Variable Rate Revenue Bonds, Series 2005A, Series 2005B, Series 2005C, and Series 2005D, and on June 16, 2005, the Illinois Finance Authority issued Variable Rate Revenue Bonds, Series 2005E (collectively referred to as the Series 2005 bonds), in the aggregate amount of $350,000 on behalf of RHC. A portion of the proceeds from the Series 2005 bond issuance was used to advance refund various outstanding debt. The remaining proceeds were used to reimburse RHC and Affiliates for prior capital expenditures, to finance future capital expenditures, to provide working capital, and to reimburse RHC for costs of issuance. Principal on the bonds is payable annually commencing on May 14, 2006 through 2035. Interest is payable monthly at variable rates. During 2008 and 2007, the effective interest rate on the Series 2005 bonds was 3.69% and 3.65%, respectively. The Series 2005 bonds were issued pursuant to five separate Bond Trust Indentures, each dated as of May 1, 2005. The Series 2005B and 2005C bonds are secured by direct pay letters of credit issued by commercial banks, which currently expire on May 26, 2009, in amounts equal to the principal amount of the bonds and accrued interest on such principal. The remaining Series 2005 bonds are unsecured. Holders of the Series 2005 bonds have a put option that allows them to redeem the bonds prior to maturity. The Obligated Group has an agreement with an underwriter to remarket any bonds redeemed through the exercise of put options. Principal on the Series 2005B and 2005C bonds outstanding at June 30, 2008 has been included in current installments as the letters of credit expire on May 26, 2009. The Series 2005D and Series 2005E bonds were cash defeased in 2008.

On August 27, 1999, the Illinois Health Facility Authorities issued Variable Rate Demand Revenue Bonds, Series 1999A and Series 1999B, and Periodic Auction Reset Securities, Series 1999C (collectively referred to as the Series 1999 bonds), in the aggregate amount of $380,000 on behalf of RHC. The proceeds were used to advance refund or retire various outstanding debt. The remaining proceeds were deposited into a construction fund to be used to provide for various future capital needs of RHC and Affiliates. Principal on the bonds is payable annually through 2029. Effective May 26, 2005, the Obligated Group reissued $243,800 of Series 1999 bonds. Interest was payable monthly at PARS rates and variable rates. During

2008 and 2007, the effective interest rate on the Series 1999 bonds was 5.16% and 3.68%, respectively. On June 5, 2008, RHC converted the outstanding principal amount of the Series 1999A and Series 1999B bonds from bearing interest at a variable rate to bear interest at a fixed rate. Principal on the Series 1999A and Series 1999B bonds is payable annually commencing on May 14, 2009 through 2029. Interest is payable semi-annually at an effective fixed rate of 5.00% at June 30, 2008. The Series 1999A and Series 1999B bonds were issued pursuant to amended and restated Bond Trust Indentures, each dated as of June 1, 2008. Payment of principal and interest on the Series 1999A and Series 1999B bonds when due is guaranteed under municipal bond insurance policies. The Series 1999C bonds were advance refunded in 2008.

On December 23, 1997, the Illinois Health Facilities Authority on behalf of HFMC issued its Revenue Bonds, Series 1997, in the principal amount of $41,000 pursuant to a loan agreement dated December 1, 1997 between the Illinois Health Facilities Authority and HFMC (Series 1997B). Interest is payable at rates varying between 4.25% and 5.00% in annual installments through 2027. Effective February 6, 2001, HFMC entered into a Reimbursement, Mortgage, and Security Agreement (RHC Reimbursement Agreement) with RHC. The RHC Reimbursement Agreement provides that RHC will guarantee payment to the Bond Insurer of all amounts paid by the Bond Insurer in connection with the Series 1997B bonds under either the Bond Insurance Policy or the Surety Bond, which are not reimbursed to the Bond Insurer by HFMC. In conjunction with the RHC Reimbursement Agreement, HFMC issued its Direct Note Obligation, Series 2001A (Series 2001A), in a principal amount equal to the amount owed under the RHC Reimbursement Agreement, if any. Series 2001A is secured by a mortgage of the land and healthcare facilities of HFMC's main campus located in Des Plaines, Illinois and HFMC's accounts receivable. All intercompany amounts related to the Series 2001A bonds have been eliminated in consolidation.

In October 1999, HFMC entered into a ten-year term loan (Term Loan) in the amount of $10,275. Under the terms of the Term Loan, HFMC pays interest at a fixed rate of 7.75%. Principal installments are due annually in amounts ranging from $227 to $420 through October 2009 with a lump-sum payment of $6,951, due November 2009. The Term Loan is secured by HFMC's medical office building and applicable rental income.

RNH and MLNH have two mortgage loan agreements through the Dormitory Authority of the State of New York. Principal and interest on the first note are payable in fixed monthly amounts of $46 through July 2027. The note bears interest at a fixed annual rate of 7.25% and is secured by certain real estate. Principal and interest on the second note are payable in fixed monthly amounts of $53 through January 2033. The note bears interest at a fixed annual rate of 7.90% and is secured by certain assets of RNH and MLNH.

At June 30, 2008, the fair value of RHC and Affiliates' total long-term debt was approximately $650,117. The fair value of total long-term debt approximated its carrying value at June 30, 2007. Fair value was estimated using quoted market prices based upon the Obligated Group's current borrowing rates for similar types of long-term debt securities.

Under Section 148(f) of the Code, an issuer of tax-exempt bonds is required to rebate to the Internal Revenue Service the excess of investment income earned on all nonpurpose investments made with the gross proceeds of tax-exempt bond issues over the amount, which would have been earned if such

nonpurpose investments had been invested at a rate equal to the interest yield on the related bond issue. The estimated rebate liability of $1,340 and $1,309 at June 30, 2008 and 2007, respectively, related to the Series 2005 bonds is recorded within accounts payable and accrued expenses in the accompanying consolidated statements of financial position.

Scheduled annual principal payments on long-term debt for the ensuing five years are as follows:

Year:	Amount
2009	$ 352,078
2010	20,334
2011	13,882
2012	14,393
2013	14,901

(9) Employees' Retirement Plans

RHC and Affiliates have two cash balance plans (defined benefit plans that operate like defined contribution plans) (Plan A and Plan B) that cover substantially all eligible employees of RHC and Affiliates. Each eligible participant has a benefit account balance, which accrues as a percentage of current year's pay and earns interest at a specified rate.

RHC and Affiliates record pension cost at an amount calculated by an independent consulting actuary. RHC and Affiliates recognize the cost related to employee service using the projected unit credit cost method. Gains and losses, calculated as the difference between estimated and actual amounts of plan assets and the projected benefit obligation, and prior service cost are amortized over the expected future service period.

In September of 2006, the FASB issued SFAS No. 158, *Employers' Accounting for Defined Benefit Pension and Other Postretirement Plans—an amendment of FASB Statements No. 87, 88, 106, and 132(R)*, effective for fiscal years ending after December 31, 2006. SFAS No. 158 requires recognition in the consolidated statement of financial position of the funded status of defined benefit pension plans and other postretirement benefit plans, including all previously unrecognized actuarial gains and losses and unamortized prior service cost, as a component of unrestricted net assets. RHC and Affiliates adopted the provisions of SFAS No. 158 as of June 30, 2007 through a direct addition of unrestricted net assets of $11,312. There was no impact on the consolidated results of operations or cash flows.

The following table sets forth the consolidated funded status, assumptions, and amounts recognized in the accompanying consolidated financial statements as of and for the years ended June 30, 2008 and 2007 for Plans A and B:

		2008	2007
Change in benefit obligation:			
Benefit obligation at beginning of year	$	(276,724)	(257,088)
Service cost		(20,843)	(20,828)
Interest cost		(16,596)	(15,616)
Actuarial gain (loss)		16,418	(1,913)
Benefits paid		22,519	18,721
Benefit obligation at end of year	$	(275,226)	(276,724)
Change in plan assets:			
Fair value of plan assets at beginning of year	$	121,967	96,319
Actual return on plan assets		(4,837)	14,819
Adjustments for transfers		(450)	(450)
Employer contributions		31,000	30,000
Benefits paid		(22,519)	(18,721)
Fair value of plan assets at end of year	$	125,161	121,967
Reconciliation of funded status:			
Funded status	$	(150,065)	(154,757)
Unrecognized actuarial loss		—	—
Unrecognized prior service cost		—	—
Net amount recognized at year-end	$	(150,065)	(154,757)

		2008	2007
Amount recognized in the accompanying consolidated statements of financial position:			
Accrued pension liability	$	(150,065)	(154,757)
Accumulated charge to unrestricted net assets		—	—
Net amount recognized	$	(150,065)	(154,757)
Accumulated benefit obligation	$	(273,374)	(274,317)

		2008	2007
Components of net periodic benefit cost:			
Service cost	$	20,843	20,828
Expense load		450	450
Interest cost		16,596	15,616
Expected return on plan assets		(10,857)	(8,652)
Amortization of unrecognized net loss		1,507	2,460
Amortization of unrecognized prior service cost		(650)	(650)
Net periodic benefit cost	$	27,889	30,052
Other changes in plan assets and benefit obligation recognized in unrestricted net assets:			
Net actuarial gain	$	724	—
Reversal of amortization item:			
Net actuarial gain		1,507	—
Prior service credit		(650)	—
Total recognized in unrestricted net assets	$	1,581	—
Estimated future benefit payments:			
Fiscal year 2009	$	27,762	
Fiscal year 2010		25,523	
Fiscal year 2011		25,104	
Fiscal year 2012		25,200	
Fiscal year 2013 – 2017		179,190	
Expected contribution during fiscal year 2009	$	31,000	
Weighted average assumptions used to determine benefit obligations at June 30:			
Settlement (discount) rate		6.93%	6.26%
Weighted average rate of increase in future compensation levels		4.00	4.00
Weighted average assumptions used to determine net periodic benefit cost for years ended June 30:			
Discount rate		6.26%	6.25%
Expected return on plan assets		8.50	8.50
Rate of compensation increase		4.00	4.00

RHC's overall expected long-term rate of return on assets is 8.5%. The expected long-term rate of return is based on the portfolio as a whole and not on the sum of the returns on individual asset categories. The return is based exclusively on historical returns, without adjustments.

RHC's pension plan weighted average asset allocations at June 30, 2008 and 2007, by asset category, are as follows:

Asset category	Plan assets at June 30	
	2008	2007
Equities	53.6%	75.5%
Fixed income securities	43.0	15.6
Cash and cash equivalents	3.4	8.9

RHC has developed a plan investment policy, which is reviewed and approved by the RHC Finance Committee and the boards of directors. The policy established goals and objectives of the fund, asset allocations, asset classifications, and manager guidelines. The policy reflects a target of up to 60% for equity securities. Investments are managed by independent advisors who are monitored by management and the Finance Committee. RHC monitors the asset allocation and executes required recalibrations of the portfolio allocation on a regular basis in response to fluctuations in market conditions and the overall portfolio composition.

RHC and Affiliates also have a defined contribution money purchase plan (Defined Contribution Plan). RHC and Affiliates contribute 25% of contributions made by employees to their tax deferred account up to a maximum contribution percentage of 1% of the participant's qualified income. RHC and Affiliates' boards of directors have amended Plan A and the Defined Contribution Plan whereby the employer matching contribution of the Defined Contribution Plan is considered a component of Plan A. Accordingly, this employer matching component has been included as a component of the accrued pension liability of Plan A as determined by the professional consulting actuary.

The WSMC retirement program consists of the West Suburban Health Care Retirement Income Plan (Income Plan), a noncontributory defined benefit pension plan, and the West Suburban Health Care Retirement Savings Plan (Savings Plan), a defined contribution pension plan, for which WSMC's employees are eligible. Effective January 1, 2002, the board of directors of WSMC authorized the curtailment of the Income Plan. As a result of this action, participation in the Income Plan is limited to participants entering on or before January 1, 2002, and no new benefits will accrue to participants subsequent to that date.

The Savings Plan became effective on January 1, 2002 and covers employees on the first day of employment after attaining the age of 21. Under the terms of the Savings Plan, employees may contribute up to 40.0% of eligible compensation subject to the Code's salary deferral limitations. WSMC makes matching payments equal to 50.0% of a participant's salary deferral contributions up to the first 3.0%. WSMC also contributes 1.5% of each eligible employee's compensation into the Savings Plan, regardless of whether or not the employee elects to make salary deferrals into the Savings Plan. Participants vest 100.0% in WSMC contributions after one year of service. WSMC funds the Savings Plan on a current basis.

Effective January 1, 2004, participants of the West Suburban Health Care Retirement Income Plan and the West Suburban Health Care Retirement Savings Plan became participants in the RHC and Affiliates cash balance plans.

A summary of the changes in the projected benefit obligation and plan assets and the resulting funded status of the Income Plan is as follows at June 30, 2008 and 2007 (measurement dates):

		2008	2007
Change in projected benefit obligation:			
Projected benefit obligation at beginning of period	$	(56,088)	(58,676)
Interest cost		(3,540)	(3,510)
Actuarial gain		3,262	4,144
Benefits paid		2,061	1,954
Projected benefit obligation at end of period	$	(54,305)	(56,088)
Change in plan assets:			
Fair value of plan assets at beginning of period	$	53,969	43,283
Actual return on plan assets		(2,404)	8,228
Employer contributions		2,760	4,412
Benefits paid		(2,061)	(1,954)
Fair value of plan assets at end of period	$	52,264	53,969
Reconciliation of funded status:			
Funded status	$	(2,041)	(2,119)
Unrecognized net actuarial loss		—	—
Net amount recognized	$	(2,041)	(2,119)

		2008	2007
Accumulated benefit obligation	$	(54,305)	(56,088)
Amount recognized in the accompanying consolidated statements of financial position:			
Accrued pension liability	$	(2,041)	(2,119)
Accumulated charge to unrestricted net assets		—	—
Net amount recognized	$	(2,041)	(2,119)
Components of net periodic benefit cost:			
Interest cost	$	3,540	3,511
Expected return on plan assets		(4,679)	(3,743)
Amortization of unrecognized net loss		83	1,117
Net periodic benefit cost	$	(1,056)	885
Other changes in plan assets and benefit obligation recognized in unrestricted net assets:			
Net actuarial loss	$	(3,820)	—
Reversal of amortization item:			
Net actuarial gain		83	—
Total recognized in unrestricted net assets	$	(3,737)	—
Estimated future benefit payments:			
Fiscal year 2009	$	2,676	
Fiscal year 2010		2,904	
Fiscal year 2011		3,116	
Fiscal year 2012		3,288	
Fiscal years 2013 – 2017		24,273	
Expected contributions during fiscal year 2009:			
Minimum required contribution	$	800	
Weighted average assumptions used to determine benefit obligations:			
Settlement (discount) rate		7.13%	6.43%
Weighted average assumptions used to determine net periodic benefit cost:			
Discount rate		6.43%	6.25%
Expected return on plan assets		8.50%	8.50%

WSMC's overall expected long-term rate of return on assets is 8.5%. The expected long-term rate of return is based on the portfolio as a whole and not on the sum of the returns on individual asset categories. The return is based exclusively on historical returns, without adjustments.

WSMC's pension plan weighted average asset allocations at June 30, 2008 and 2007 by asset category are as follows:

Asset category	Plan assets at June 30 2008	2007
Equities	57.2%	72.4%
Fixed income securities	40.0	26.4
Cash and cash equivalents	2.8	1.2

WSMC has developed a plan investment policy, which is reviewed and approved by the RHC Finance Committee and the boards of directors. The policy established goals and objectives of the fund, asset allocations, asset classifications, and manager guidelines. The policy dictates a specific asset allocation between equity and fixed income securities. Investments are managed by independent advisors who are monitored by management and the Finance Committee. RHC monitors the asset allocation and executes required recalibrations of the portfolio allocation on a regular basis in response to fluctuations in market conditions and the overall portfolio composition.

(10) Self-Insurance

Professional and General Liability

RHC and Affiliates are self-insured for professional and general liability claims up to specified limits arising from incidents occurring after dates of entry into the program, which vary by corporation. Excess insurance coverage was occurrence-based through various dates, at which time all corporations changed to claims made-based coverage. There are no assurances that RHC and Affiliates will be able to renew existing policies or procure coverage on similar terms in the future.

RHC and Affiliates are involved in litigation arising in the ordinary course of business. Claims alleging malpractice have been asserted against RHC and Affiliates and are currently in various stages of litigation. Provisions for professional and general liability claims include the ultimate cost of known claims and claims incurred but not reported as of the respective consolidated statement of financial position dates. It is the opinion of management that the estimated malpractice liabilities accrued at June 30, 2008 and 2007 are adequate to provide for the ultimate cost of potential losses resulting from pending or threatened litigation; however, such estimates may be more or less than the amounts ultimately paid when claims are resolved. Estimated malpractice claims have been discounted at rates of 4% and 5% at June 30, 2008 and 2007, respectively. The accrued liability estimated for self-insured professional and general liability claims amounted to $255,514 and $249,502 at June 30, 2008 and 2007, respectively. All self-insured malpractice and general claim liabilities are reported as long-term liabilities as the portion expected to be paid within one year is not readily determinable.

Workers' Compensation

The Hospitals maintain self-insurance programs for workers' compensation coverage. These programs limit the self-insured retention to specific amounts on a per occurrence basis. Coverage

from commercial insurance carriers is maintained for claims in excess of the self-insured retention. Accrued workers' compensation claims amounted to $5,617 and $5,985 at June 30, 2008 and 2007, respectively. Management believes the estimated self-insured workers' compensation claims liability at June 30, 2008 and 2007 is adequate to cover the ultimate liability; however, such estimates may be more or less than the amounts ultimately paid when claims are resolved. The portion of workers' compensation claims expected to be paid beyond one year of the consolidated statements of financial position dates is not readily determinable, and therefore, the entire accrual is classified as a current liability included within accounts payable and accrued expenses in the accompanying consolidated statements of financial position.

Health Care

RHC and Affiliates also maintain a program of self-insurance for employee health coverage. Stop-loss reinsurance coverage is maintained for claims in excess of stop-loss limits. Accrued self-insured employee health care claims amounted to $4,169 and $4,831 for 2008 and 2007, respectively, and are included with accounts payable and accrued expenses in the accompanying consolidated statements of financial position. It is the opinion of management that the estimated health care costs accrued at June 30, 2008 and 2007 are adequate to provide for the ultimate liability; however, final payouts as claims are paid may vary significantly from estimated claim liabilities.

(11) Contingencies

Medicare Reimbursement

For the year ended June 30, 2008, RHC and Affiliates recognized approximately $608,087 of net service revenue from services provided to Medicare beneficiaries. Recent federal legislation has included provisions to reduce Medicare payments to health care providers as well as phase out cost based reimbursement mechanisms to prospective payment methodologies. Changes in Medicare reimbursement as a result of the Health Care Financing Administration's implementation of the provisions of recent Medicare legislation may have an adverse effect on RHC and Affiliates' net service revenues.

Litigation

RHC and Affiliates are involved in litigation and regulatory investigations arising in the normal course of business. In consultation with legal counsel, management estimates that these matters will be resolved without material adverse effect on RHC and Affiliates' consolidated financial position or results from operations.

Regulatory Investigations

The U.S. Department of Justice and other federal agencies routinely conduct regulatory investigations and compliance audits of health care providers. RHC and Affiliates are subject to these regulatory efforts. Management is currently unaware of any regulatory matters, which may have a material adverse effect on RHC and Affiliates' consolidated financial position or results of operations.

(12) Asbestos Removal Costs

In March 2005, the FASB issued Interpretation No. 47, *Accounting for Conditional Asset Retirement Obligations* (FIN 47). FIN 47 requires the current recognition of a liability when a legal obligation exists to perform an asset retirement obligation (ARO) in which the timing or method of settlement are conditional on a future event that may or may not be under the control of the entity. FIN 47 requires an ARO liability be recorded at its net present value with recognition of a related long-lived asset in a corresponding amount. The ARO liability is accreted through periodic charges to depreciation expense. The initially capitalized ARO long-lived asset is depreciated over the corresponding long-lived asset's remaining useful life. RHC and Affiliates adopted FIN 47 effective as of June 30, 2006.

RHC and Affiliates are legally liable to remove asbestos from existing buildings prior to future remodeling or demolishing of the existing buildings. The estimated asbestos removal cost at June 30, 2008 and 2007 was $13,158 and $13,418, respectively. The net book value of the ARO long-lived asset at June 30, 2008 and 2007 was $0.

(13) Risks and Uncertainties

RHC and Affiliates invest in various investment securities. Investment securities are exposed to various risks such as interest rate, credit, and overall market volatility risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect the amounts reported in the accompanying consolidated statements of financial position.

Schedule 1

RESURRECTION HEALTH CARE AND AFFILIATES

Consolidating Schedule – Financial Position Information

June 30, 2008

(In thousands)

Assets	Resurrection Health Care	Resurrection Medical Center	Saint Francis Hospital	Our Lady of the Resurrection Medical Center	Westlake Hospital	Saints Mary and Elizabeth Medical Center	Holy Family Medical Center	Saint Joseph Hospital
Current assets:								
Cash and cash equivalents	$ 95	—	2,141	—	621	3,269	—	1,040
Assets whose use is limited or restricted – required for current liabilities	157,239	85,448	47,851	—	—	—	—	—
Patient and resident accounts receivable, net of allowance for uncollectible accounts of $106,382	—	40,914	20,186	19,660	11,585	28,986	21,485	19,748
Other receivables	2,559	1,360	791	220	2,675	1,007	16	1,550
Inventory of supplies	—	2,767	1,249	990	541	3,543	1,092	3,854
Estimated receivables under third-party reimbursement programs	—	—	—	—	526	—	—	—
Prepaid expenses and other current assets	16,506	7,711	306	495	116	33	281	432
Due from affiliates	76,834	319,385	10,050	3,059	—	—	—	—
Total current assets	253,233	457,585	82,574	24,424	16,064	36,838	22,874	26,624
Assets whose use is limited or restricted:								
By Boards for reinvestment and self-insurance	155,211	88,524	53,225	31,856	—	47,060	1,152	—
Under bond indenture agreements – held by trustee	4,476	—	—	—	—	—	1,204	—
By donors – permanently restricted	—	—	—	—	—	—	—	—
	159,687	88,524	53,225	31,856	—	47,060	2,356	—
Land, buildings, and equipment, net	161,148	23,732	80,514	35,288	22,325	96,266	32,939	77,168
Deferred finance charges	8,693	—	—	—	—	—	1,184	—
Other assets	30,887	1,538	—	—	—	798	—	—
	$ 613,648	571,379	216,313	91,568	38,389	180,962	59,353	103,792

(Continued)

ATTACHMENT 75

Schedule 1

RESURRECTION HEALTH CARE AND AFFILIATES

Consolidating Schedule – Financial Position Information

June 30, 2008

(In thousands)

Assets	West Suburban Medical Center	Resurrection Senior Services	Resurrection Services	Resurrection Behavioral Health	Resurrection Home Health Services	Resurrection Development Foundation	Resurrection Health Care Preferred	Eliminations	Consolidated
Current assets:									
Cash and cash equivalents	$ —	8,315	674	1,189	66	2,146	3,297	—	22,853
Assets whose use is limited or restricted – required for current liabilities	2,781	61,521	—	—	—	—	—	—	354,840
Patient and resident accounts receivable, net of allowance for uncollectible accounts of $106,382	25,447	13,484	10,102	1,286	2,106	—	—	—	214,989
Other receivables	3,831	1,076	2,153	—	15	6,158	—	—	23,411
Inventory of supplies	1,524	496	1,149	—	—	—	—	—	17,205
Estimated receivables under third-party reimbursement programs	—	—	—	—	—	—	—	—	526
Prepaid expenses and other current assets	609	458	563	29	—	614	419	—	28,572
Due from affiliates	—	—	—	—	—	436	—	(409,764)	—
Total current assets	34,192	85,350	14,641	2,504	2,187	9,354	3,716	(409,764)	662,396
Assets whose use is limited or restricted:									
By Boards for reinvestment and self-insurance	82	61,205	819	—	—	19,851	—	—	458,985
Under bond indenture agreements – held by trustee	—	—	—	—	—	—	—	—	5,680
By donors – permanently restricted	—	—	—	—	—	14,492	—	—	14,492
	82	61,205	819	—	—	34,343	—	—	479,157
Land, buildings, and equipment, net	64,462	122,623	105,650	3,296	267	188	50	—	825,916
Deferred finance charges	—	—	—	—	—	—	—	—	9,877
Other assets	595	302	4,804	—	2,254	—	—	(28,026)	13,152
	$ 99,331	269,480	125,914	5,800	4,708	43,885	3,766	(437,790)	1,990,498

(Continued)

ATTACHMENT 75

Schedule 1

RESURRECTION HEALTH CARE AND AFFILIATES

Consolidating Schedule – Financial Position Information

June 30, 2008

(In thousands)

Liabilities and Net Assets	Resurrection Health Care	Resurrection Medical Center	Saint Francis Hospital	Our Lady of the Resurrection Medical Center	Westlake Hospital	Saints Mary and Elizabeth Medical Center	Holy Family Medical Center	Saint Joseph Hospital
Current liabilities:								
Current installments of long-term debt	$ 350,390	—	—	—	—	—	1,449	—
Accounts payable and accrued expenses	21,086	30,054	2,845	2,600	1,347	4,789	2,010	1,592
Accrued payroll and fringe benefits	—	67,746	23	—	—	164	—	1,052
Estimated payables under third-party reimbursement programs	—	18,285	9,106	5,117	—	9,567	12,827	27,807
Deferred revenue and refundable deposits	—	—	—	—	—	—	—	—
Due to affiliates	—	—	—	—	28,277	14,518	42,902	27,060
Total current liabilities	371,476	116,085	11,974	7,717	29,624	29,038	59,188	57,511
Long-term debt, excluding current installments and unamortized bond discount	247,745	—	—	—	28,026	—	38,754	—
Accrued pension liability	—	152,106	—	—	—	—	—	—
Estimated self-insured professional and general liability claims	—	42,848	56,717	11,305	34,724	40,700	7,003	18,880
Asset retirement obligation	13,158	—	—	—	—	—	—	—
Total liabilities	632,379	311,039	68,691	19,022	92,374	69,738	104,945	76,391
Net assets (liabilities):								
Unrestricted	(18,731)	260,340	147,622	72,546	(53,985)	111,150	(45,592)	27,401
Temporarily restricted	—	—	—	—	—	74	—	—
Permanently restricted	—	—	—	—	—	—	—	—
Total net assets (liabilities)	(18,731)	260,340	147,622	72,546	(53,985)	111,224	(45,592)	27,401
	$ 613,648	571,379	216,313	91,568	38,389	180,962	59,353	103,792

(Continued)

Schedule 1

RESURRECTION HEALTH CARE AND AFFILIATES

Consolidating Schedule – Financial Position Information

June 30, 2008

(In thousands)

Liabilities and Net Assets	West Suburban Medical Center	Resurrection Senior Services	Resurrection Services	Resurrection Behavioral Health	Resurrection Home Health Services	Resurrection Development Foundation	Resurrection Health Care Preferred	Eliminations	Consolidated
Current liabilities:									
Current installments of long-term debt	$ —	239	—	—	—	—	—	—	352,078
Accounts payable and accrued expenses	9,291	5,916	8,470	266	351	280	5,702	—	96,599
Accrued payroll and fringe benefits	—	—	—	—	—	—	—	—	68,985
Estimated payables under third-party reimbursement programs	3,948	2,768	—	—	—	—	—	—	89,425
Deferred revenue and refundable deposits	—	44,474	—	109	—	—	—	—	44,583
Due to affiliates	99,431	59,580	121,239	3,953	11,872	—	932	(409,764)	—
Total current liabilities	112,670	112,977	129,709	4,328	12,223	280	6,634	(409,764)	651,670
Long-term debt, excluding current installments and unamortized bond discount	—	12,533	—	—	—	—	—	(28,026)	299,032
Accrued pension liability	—	—	—	—	—	—	—	—	152,106
Estimated self-insured professional and general liability claims	43,337	—	—	—	—	—	—	—	255,514
Asset retirement obligation	—	—	—	—	—	—	—	—	13,158
Total liabilities	156,007	125,510	129,709	4,328	12,223	280	6,634	(437,790)	1,371,480
Net assets (liabilities):									
Unrestricted	(56,688)	143,970	(3,795)	1,472	(7,515)	10,980	(2,868)	—	586,307
Temporarily restricted	12	—	—	—	—	18,133	—	—	18,219
Permanently restricted	—	—	—	—	—	14,492	—	—	14,492
Total net assets (liabilities)	(56,676)	143,970	(3,795)	1,472	(7,515)	43,605	(2,868)	—	619,018
	$ 99,331	269,480	125,914	5,800	4,708	43,885	3,766	(437,790)	1,990,498

See accompanying independent auditors' report.

ATTACHMENT 75

Schedule 2

RESURRECTION HEALTH CARE AND AFFILIATES

Consolidating Schedule – Operations and Changes in Unrestricted Net Assets Information

Year ended June 30, 2008

(In thousands)

	Resurrection Health Care	Resurrection Medical Center	Saint Francis Hospital	Our Lady of the Resurrection Medical Center	Westlake Hospital	Saints Mary and Elizabeth Medical Center	Holy Family Medical Center	Saint Joseph Hospital
Net service revenue	$ —	294,436	182,394	136,091	101,845	283,267	64,934	182,459
Other revenue:								
Auxiliary services	734	4,197	3,251	1,113	2,202	4,332	1,070	2,886
Services provided to affiliates	160,819	—	—	—	—	—	—	—
Net assets released from restrictions for operations	8	295	317	235	688	41	14	163
Total revenue	161,561	298,928	185,962	137,439	104,735	287,640	66,018	185,508
Expenses:								
Salaries and wages	79,445	101,402	49,698	44,728	36,394	92,362	26,740	65,706
Payroll taxes and fringe benefits	20,646	28,023	13,560	11,748	9,710	24,129	6,918	18,750
Physicians' fees	930	15,804	11,058	5,437	9,674	9,799	1,551	13,766
Supplies	291	51,470	18,813	15,651	11,629	32,110	6,252	21,762
Other	45,643	28,148	11,802	9,409	4,535	9,981	6,135	14,967
Management services	—	27,095	19,833	15,136	12,009	30,058	3,906	18,473
Purchased services	9,204	4,803	4,262	2,341	5,435	16,076	1,766	8,329
Insurance	59	5,505	22,578	(343)	12,981	3,652	335	(327)
Depreciation and amortization	15,691	5,576	10,139	4,994	4,734	8,437	4,453	7,336
Provision for uncollectible accounts receivable	—	21,187	24,998	29,182	11,871	38,648	4,880	8,271
Interest	—	—	—	—	—	—	1,702	—
Loss on early extinguishment of long-term debt	2,593	—	—	—	—	—	—	—
Assessments and taxes	—	7,613	5,138	4,238	3,319	9,450	2,299	6,987
Total expenses, before impairment costs	174,502	296,626	191,879	142,521	122,291	274,702	66,937	184,020
Income (loss) before impairment costs	(12,941)	2,302	(5,917)	(5,082)	(17,556)	12,938	(919)	1,488
Impairment costs	—	—	—	—	17,942	—	—	—
Income (loss) from operations	(12,941)	2,302	(5,917)	(5,082)	(35,498)	12,938	(919)	1,488
Nonoperating gains (losses):								
Investment income (loss) and other, net	(38,961)	15,785	5,071	2,291	62	4,047	3	50
Unrestricted contributions	—	—	—	—	—	—	—	—
Net nonoperating gains (losses)	(38,961)	15,785	5,071	2,291	62	4,047	3	50
Revenue and gains in excess (deficient) of expenses and losses	(51,902)	18,087	(846)	(2,791)	(35,436)	16,985	(916)	1,538
Other changes in unrestricted net assets:								
Net assets released from restrictions for purchases of land, building, and equipment	—	92	2,054	48	1,006	63	566	248
Net reclassification of net assets based on donor intent	—	—	—	—	—	—	—	—
Recognition of change in pension funded status	—	(2,156)	—	—	—	—	—	—
Increase (decrease) in unrestricted net assets	$ (51,902)	16,023	1,208	(2,743)	(34,430)	17,048	(350)	1,786

(Continued)

ATTACHMENT 75

Schedule 2

RESURRECTION HEALTH CARE AND AFFILIATES

Consolidating Schedule – Operations and Changes in Unrestricted Net Assets Information

Year ended June 30, 2008

(In thousands)

	West Suburban Medical Center	Resurrection Senior Services	Resurrection Services	Resurrection Behavioral Health	Resurrection Home Health Services	Resurrection Development Foundation	Resurrection Health Care Preferred	Eliminations	Consolidated
Net service revenue	$ 165,528	123,590	34,718	—	14,320	—	—	—	1,583,582
Other revenue:									
Auxiliary services	6,713	2,047	23,518	18,837	37	—	43,260	(12,481)	101,716
Services provided to affiliates	—	9,325	—	—	—	—	—	(170,144)	—
Net assets released from restrictions for operations	14	147	234	242	—	—	—	—	2,398
Total revenue	172,255	135,109	58,470	19,079	14,357	—	43,260	(182,625)	1,687,696
Expenses:									
Salaries and wages	58,095	56,359	11,998	9,144	8,308	2,448	2,480	—	645,307
Payroll taxes and fringe benefits	15,281	18,816	4,605	2,873	1,789	360	575	—	177,783
Physicians' fees	10,667	370	7,108	2,204	—	—	216	—	88,584
Supplies	19,757	19,681	12,078	423	770	4	136	(6,978)	203,849
Other	14,757	16,799	19,229	2,231	849	429	41,803	(17,188)	209,529
Management services	15,746	7,523	1,852	897	2,438	44	—	(155,010)	—
Purchased services	9,078	2,149	3,029	1,280	143	435	186	(3,449)	65,067
Insurance	3,580	1,200	(2,093)	112	315	2	—	—	47,556
Depreciation and amortization	9,162	7,321	8,133	291	151	14	36	—	86,468
Provision for uncollectible accounts receivable	21,420	3,700	—	—	—	—	—	—	164,157
Interest	—	939	609	—	—	—	—	—	3,250
Loss on early extinguishment of long-term debt	—	—	—	—	—	—	—	—	2,593
Assessments and taxes	8,237	1,782	—	—	—	—	—	—	49,063
Total expenses, before impairment costs	185,780	136,639	66,548	19,455	14,763	3,736	45,432	(182,625)	1,743,206
Income (loss) before impairment costs	(13,525)	(1,550)	(8,078)	(376)	(406)	(3,736)	(2,172)	—	(55,510)
Impairment costs	—	—	—	—	—	—	—	—	17,942
Income (loss) from operations	(13,525)	(1,530)	(8,078)	(376)	(406)	(3,736)	(2,172)	—	(73,452)
Nonoperating gains (losses):									
Investment income (loss) and other, net	430	6,239	2,178	(18)	318	1,071	140	—	(1,294)
Unrestricted contributions	—	—	—	—	—	1,724	—	—	1,724
Net nonoperating gains (losses)	430	6,239	2,178	(18)	318	2,795	140	—	430
Revenue and gains in excess (deficient) of expenses and losses	(13,095)	4,709	(5,900)	(394)	(88)	(941)	(2,032)	—	(73,022)
Other changes in unrestricted net assets:									
Net assets released from restrictions for purchases of land, building, and equipment	128	442	—	—	—	—	—	—	4,647
Net reclassification of net assets based on donor intent	—	—	—	—	—	(91)	—	—	(91)
Recognition of change in pension funded status	—	—	—	—	—	—	—	—	(2,156)
Increase (decrease) in unrestricted net assets	$ (12,967)	5,151	(5,900)	(394)	(88)	(1,032)	(2,032)	—	(70,622)

See accompanying independent auditors' report.

ATTACHMENT 75

RESURRECTION HEALTH CARE AND AFFILIATES

Consolidated Financial Statements and Schedules

June 30, 2007 and 2006

(With Independent Auditors' Report Thereon)

ATTACHMENT 75

KPMG LLP
303 East Wacker Drive
Chicago, IL 60601-5212

Independent Auditors' Report

Boards of Directors
Resurrection Health Care and Affiliates:

We have audited the accompanying consolidated statements of financial position of Resurrection Health Care and affiliates as of June 30, 2007 and 2006, and the related consolidated statements of operations, changes in net assets, and cash flows for the years then ended. These consolidated financial statements are the responsibility of Resurrection Health Care and affiliates' management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. Our audits included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Resurrection Health Care and affiliates' internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Resurrection Health Care and affiliates as of June 30, 2007 and 2006, and the results of their operations, changes in net assets, and cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

As discussed in note 9 to the consolidated financial statements, Resurrection Health Care and affiliates adopted the provisions of Financial Accounting Standards Board (FASB) Statement of Financial Accounting Standards (SFAS) No. 158, *Employers' Accounting for Defined Benefit Pension and Other Postretirement Plans—an Amendment of FASB Statements No. 87, 88, 106, and 132(R)*, in 2007.

As discussed in note 12 to the consolidated financial statements, Resurrection Health Care and affiliates adopted the provisions of FASB Interpretation No. 47, *Accounting for Conditional Asset Retirement Obligations*, in 2006.

KPMG

Our audits were made for the purpose of forming an opinion on the consolidated financial statements taken as a whole. The consolidating information in schedules 1 and 2 is presented for purposes of additional analysis of the 2007 consolidated financial statements rather than to present the financial position and results of operations of the individual organizations. The consolidating information has been subjected to the auditing procedures applied in the audit of the 2007 consolidated financial statements and, in our opinion, is fairly stated in all material respects in relation to the 2007 consolidated financial statements taken as a whole.

KPMG LLP

November 12, 2007

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RESURRECTION HEALTH CARE AND AFFILIATES

Consolidated Statements of Financial Position

June 30, 2007 and 2006

(In thousands)

Assets		2007	2006
Current assets:			
Cash and cash equivalents	$	32,893	22,672
Assets whose use is limited or restricted – required for current liabilities		19,875	21,829
Patient and resident accounts receivable, net of allowance for uncollectible accounts of $89,568 in 2007 and $80,818 in 2006		207,031	205,097
Other receivables		102,040	24,339
Inventory of supplies		15,876	16,531
Prepaid expenses and other current assets		32,938	32,375
Total current assets		410,653	322,843
Assets whose use is limited or restricted:			
By Boards for reinvestment and self-insurance		932,693	885,028
Under bond indenture agreements – held by trustee		7,008	128,695
By donors – permanently restricted		14,050	11,512
		953,751	1,025,235
Land, buildings, and equipment, net		804,375	744,493
Deferred finance charges		10,768	11,163
Other assets		13,369	13,849
	$	2,192,916	2,117,583

See accompanying notes to consolidated financial statements.

Liabilities and Net Assets	2007	2006
Current liabilities:		
Current installments of long-term debt	$ 15,520	14,934
Accounts payable and accrued expenses	119,890	82,629
Accrued payroll and fringe benefits	63,716	66,088
Estimated payables under third-party reimbursement programs	104,500	108,707
Deferred revenue and refundable deposits	46,026	46,297
Total current liabilities	349,652	318,655
Long-term debt, excluding current installments and unamortized bond discount	733,189	748,728
Accrued pension liability	156,876	172,993
Estimated self-insured professional and general liability claims	249,502	242,309
Asset retirement obligation	13,418	14,121
Other	1,334	4,573
Total liabilities	1,503,971	1,501,379
Net assets:		
Unrestricted	656,929	586,783
Temporarily restricted	17,966	17,909
Permanently restricted	14,050	11,512
Total net assets	688,945	616,204
	$ 2,192,916	2,117,583

ATTACHMENT 75

RESURRECTION HEALTH CARE AND AFFILIATES

Consolidated Statements of Operations

Years ended June 30, 2007 and 2006

(In thousands)

	2007	2006
Net service revenue	$ 1,606,564	1,437,808
Other revenue:		
Auxiliary services	60,959	55,522
Net assets released from restrictions for operations	2,276	2,780
Total revenue	1,669,799	1,496,110
Expenses:		
Salaries and wages	615,627	602,093
Payroll taxes and fringe benefits	176,990	172,858
Physicians' fees	82,540	79,388
Supplies	206,099	198,276
Other	155,636	152,679
Purchased services	55,818	52,960
Insurance	37,497	66,270
Depreciation and amortization	81,210	78,390
Provision for uncollectible accounts receivable	154,963	166,185
Interest	3,404	3,527
Assessments and taxes	95,938	1,411
Total expenses	1,665,722	1,574,037
Income (loss) from operations	4,077	(77,927)
Nonoperating gains and losses:		
Investment income and other, net	36,856	26,183
Unrestricted contributions	1,429	2,474
Net nonoperating gains	38,285	28,657
Revenue and gains in excess (deficient) of expenses and losses	42,362	(49,270)
Other changes in unrestricted net assets:		
Net assets released from restrictions for purchase of land, buildings, and equipment	4,575	3,123
Change in minimum pension liability	—	21,795
Transfers from temporarily restricted net assets	—	123
Change in net unrealized gains and losses on other than trading securities	21,902	(39,785)
Designation of investments as trading	(10,005)	—
Cumulative effect of changes in accounting principles	11,312	(14,121)
Increase (decrease) in unrestricted net assets	$ 70,146	(78,135)

See accompanying notes to consolidated financial statements.

RESURRECTION HEALTH CARE AND AFFILIATES

Consolidated Statements of Changes in Net Assets

Years ended June 30, 2007 and 2006

(In thousands)

	2007	2006
Unrestricted net assets:		
Revenue and gains in excess (deficient) of expenses and losses	$ 42,362	(49,270)
Net assets released from restrictions for purchase of land, buildings, and equipment	4,575	3,123
Change in minimum pension liability	—	21,795
Transfers from temporarily restricted net assets	—	123
Change in net unrealized gains and losses on other than trading securities	21,902	(39,785)
Designation of investments as trading	(10,005)	—
Cumulative effect of changes in accounting principles	11,312	(14,121)
Increase (decrease) in unrestricted net assets	70,146	(78,135)
Temporarily restricted net assets:		
Pledges and contributions	5,830	5,567
Investment income	319	207
Net realized and unrealized gains and losses on temporarily restricted net assets	759	23
Transfers to unrestricted net assets	—	(123)
Net assets released from restrictions for purchase of land, building, and equipment	(4,575)	(3,123)
Net assets released from restrictions for operations	(2,276)	(2,780)
Increase (decrease) in temporarily restricted net assets	57	(229)
Permanently restricted net assets:		
Contributions	2,538	445
Increase in permanently restricted net assets	2,538	445
Change in net assets	72,741	(77,919)
Net assets at beginning of year	616,204	694,123
Net assets at end of year	$ 688,945	616,204

See accompanying notes to consolidated financial statements.

RESURRECTION HEALTH CARE AND AFFILIATES

Consolidated Statements of Cash Flows

Years ended June 30, 2007 and 2006

(In thousands)

	2007	2006
Cash flows from operating activities:		
Change in net assets	$ 72,741	(77,919)
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Cumulative effect of changes in accounting principles	(11,312)	14,121
Depreciation and amortization	81,210	78,390
Provision for uncollectible accounts receivable	154,963	166,185
Amortization of deferred occupancy and care revenue	(292)	(186)
Change in minimum pension liability	—	(21,795)
Change in net unrealized gains and losses on other than trading securities	(21,902)	39,762
Designation of investments as trading	10,005	—
Permanently restricted contributions	(2,538)	(445)
Changes in assets and liabilities:		
Patient and resident accounts receivable	(156,897)	(148,181)
Other assets	(77,129)	5,876
Accounts payable and accrued expenses and other liabilities	30,947	(1,726)
Estimated payables under third-party reimbursement programs, net	(4,207)	5,464
Accrued pension	(16,117)	30,550
Estimated self-insured professional, general, and workers' compensation liability claims	7,193	23,133
Net cash provided by operating activities	66,665	113,229
Cash flows from investing activities:		
Acquisition of land, buildings, and equipment, net	(141,092)	(114,087)
Gross purchases of securities	(979,143)	(956,161)
Gross sales or maturities of securities	1,075,188	946,780
Net cash used in investing activities	(45,047)	(123,468)
Cash flows from financing activities:		
Repayments of long-term debt	(14,953)	(14,785)
Net proceeds of entrance fees and membership deposits	1,018	375
Permanently restricted contributions	2,538	445
Net cash used in financing activities	(11,397)	(13,965)
Net increase (decrease) in cash and cash equivalents	10,221	(24,204)
Cash and cash equivalents at beginning of year	22,672	46,876
Cash and cash equivalents at end of year	$ 32,893	22,672
Supplemental disclosure of cash flow information:		
Cash paid for interest, net of amounts capitalized	$ 23,525	24,860

See accompanying notes to consolidated financial statements.

(1) Organization and Operations

Resurrection Health Care (RHC), a not-for-profit tax-exempt corporation, was incorporated for charitable, educational, and scientific purposes to support health and human services by providing management assistance and in all other relevant ways. The accompanying consolidated financial statements include the accounts of RHC and the following affiliates (collectively RHC and Affiliates) for which it serves as the parent corporation through ownership, sole member powers, the authority to approve Board membership, or the holding of certain reserve powers:

- Resurrection Medical Center (RMC), a not-for-profit acute care hospital providing various inpatient and outpatient services and programs.
- Saint Francis Hospital (SFH), a not-for-profit acute care hospital providing various inpatient and outpatient services and programs.
- Our Lady of the Resurrection Medical Center (OLR), a not-for-profit acute care hospital providing various inpatient and outpatient services and programs.
- Westlake Hospital (WH), a not-for-profit acute care hospital providing various inpatient and outpatient services and programs.
- Saints Mary and Elizabeth Medical Center (SMEMC), not-for-profit acute care facilities providing various inpatient and outpatient services and programs.
- Holy Family Medical Center (HFMC), a not-for-profit acute care hospital provided various inpatient and outpatient services and programs through August 2005. Effective September 2005, HFMC converted to a long-term acute care hospital providing various services and programs to patients in between acute care and skilled nursing.
- Saint Joseph Hospital (SJH), a not-for-profit acute care hospital providing various inpatient and outpatient services and programs.
- West Suburban Medical Center (WSMC), a not-for-profit acute care hospital providing various inpatient and outpatient services and programs.
- Resurrection Senior Services (Senior Services), which encompasses the following: Resurrection Nursing and Rehabilitation Center (RNRC), Resurrection Retirement Community (RRC), Resurrection Life Center (RLC), St. Francis Nursing and Rehabilitation Center (SFNR), Scalabrini Life Center (SLC), Bethlehem Woods Retirement Community (BWRC), Casa San Carlo Retirement Community (CSCRC), St. Benedict Nursing and Rehabilitation Center (SBNRC), Villa Scalabrini Nursing and Rehabilitation Center (VSNRC), Maryhaven Nursing and Rehabilitation Center (MNRC), St. Andrew Life Center (SALC), Holy Family Nursing and Rehabilitation Center (HFNRC), Resurrection Nursing Home (RNH), and Mt. Loretto Nursing Home (MLNH), provide various independent living and nursing services and programs. SLC closed in January 2006.
- Resurrection Services (Services), which encompasses the following corporations and/or operating divisions: Resurrection Ambulatory Care Services (RACS), Resurrection Properties (RP), Resurrection Pharmacies, and Resurrection Medical Network.

- Resurrection Behavioral Health (RBH), a not-for-profit corporation established to provide behavioral health services.
- Resurrection Home Health Services (Home Care), a not-for-profit corporation established to provide home care services. Home Care also includes RHC's membership interest in Rainbow Hospice.
- Resurrection Development Foundation (Foundation), a not-for-profit corporation established to coordinate fund-raising activities that support the benevolent care and other programs at RHC and Affiliates.

The above listed entities are not-for-profit corporations as described in Section 501(c)(3) of the Internal Revenue Code (Code) and are exempt from federal income taxes on related income pursuant to Section 501(a) of the Code.

(2) Summary of Significant Accounting Policies

Significant accounting policies of RHC and Affiliates are as follows:

- The preparation of financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosures of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenue and expenses during the reporting periods. Actual results could differ from those estimates.
- Cash and cash equivalents include demand deposits and investments in highly liquid debt instruments with maturities of three months or less, excluding amounts classified as assets whose use is limited or restricted.
- Inventory of supplies is stated at lower of cost (first-in, first-out method) or market.
- Assets whose use is limited or restricted include: assets set aside by the boards of directors for reinvestment and self-insurance purposes, over which the boards retain control and may at their discretion use for other purposes, assets held by a trustee under bond indenture agreements, and funds restricted by donors.
- Except as otherwise noted, the carrying value of all financial instruments approximates their fair values.
- Land, buildings, and equipment are stated at cost, or if donated, at fair value at date of donation. Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed on the straight-line method.
- Deferred finance charges and bond discount are amortized on the straight-line basis over the period the related obligations are outstanding.
- Deferred revenue and refundable deposits represent various types of entrance and membership fees. RRC resident membership deposits are fully refundable, net of applicable processing fees, to the resident upon termination of the lease agreement between RRC and the resident, with any interest earned on such deposits accruing to RRC. BWRC and CSCRC offer a variety of partially refundable

entrance fees. These entrance payments are included with deferred revenue and refundable deposits in the accompanying consolidated statements of financial position. Total deferred entrance payments subject to refund at June 30, 2007 and 2006 approximated $43,593 and $43,661, respectively.

- Unconditional promises to give cash or other assets are reported at fair value at the date the promise is received. All contributions are considered to be available for unrestricted use unless specifically restricted by donors. Contributions are reported as direct additions to temporarily restricted net assets if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or a purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the consolidated statements of operations as net assets released from restrictions. Gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

- Temporarily restricted net assets are those assets whose use has been limited by donors to a specific time period or purpose. Temporarily restricted net assets principally represent amounts restricted for the purpose of acquiring long-lived assets or for specific operating purposes.

- Permanently restricted net assets represent donor-restricted contributions, the principal amount of which may not be expended. Amounts reported as permanently restricted net assets represent the cumulative amount of contributions received, including investment return earned thereon, for an endowment fund. Investment return currently earned on permanently restricted investments is reported as nonoperating investment income.

- Net service revenue is reported at the estimated net realizable amounts from patients and residents, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Those adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined.

- The consolidated statements of operations include revenue and gains in excess (deficient) of expenses and losses. Transactions deemed by management to be ongoing, major, or central to the provision of health and residential care services are reported as revenue and expenses. Transactions incidental to the provision of health and residential care services are reported as gains and losses. Changes in unrestricted net assets, which are excluded from revenue and gains in excess (deficient) of expenses and losses, consistent with industry practice, include changes in net unrealized gains and losses on investments other than trading securities, designation of investments as trading, contributions of long-lived assets (including assets acquired using contributions, which by donor restriction were to be used for the purposes of acquiring such assets), changes in the minimum pension liability, permanent transfers of assets to and from affiliates for other than goods and services, and cumulative effects of changes in accounting principles. During 2006, donors modified their intentions for $123 of unrestricted net assets whereby the amounts were reclassified from temporarily restricted net assets.

- Investment income or loss (including realized gains and losses on investments, changes in unrealized gains and losses on trading securities, interest, dividends, and other-than-temporary declines in investments) is included in revenue and gains in excess (deficient) of expenses and losses unless the income or loss is restricted by donors, in which case the investment income is recorded directly to temporarily or permanently restricted net assets. Unrealized gains and losses on investments are excluded from revenue and gains in excess (deficient) of expenses and losses unless the investments are classified by management as trading securities. Effective June 30, 2007, management redesignated all investments to be trading securities. As a result of such redesignation, the net unrealized gain on the investment portfolio of $10,005 at June 30, 2007 was reclassified from unrestricted net assets to investment income and other in the accompanying 2007 consolidated statement of operations. Unrealized gains and losses of temporarily and permanently restricted investments are recorded directly to temporarily and permanently restricted net assets. Other-than-temporary declines in investments are considered to be realized losses. All interest expense, letter of credit fees, and rebate expense (note 8) on the Series 1999 and Series 2005 revenue bonds ($29,017 in 2007 and $26,684 in 2006) are netted against nonoperating investment income in the accompanying consolidated statements of operations.
- RHC and Affiliates incur expenses for the provision of health and residential care services and related general and administrative activities.
- All significant intercompany balances and transactions have been eliminated in the preparation of the accompanying consolidated financial statements.
- Certain 2006 amounts have been reclassified to conform to the 2007 consolidated financial statement presentation.

Other significant accounting policies are set forth in the consolidated financial statements and in the following notes.

(3) Third-Party Reimbursement Programs

RHC and Affiliates have agreements with third-party payors, which provide for reimbursement at amounts different from their established rates. Contractual adjustments under third-party reimbursement programs principally represent the difference between the billings at list price and the amounts reimbursed by Blue Cross and certain other contracted third-party payors; the difference between the billings at list price and the allocated cost of services provided to Medicare and Medicaid patients; and any differences between estimated third-party reimbursement settlements for prior years and subsequent final settlements. A summary of the reimbursement methodologies with major third-party payors follows:

Medicare

RMC, OLR, SFH, WH, SMEMC, HFMC, SJH, and WSMC (collectively known as the Hospitals) and Senior Services are paid for inpatient acute care services, long-term care services, outpatient services, rehabilitation services, and home health services rendered to Medicare program beneficiaries under prospective reimbursement rates. These rates vary according to patient classification systems that are based on clinical, diagnostic, and other factors. The prospectively

determined rates are not subject to retroactive adjustment. The Hospitals' classification of patients under the Medicare prospective payment systems and the appropriateness of the patients' admissions are subject to validation reviews.

For services rendered to Medicare beneficiaries for psychiatric services, rehabilitation services, and defined "pass-through" costs (i.e., medical education related costs), the Hospitals are reimbursed based upon cost reimbursement methodologies. The Hospitals are reimbursed at tentative rates with final settlement determined after submission of annual cost reports by the Hospitals and audits thereof by the Medicare fiscal intermediary. The Medicare cost reports have been audited and settled by the Medicare fiscal intermediary through 2004 for SFH and WSMC; through 2005 for WH, OLR, RMC, SMEMC, and SJH; and through 2006 for HFMC.

Medicaid

Under the State of Illinois' (the State) Medicaid reimbursement system, the Hospitals are paid for inpatient acute care services rendered to Medicaid program beneficiaries under prospectively determined rates-per-discharge. These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Senior Services are reimbursed based upon an all inclusive per-diem rate. SMEMC also receives incremental Medicaid reimbursement for specific programs and services at the discretion of the State of Illinois Medicaid program. Medicaid reimbursement methodologies and payment rates are subject to change based on the amount of funding available to the State of Illinois Medicaid program and any such changes could have a significant effect on RHC and Affiliates' revenues.

During 2004, the State enacted an assessment program to assist in the financing of its Medicaid program through June 30, 2005. The program was renewed in December 2006 for the State's fiscal years ended June 30, 2006, 2007, and 2008. Pursuant to this program, hospitals within the State are required to remit payment to the State of Illinois Medicaid program under an assessment formula approved by the Centers for Medicare & Medicaid Services (CMS). No amounts have been recorded during 2006 as no assessment program had been approved by CMS as of June 30, 2006. As of June 30, 2007, RHC and Affiliates have included their 2006 and 2007 related assessment of $94,564 within assessments and taxes expense in the accompanying 2007 consolidated statement of operations. RHC and Affiliates paid $47,282 of the assessment in 2007, and has recorded the remaining balance within accounts payable and accrued expenses in the accompanying 2007 consolidated statement of financial position. The assessment program also provides hospitals within the State with additional Medicaid reimbursement based on funding formulas also approved by CMS. RHC and Affiliates have included their additional 2006 and 2007 related reimbursement of $156,338 within net service revenue in the accompanying 2007 consolidated statement of operations. RHC and Affiliates received $78,169 of its additional reimbursement in 2007, and has recorded the remaining balance within other receivables in the accompanying 2007 consolidated statement of financial position.

Blue Cross

The Hospitals also participate as providers of health care services under reimbursement agreements with Blue Cross. The provisions of these agreements stipulate that services will be reimbursed at a tentative reimbursement rate and that final reimbursement for these services is determined after the submission of annual cost reports by the Hospitals and reviews thereof by Blue Cross. The Blue Cross traditional indemnity reimbursement reports for 2006 and prior years have been reviewed by Blue Cross. The Blue Cross HMOI, PPO, and MCNP reimbursement reports for 2005 and prior years have been reviewed by Blue Cross.

Other

The Hospitals have also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for reimbursement under these agreements includes prospectively determined rates-per-discharge, discounts from established charges, and prospectively determined per diem rates.

A summary of gross and net service revenue for the years ended June 30, 2007 and 2006 follows:

	2007	2006
Service revenue:		
Nursing, dietary, and room service	$ 836,628	802,350
Ancillary services	3,124,607	2,999,395
Long-term care services	133,867	123,505
Retirement communities	18,745	18,171
Ambulatory care services	15,224	26,440
Apothecary, durable medical equipment, home, health services, and other	29,648	37,050
Gross service revenue	4,158,719	4,006,911
Less provisions for estimated contractual adjustments under third-party reimbursement programs and other discounts and allowances	2,552,155	2,569,103
Net service revenue	$ 1,606,564	1,437,808

(Continued)

A summary of RHC and Affiliates' Medicare, Medicaid, Blue Cross, managed care, self-pay, and commercial utilization percentages based upon gross service revenue follows:

	2007	2006
Medicare	47%	48%
Medicaid	18	17
Blue Cross	1	1
Managed care	24	24
Self-pay, commercial, and other	10	10

(4) Concentration of Credit Risk

RHC and Affiliates grant credit without collateral to their patients, most of whom are local residents and are generally insured under third-party payor agreements. The mix of receivables from patients and third-party payors as of June 30, 2007 and 2006 was as follows:

	2007	2006
Medicare	32%	31%
Medicaid	24	22
Blue Cross	1	1
Managed care	25	26
Self-pay	12	15
Commercial and other	6	5

(5) Charity Care

RHC and Affiliates provide necessary medical care to patients who meet certain criteria under their charity care policies without charge or at amounts less than their established rates. Because RHC and Affiliates do not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue. The following information presents the level of charity care provided during the years ended June 30, 2007 and 2006.

		2007	2006
Charges forgone for non-Medicare and non-Medicaid patients, based on established rates	$	72,184	53,234

(6) Investments

RHC and Affiliates report investments in equity securities with readily determinable fair values and all investments in debt securities at fair value. Fair value is determined primarily on the basis of quoted market prices. A summary of the composition of the RHC and Affiliates' investment portfolios at June 30, 2007 and 2006 follows:

	2007	2006
Cash and cash equivalents	$ 45,687	102,766
Common stocks and mutual funds	149,393	118,314
U.S. treasury securities	100,030	115,221
Corporate and municipal bonds and notes	417,457	347,581
U.S. government agencies	261,059	363,182
	$ 973,626	1,047,064

Investments are reported in the accompanying consolidated statements of financial position at June 30 as follows:

	2007	2006
Assets whose use is limited or restricted – required for current liabilities	$ 19,875	21,829
Assets whose use is limited or restricted, less amounts required for current liabilities:		
By Boards for reinvestment and self-insurance	932,693	885,028
Under bond indenture agreements – held by trustee	7,008	128,695
By donors – permanently restricted	14,050	11,512
	$ 973,626	1,047,064

The composition of investment return on the RHC and Affiliates' investment portfolio for the years ended June 30, 2007 and 2006 is as follows:

	2007	2006
Interest and dividend income, net of fees and expenses	$ 50,339	47,983
Net realized gains on sale of investments	3,168	904
Net change in unrealized gains and losses during the holding period	22,607	(39,762)
	$ 76,114	9,125

Prior to the June 30, 2007 designation of investments as trading, changes in net unrealized gains and losses during the holding period were attributable to other than trading securities, and accordingly, are excluded from the determination of revenue and gains in excess of expenses and losses. Investment returns are included in the accompanying consolidated financial statements for the years ended June 30, 2007 and 2006 as follows:

	2007	2006
Nonoperating gains – investment income and other, net	$ 52,857	48,887
Other changes in unrestricted net assets – change in net unrealized gains and losses on other than trading securities	21,902	(39,785)
Net realized and unrealized gains and losses on temporarily restricted investments	759	23
Interest income offset against capitalized interest cost	596	—
	$ 76,114	9,125

The composition of temporarily impaired investments and length of time such investments were in an unrealized loss position as of June 30, 2006 follows:

	Less than twelve months		Twelve months or longer		Total	
June 30, 2006	Fair value	Unrealized losses	Fair value	Unrealized losses	Fair value	Unrealized losses
Common stocks and mutual funds	$ 27,722	(2,600)	9,836	(1,333)	37,558	(3,933)
U.S. treasury securities	87,243	(3,821)	7,806	(102)	95,049	(3,923)
Corporate and municipal bonds and notes	221,969	(9,348)	54,236	(2,764)	276,205	(12,112)
U.S. government agencies	205,943	(5,535)	65,415	(3,329)	271,358	(8,864)
	$ 542,877	(21,304)	137,293	(7,528)	680,170	(28,832)

Temporarily impaired investments at June 30, 2006 consisted primarily of common stocks, mutual funds, corporate bonds, and government securities, which were in temporarily impaired positions primarily due to market conditions over the past few years. Only ten securities were in unrealized loss positions over 25% as of June 30, 2006. Management of RHC and Affiliates believed the impairments were temporary in nature due to market conditions combined with their typical buy and hold strategy employed on such investments.

(7) Land, Buildings, and Equipment

A summary of land, buildings, and equipment at June 30, 2007 and 2006 follows:

	2007	2006
Land	$ 68,792	68,469
Land improvements	45,760	45,372
Buildings and building equipment	1,089,474	1,000,171
Departmental equipment	781,779	713,792
	1,985,805	1,827,804
Less accumulated depreciation	1,230,323	1,150,939
	755,482	676,865
Construction in progress	48,893	67,628
Land, buildings, and equipment, net	$ 804,375	744,493

Construction in progress at June 30, 2007 and 2006 consists primarily of costs associated with various projects. The remaining costs associated with these projects at June 30, 2007 are approximately $45,282, substantially all of which have been contractually committed. These projects are expected to be completed in fiscal year 2008 and are expected to be financed from operations. For the year ended June 30, 2007, RHC and Affiliates capitalized interest cost of $2,352 and offset such capitalized interest cost by $596 of interest income earned on unexpended project specific borrowed funds.

(8) Long-term Debt

A summary of long-term debt at June 30, 2007 and 2006 follows:

	2007	2006
Variable Rate Revenue Bonds (Series 2005A)	$ 26,130	26,130
Variable Rate Revenue Bonds (Series 2005B)	121,975	123,310
Variable Rate Revenue Bonds (Series 2005C)	122,110	123,535
Variable Rate Revenue Bonds (Series 2005D)	61,750	62,550
Variable Rate Revenue Bonds (Series 2005E)	10,620	10,620
Variable Rate Demand Revenue Bonds (Series 1999A)	116,100	118,600
Variable Rate Demand Revenue Bonds (Series 1999B)	116,100	118,600
Periodic Auction Reset Securities (PARS) (Series 1999C)	119,375	124,275
Revenue Bonds (Series 1997B) (HFMC)	34,355	35,265
Term loan (HFMC)	7,885	8,271
Mortgage loans (RMNY)	13,010	13,244
Total long-term debt	749,410	764,400
Less:		
Current installments	15,520	14,934
Unamortized bond discount	701	738
Long-term debt, excluding current installments and unamortized bond discount	$ 733,189	748,728

On August 1, 1999, RHC entered into a Master Trust Indenture under which RHC was the only Obligated Group member. RMC, OLR, WH, SFH, Services, Senior Services, Home Care, and the Foundation were named Unlimited Credit Group Participants required to permit RHC to perform all obligations and covenants under the Master Trust Indenture. The Master Trust Indenture was amended and restated as of May 1, 2005, pursuant to the issuance of the Series 2005 Bonds and the reissuance of the Variable Rate Demand Bonds (Series 1999A and Series 1999B). RHC, RMC, OLR, WH, SFH, SJH, SMEMC, and WSMC were named Obligated Group Members under the amended and restated Master Trust Indenture. Services, Senior Services, Home Care, and the Foundation were named Unlimited Credit Group Participants required to permit the Obligated Group to perform all obligations and covenants under the amended and restated Master Trust Indenture, and required to pay such amounts as are necessary to make all payments on the Series 1999 and Series 2005 obligations. The purpose of the Master Trust Indenture is to provide a mechanism for the efficient and economical issuance of notes by individual members of the Obligated Group using the collective borrowing capacity and credit rating of the Obligated Group. The Master Trust Indenture requires the individual members of the Obligated Group to make principal and interest payments on notes issued for their benefit and to pay such amounts as are otherwise necessary to enable the Obligated Group to satisfy all obligations issued under the Master Trust Indenture.

On May 26, 2005, the Illinois Finance Authority issued Variable Rate Revenue Bonds, Series 2005A, Series 2005B, Series 2005C, and Series 2005D, and on June 16, 2005, the Illinois Finance Authority issued Variable Rate Revenue Bonds, Series 2005E (collectively referred to as the Series 2005 bonds) in the aggregate amount of $350,000 on behalf of RHC. A portion of the proceeds from the Series 2005 bond issuance were used to advance refund various outstanding debt. The remaining proceeds were used to reimburse RHC and Affiliates for prior capital expenditures, to finance future capital expenditures, provide working capital, and reimburse RHC for costs of issuance. Principal on the bonds is payable annually commencing on May 14, 2006 through 2035. Interest is payable monthly at variable rates. During 2007 and 2006, the effective interest rate on the Series 2005 bonds was 3.65% and 3.48%, respectively. The Series 2005 bonds were issued pursuant to five separate Bond Trust Indentures, each dated as of May 1, 2005. The Series 2005B and 2005C bonds are secured by direct pay letters of credit issued by commercial banks which currently expire on May 26, 2008, in amounts equal to the principal amount of the bonds and accrued interest on such principal. The remaining Series 2005 bonds are unsecured. Holders of the Series 2005 bonds have a put option that allows them to redeem the bonds prior to maturity. The Obligated Group has an agreement with an underwriter to remarket any bonds redeemed through the exercise of put options.

On August 27, 1999, the Illinois Health Facility Authorities issued Variable Rate Demand Revenue Bonds, Series 1999A and Series 1999B, and Periodic Auction Reset Securities, Series 1999C (collectively referred to as the Series 1999 bonds) in the aggregate amount of $380,000 on behalf of RHC. The proceeds were used to advance refund or retire various outstanding debt. The remaining proceeds were deposited into a construction fund to be used to provide for various future capital needs of RHC and Affiliates. Principal on the bonds is payable annually through 2029. Effective May 26, 2005, the Obligated Group reissued $243,800 of Series 1999 bonds. Interest is payable monthly at PARS rates and variable rates. During 2007 and 2006, the effective interest rate on the Series 1999 bonds was 3.68% and 2.60%, respectively. Series 1999 bonds are unsecured. Holders of the Series 1999 bonds have a put option that allows them to redeem the bonds prior to maturity. The Obligated Group has an agreement with an underwriter to remarket any bonds redeemed through the exercise of put options.

On December 23, 1997, the Illinois Health Facilities Authority on behalf of HFMC issued its Revenue Bonds, Series 1997, in the principal amount of $41,000 pursuant to a loan agreement dated December 1, 1997, between the Illinois Health Facilities Authority and HFMC (Series 1997B). Interest is payable at rates varying between 4.25% and 5.00% in annual installments through 2027. Effective February 6, 2001, HFMC entered into a Reimbursement, Mortgage, and Security Agreement (RHC Reimbursement Agreement) with RHC. The RHC Reimbursement Agreement provides that RHC will guarantee payment to the Bond Insurer of all amounts paid by the Bond Insurer in connection with the Series 1997B Bonds under either the Bond Insurance Policy or the Surety Bond, which are not reimbursed to the Bond Insurer by HFMC. In conjunction with the RHC Reimbursement Agreement, HFMC issued its Direct Note Obligation Series 2001A (Series 2001A) in a principal amount equal to the amount owed under the RHC Reimbursement Agreement, if any. Series 2001A is secured by a mortgage of the land and healthcare facilities of HFMC's main campus located in Des Plaines, Illinois and HFMC's accounts receivable. All intercompany amounts related to the Series 2001A Bonds have been eliminated in consolidation.

In October 1999, HFMC entered into a ten-year term loan (Term Loan) in the amount of $10,275. Under the terms of the Term Loan, HFMC pays interest at a fixed rate of 7.75%. Principal installments are due annually in amounts ranging from $227 to $420 through October 2009 with a lump-sum payment of $6,951, due November 2009. The Term Loan is secured by HFMC's medical office building and applicable rental income.

RNH and MLNH have two mortgage loan agreements through the Dormitory Authority of the State of New York. Principal and interest on the first note is payable in fixed monthly amounts of $46 through July 2027. The note bears interest at a fixed annual rate of 7.25% and is secured by certain real estate. Principal and interest on the second note is payable in fixed monthly amounts of $53 through January 2033. The note bears interest at a fixed annual rate of 7.90% and is secured by certain assets of RNH and MLNH.

The fair value of RHC and Affiliates' long-term debt approximated its carrying value at June 30, 2007 and 2006.

Under Section 148(f) of the Code, an issuer of tax-exempt bonds is required to rebate to the Internal Revenue Service the excess of investment income earned on all nonpurpose investments made with the gross proceeds of tax-exempt bond issues over the amount, which would have been earned if such nonpurpose investments had been invested at a rate equal to the interest yield on the related bond issue. The estimated rebate liability of $1,309 and $594 at June 30, 2007 and 2006, respectively, related to the Series 2005 bonds is recorded within accounts payable and accrued expenses in the accompanying consolidated statements of financial position.

Scheduled annual principal payments on long-term debt for the ensuing five years are as follows:

	Amount
Year:	
2008	$ 15,520
2009	16,556
2010	17,664
2011	17,932
2012	18,543

(9) Employees' Retirement Plans

RHC and Affiliates have two cash balance plans (defined benefit plans which operate like defined contribution plans) (Plan A and Plan B) that cover substantially all eligible employees of RHC and Affiliates. Each eligible participant has a benefit account balance, which accrues as a percentage of current year's pay and earns interest at a specified rate.

RHC and Affiliates record pension cost at an amount calculated by an independent consulting actuary. RHC and Affiliates recognize the cost related to employee service using the projected unit credit cost method. Gains and losses, calculated as the difference between estimated and actual amounts of plan assets and the projected benefit obligation, and prior service cost are amortized over the expected future service period.

In September of 2006, the FASB issued SFAS No. 158, *Employers' Accounting for Defined Benefit Pension and Other Postretirement Plans—an amendment of FASB Statements No. 87, 88, 106, and 132(R)*, effective for fiscal years ending after December 31, 2006. SFAS No. 158 requires recognition in the consolidated statement of financial position of the funded status of defined benefit pension plans and other postretirement benefit plans, including all previously unrecognized actuarial gains and losses and unamortized prior service cost, as a component of unrestricted net assets. RHC and Affiliates adopted the provisions of SFAS No. 158 as of June 30, 2007 through a direct addition of unrestricted net assets of $11,312. There was no impact on the results of operations or cash flows.

The following table sets forth the consolidated funded status, assumptions, and amounts recognized in the accompanying consolidated financial statements as of and for the years ended June 30, 2007 and 2006 for Plans A and B:

		2007	2006
Change in benefit obligation:			
Benefit obligation at beginning of year	$	(257,088)	(252,048)
Service cost		(20,828)	(21,615)
Interest cost		(15,616)	(13,297)
Actuarial gain (loss)		(1,913)	11,535
Benefits paid		18,721	18,337
Benefit obligation at end of year	$	(276,724)	(257,088)
Change in plan assets:			
Fair value of plan assets at beginning of year	$	96,319	110,263
Actual return on plan assets		14,819	4,843
Adjustments for transfers		(450)	(450)
Employer contributions		30,000	—
Benefits paid		(18,721)	(18,337)
Fair value of plan assets at end of year	$	121,967	96,319
Reconciliation of funded status:			
Funded status	$	(154,757)	(160,769)
Unrecognized actuarial loss		—	54,003
Unrecognized prior service cost		—	(3,825)
Net amount recognized at year-end	$	(154,757)	(110,591)

		2007	2006
Amount recognized in the accompanying consolidated statement of financial position consist of:			
Accrued pension liability	$	(154,757)	(157,599)
Accumulated charge to unrestricted net assets		—	47,008
Net amount recognized	$	(154,757)	(110,591)
Accumulated benefit obligation	$	(274,317)	(253,918)

		2007	2006
Components of net periodic benefit cost:			
Service cost	$	20,828	21,615
Expense load		450	450
Interest cost		15,616	13,297
Expected return on plan assets		(8,652)	(8,663)
Amortization of unrecognized net loss		2,460	4,030
Amortization of unrecognized prior service cost		(650)	(650)
Net periodic benefit cost	$	30,052	30,079
Estimated future benefit payments:			
Fiscal 2008	$	21,247	
Fiscal 2009		20,386	
Fiscal 2010		19,822	
Fiscal 2011		20,517	
Fiscal 2012		20,447	
Fiscal 2013 – 2017		122,433	
Expected contribution during fiscal 2008	$	30,000	
Weighted average assumptions used to determine benefit obligations at June 30:			
Settlement (discount) rate		6.26%	6.25%
Weighted average rate of increase in future compensation levels		4.00	4.00
Weighted average assumptions used to determine net periodic benefit cost for years ended June 30:			
Discount rate		6.25%	5.25%
Expected return on plan assets		8.50	8.50
Rate of compensation increase		4.00	4.00

RHC's overall expected long-term rate of return on assets is 8.5%. The expected long-term rate of return is based on the portfolio as a whole and not on the sum of the returns on individual asset categories. The return is based exclusively on historical returns, without adjustments.

RHC's pension plan weighted average asset allocations at June 30, 2007 and 2006, by asset category are as follows:

Asset category	Plan assets at June 30	
	2007	2006
Equities	75.5%	80.9%
Fixed income securities and cash equivalents	24.5	19.1

RHC has developed a Plan investment policy, which is reviewed and approved by the RHC Finance Committee and the boards of directors. The policy established goals and objectives of the fund, asset allocations, asset classifications, and manager guidelines. The policy reflects a target of up to 60% for equity securities. Investments are managed by independent advisors who are monitored by management and the Finance Committee. RHC monitors the asset allocation and executes required recalibrations of the portfolio allocation on a regular basis in response to fluctuations in market conditions and the overall portfolio composition.

RHC and Affiliates also have a defined contribution money purchase plan (Defined Contribution Plan). RHC and Affiliates contribute 25% of contributions made by employees to their tax deferred account up to a maximum contribution percentage of 1% of the participant's qualified income. RHC and Affiliates' boards of directors have amended Plan A and the Defined Contribution Plan whereby the employer matching contribution of the Defined Contribution Plan is considered a component of Plan A. Accordingly, this employer matching component has been included as a component of the accrued pension liability of Plan A as determined by the professional consulting actuary.

The WSMC retirement program consists of the West Suburban Health Care Retirement Income Plan (Income Plan), a noncontributory defined benefit pension plan, and the West Suburban Health Care Retirement Savings Plan (Savings Plan), a defined contribution pension plan, for which WSMC's employees are eligible. Effective January 1, 2002, the board of directors of WSMC authorized the curtailment of the Income Plan. As a result of this action, participation in the Income Plan is limited to participants entering on or before January 1, 2002, and no new benefits will accrue to participants subsequent to that date.

The Savings Plan became effective on January 1, 2002 and covers employees on the first day of employment after attaining the age of 21. Under the terms of the Savings Plan, employees may contribute up to 40% of eligible compensation subject to Internal Revenue Code salary deferral limitations. WSMC makes matching payments equal to 50% of a participant's salary deferral contributions up to the first 3%. WSMC also contributes 1.5% of each eligible employee's compensation into the Savings Plan, regardless of whether or not the employee elects to make salary deferrals into the Savings Plan. Participants vest 100% in WSMC contributions after one year of service. WSMC funds the Savings Plan on a current basis.

Effective January 1, 2004, participants of the West Suburban Health Care Retirement Income Plan and the West Suburban Health Care Retirement Savings Plan became participants in the RHC and Affiliates cash balance plans.

A summary of the changes in the projected benefit obligation and plan assets and the resulting funded status of the Income Plan is as follows at June 30, 2007 and 2006 (measurement dates):

		2007	2006
Change in projected benefit obligation:			
Projected benefit obligation at beginning of period	$	(58,676)	(67,050)
Interest cost		(3,510)	(3,477)
Actuarial gain		4,144	10,019
Benefits paid		1,954	1,832
Projected benefit obligation at end of period	$	(56,088)	(58,676)
Change in plan assets:			
Fair value of plan assets at beginning of period	$	43,283	42,473
Actual return on plan assets		8,228	2,642
Employer contributions		4,412	—
Benefits paid		(1,954)	(1,832)
Fair value of plan assets at end of period	$	53,969	43,283
Reconciliation of funded status:			
Funded status	$	(2,119)	(15,393)
Unrecognized net actuarial loss		—	15,909
Net amount recognized	$	(2,119)	516

		2007	2006
Accumulated benefit obligation	$	(56,088)	(58,676)
Amount recognized in the accompanying consolidated statement of financial position:			
Accrued pension liability	$	(2,119)	15,909
Accumulated charge to unrestricted net assets		—	(15,393)
Net amount recognized	$	(2,119)	516
Components of net periodic benefit cost:			
Interest cost	$	3,511	3,477
Expected return on plan assets		(3,743)	(3,533)
Amortization of unrecognized net loss		1,117	2,594
Net periodic benefit cost	$	885	2,538
Estimated future benefit payments:			
Fiscal 2008	$	2,097	
Fiscal 2009		2,356	
Fiscal 2010		2,471	
Fiscal 2011		2,603	
Fiscal 2012		2,827	
Fiscal 2013 – 2017		17,516	
Expected contributions during fiscal 2008:			
Minimum required contribution	$	3,198	
Weighted average assumptions used to determine benefit obligations:			
Settlement (discount) rate		6.43%	6.25%
Weighted average assumptions used to determine net periodic benefit cost:			
Discount rate		6.25%	5.25%
Expected return on plan assets		8.50	8.50

WSMC's overall expected long-term rate of return on assets is 8.5%. The expected long-term rate of return is based on the portfolio as a whole and not on the sum of the returns on individual asset categories. The return is based exclusively on historical returns, without adjustments.

WSMC's pension plan weighted average asset allocations at June 30, 2007 and 2006 by asset category are as follows:

Asset category	Plan assets at June 30 2007	2006
Equities	72.4%	72.0%
Fixed income securities and cash equivalents	27.6	28.0

WSMC has developed a Plan investment policy, which is reviewed and approved by the RHC Finance Committee and the boards of directors. The policy established goals and objectives of the fund, asset allocations, asset classifications, and manager guidelines. The policy dictates a specific asset allocations between equity and fixed income securities. Investments are managed by independent advisors who are monitored by management and the Finance Committee. RHC monitors the asset allocation and executes required recalibrations of the portfolio allocation on a regular basis in response to fluctuations in market conditions and the overall portfolio composition.

(10) Self-Insurance

Professional and General Liability

RHC and affiliates are self-insured for professional and general liability claims up to specified limits arising from incidents occurring after dates of entry into the program, which vary by corporation. Excess insurance coverage was occurrence-based through various dates, at which time all corporations changed to claims made-based coverage.

RHC and Affiliates are involved in litigation arising in the ordinary course of business. Claims alleging malpractice have been asserted against RHC and Affiliates and are currently in various stages of litigation. Provisions for professional and general liability claims include the ultimate cost of known claims and claims incurred but not reported as of the respective consolidated balance sheet dates. It is the opinion of management that the estimated malpractice liabilities accrued at June 30, 2007 and 2006 are adequate to provide for the ultimate cost of potential losses resulting from pending or threatened litigation; however, such estimates may be more or less than the amounts ultimately paid when claims are resolved. Estimated malpractice claims have been discounted at a rate of 5% at June 30, 2007 and 2006. The accrued liability estimated for self-insured professional and general liability claims amounted to $249,502 and $242,309 at June 30, 2007 and 2006, respectively. All self-insured malpractice and general claim liabilities are reported as long-term liabilities as the portion expected to be paid within one year is not readily determinable.

Workers' Compensation

The Hospitals maintain self-insurance programs for workers' compensation coverage. These programs limit the self-insured retention to specific amounts on a per occurrence basis. Coverage from commercial insurance carriers is maintained for claims in excess of the self-insured retention. Accrued workers' compensation claims amounted to $5,985 and $5,242 at June 30, 2007 and 2006, respectively. Management believes the estimated self-insured workers' compensation claims liability

at June 30, 2007 and 2006 is adequate to cover the ultimate liability; however, such estimates may be more or less than the amounts ultimately paid when claims are resolved. The portion of workers' compensation claims expected to be paid beyond one year of the statements of financial position dates is not readily determinable and, therefore, the entire accrual is classified as a current liability included within accounts payable and accrued expenses in the accompanying consolidated balance sheets.

Health Care

RHC and Affiliates also maintains a program of self-insurance for employee health coverage. Stop-loss reinsurance coverage is maintained for claims in excess of stop-loss limits. Accrued self-insured employee health care claims amounted to $4,819 and $6,111 for 2007 and 2006, respectively, and are included with accounts payable and accrued expenses in the accompanying consolidated balance sheets. It is the opinion of management that the estimated health care costs accrued at June 30, 2007 and 2006 are adequate to provide for the ultimate liability; however, final payouts as claims are paid may vary significantly from estimated claim liabilities.

(11) Contingencies

Medicare Reimbursement

For the year ended June 30, 2007, RHC and Affiliates recognized approximately $595,707 of net service revenue from services provided to Medicare beneficiaries. Recent federal legislation have included provisions to reduce Medicare payments to health care providers as well as phase out cost based reimbursement mechanisms to prospective payment methodologies. Changes in Medicare reimbursement as a result of the Health Care Financing Administration's implementation of the provisions of recent Medicare legislation may have an adverse effect on RHC and Affiliates' net service revenues.

Litigation

RHC and Affiliates are involved in litigation and regulatory investigations arising in the normal course of business. In consultation with legal counsel, management estimates that these matters will be resolved without material adverse effect on RHC and Affiliates' financial position or results from operations.

Regulatory Investigations

The U.S. Department of Justice and other federal agencies routinely conduct regulatory investigations and compliance audits of health care providers. RHC and Affiliates are subject to these regulatory efforts. Management is currently unaware of any regulatory matters, which may have a material adverse effect on RHC and Affiliates' financial position or results of operations.

(12) Asbestos Removal Costs

In March 2005, the Financial Accounting Standards Board issued interpretation No. 47, *Accounting for Conditional Asset Retirement Obligations* (FIN 47). FIN 47 requires the current recognition of a liability when a legal obligation exists to perform an asset retirement obligation in which the timing or method of settlement are conditional on a future event that may or may not be under the control of the entity. FIN 47 requires an asset retirement obligation (ARO) liability be recorded at its net present value with recognition of a related long-lived asset in a corresponding amount. The ARO liability is accreted through periodic charges to depreciation expense. The initially capitalized ARO long-lived asset is depreciated over the corresponding long-lived asset's remaining useful life. RHC and Affiliates adopted FIN 47 effective as of June 30, 2006.

RHC and Affiliates are legally liable to remove asbestos from existing buildings prior to future remodeling or demolishing of the existing buildings. The estimated asbestos removal cost at June 30, 2007 and 2006 were $13,418 and $14,121, respectively. The net book value of the ARO long-lived asset at June 30, 2007 and 2006 was $0. The excess of the ARO liability over the net book value of the ARO long-lived asset at June 30, 2006 of $14,121 has been reported as a cumulative effect of a change in accounting principle.

Schedule 1

RESURRECTION HEALTH CARE AND AFFILIATES

Consolidating Schedule – Financial Position Information

June 30, 2007

(In thousands)

Assets	Resurrection Health Care	Resurrection Medical Center	Saint Francis Hospital	Our Lady of the Resurrection Medical Center	Westlake Hospital	Saints Mary and Elizabeth Medical Center	Holy Family Medical Center	Saint Joseph Hospital
Current assets:								
Cash and cash equivalents	$ 2,698	1,119	6,952	387	1,923	5,786	—	—
Assets whose use is limited or restricted – required for current liabilities	17,248	—	—	—	—	—	—	—
Patient and resident accounts receivable, net of allowance for uncollectible accounts of $89,568	—	38,326	23,608	19,879	11,172	31,668	15,640	22,197
Other receivables	2,773	5,609	18,016	3,979	10,925	26,390	2,653	8,090
Inventory of supplies	—	2,170	1,127	847	511	3,111	1,134	3,462
Prepaid expenses and other current assets	14,958	12,953	376	724	114	591	252	406
Due from affiliates	174,433	199,942	—	—	—	—	—	—
Total current assets	212,110	260,119	50,079	25,816	24,645	67,546	19,679	34,155
Assets whose use is limited or restricted:								
By Boards for reinvestment and self-insurance	346,157	266,092	85,231	38,770	—	68,617	1,064	—
Under bond indenture agreements – held by trustee	5,839	—	—	—	—	—	1,169	—
By donors – permanently restricted	—	—	—	—	—	—	—	—
	351,996	266,092	85,231	38,770	—	68,617	2,233	—
Land, buildings, and equipment, net	149,303	22,029	83,718	37,658	40,215	69,465	35,238	71,481
Deferred finance charges	9,523	—	—	—	—	—	1,245	—
Other assets	30,979	3,820	447	13	—	1,688	125	1,721
	$ 753,911	552,060	219,475	102,257	64,860	207,316	58,520	107,357

(Continued)

ATTACHMENT 75

Schedule 1

RESURRECTION HEALTH CARE AND AFFILIATES

Consolidating Schedule – Financial Position Information

June 30, 2007

(In thousands)

Assets	West Suburban Medical Center	Resurrection Senior Services	Resurrection Services	Resurrection Behavioral Health	Resurrection Home Health Services	Resurrection Development Foundation	Eliminations	Consolidated
Current assets:								
Cash and cash equivalents	$ —	8,849	1,200	1,923	9	2,047	—	32,893
Assets whose use is limited or restricted – required for current liabilities	2,627	—	—	—	—	—	—	19,875
Patient and resident accounts receivable, net of allowance for uncollectible accounts of $89,568	22,480	13,007	5,607	1,064	2,383	—	—	207,031
Other receivables	13,889	833	2,043	—	—	6,840	—	102,040
Inventory of supplies	1,737	473	1,304	—	—	—	—	15,876
Prepaid expenses and other current assets	738	500	563	31	—	732	—	32,938
Due from affiliates	—	—	—	—	—	839	(375,214)	—
Total current assets	41,471	23,662	10,717	3,018	2,392	10,458	(375,214)	410,653
Assets whose use is limited or restricted:								
By Boards for reinvestment and self-insurance	—	107,371	—	—	—	19,391	—	932,693
Under bond indenture agreements – held by trustee	—	—	—	—	—	—	—	7,008
By donors – permanently restricted	82	—	—	—	—	13,968	—	14,050
	82	107,371	—	—	—	33,359	—	953,751
Land, buildings, and equipment, net	63,815	127,218	100,215	3,549	269	202	—	804,375
Deferred finance charges	—	—	—	—	—	—	—	10,768
Other assets	342	306	17	—	1,937	—	(28,026)	13,369
	$ 105,710	258,557	110,949	6,567	4,598	44,019	(403,240)	2,192,916

(Continued)

ATTACHMENT 75

Schedule 1

RESURRECTION HEALTH CARE AND AFFILIATES

Consolidating Schedule – Financial Position Information

June 30, 2007

(In thousands)

Liabilities and Net Assets	Resurrection Health Care	Resurrection Medical Center	Saint Francis Hospital	Our Lady of the Resurrection Medical Center	Westlake Hospital	Saints Mary and Elizabeth Medical Center	Holy Family Medical Center	Saint Joseph Hospital
Current liabilities:								
Current installments of long-term debt	$ 13,895	—	—	—	—	—	1,402	—
Accounts payable and accrued expenses	13,998	27,675	8,097	5,377	4,675	18,190	4,516	9,138
Accrued payroll and fringe benefits	—	55,472	—	—	—	148	1,463	1,335
Estimated payables under third-party reimbursement programs	—	22,543	18,660	5,422	6,478	10,833	7,341	29,286
Deferred revenue and refundable deposits	—	—	—	—	—	—	—	—
Due to affiliates	—	—	7,158	2,974	21,139	44,655	40,093	19,361
Total current liabilities	27,893	105,690	33,915	13,773	32,292	73,826	54,815	59,120
Long-term debt, excluding current installments and unamortized bond discount	680,265	—	—	—	28,026	—	40,137	—
Accrued pension liability	—	156,876	—	—	—	—	—	—
Estimated self-insured professional and general liability claims	—	45,177	39,146	13,195	24,097	39,379	8,810	21,288
Asset retirement obligation	13,418	—	—	—	—	—	—	—
Other	—	—	—	—	—	—	—	1,334
Total liabilities	721,576	307,743	73,061	26,968	84,415	113,205	103,762	81,742
Net assets (liabilities):								
Unrestricted	32,335	244,317	146,414	75,289	(19,555)	94,102	(45,242)	25,615
Temporarily restricted	—	—	—	—	—	9	—	—
Permanently restricted	—	—	—	—	—	—	—	—
Total net assets (liabilities)	32,335	244,317	146,414	75,289	(19,555)	94,111	(45,242)	25,615
	$ 753,911	552,060	219,475	102,257	64,860	207,316	58,520	107,357

(Continued)

Schedule 1

RESURRECTION HEALTH CARE AND AFFILIATES

Consolidating Schedule – Financial Position Information

June 30, 2007

(In thousands)

Liabilities and Net Assets	West Suburban Medical Center	Resurrection Senior Services	Resurrection Services	Resurrection Behavioral Health	Resurrection Home Health Services	Resurrection Development Foundation	Eliminations	Consolidated
Current liabilities:								
Current installments of long-term debt	$ —	223	—	—	—	—	—	15,520
Accounts payable and accrued expenses	16,684	5,314	5,816	222	141	47	—	119,890
Accrued payroll and fringe benefits	5,298	—	—	—	—	—	—	63,716
Estimated payables under third-party reimbursement programs	1,332	2,605	—	—	—	—	—	104,500
Deferred revenue and refundable deposits	—	45,907	—	119	—	—	—	46,026
Due to affiliates	67,660	52,902	103,028	4,360	11,884	—	(375,214)	—
Total current liabilities	90,974	106,951	108,844	4,701	12,025	47	(375,214)	349,652
Long-term debt, excluding current installments and unamortized bond discount	—	12,787	—	—	—	—	(28,026)	733,189
Accrued pension liability	—	—	—	—	—	—	—	156,876
Estimated self-insured professional and general liability claims	58,410	—	—	—	—	—	—	249,502
Asset retirement obligation	—	—	—	—	—	—	—	13,418
Other	—	—	—	—	—	—	—	1,334
Total liabilities	149,384	119,738	108,844	4,701	12,025	47	(403,240)	1,503,971
Net assets (liabilities):								
Unrestricted	(43,721)	138,819	2,105	1,866	(7,427)	12,012	—	656,929
Temporarily restricted	47	—	—	—	—	17,910	—	17,966
Permanently restricted	—	—	—	—	—	14,050	—	14,050
Total net assets (liabilities)	(43,674)	138,819	2,105	1,866	(7,427)	43,972	—	688,945
	$ 105,710	258,557	110,949	6,567	4,598	44,019	(403,240)	2,192,916

See accompanying independent auditors' report.

ATTACHMENT 75

Schedule 2

RESURRECTION HEALTH CARE AND AFFILIATES

Consolidating Schedule – Operations and Changes in Unrestricted Net Assets Information

Year ended June 30, 2007

(In thousands)

	Resurrection Health Care	Resurrection Medical Center	Saint Francis Hospital	Our Lady of the Resurrection Medical Center	Westlake Hospital	Saints Mary and Elizabeth Medical Center	Holy Family Medical Center	Saint Joseph Hospital
Net service revenue	$ —	280,715	190,659	133,156	103,772	299,033	55,113	187,489
Other revenue:								
Auxiliary services	12,206	4,151	2,900	940	1,604	4,321	918	2,492
Services provided to affiliates	141,171	—	—	—	—	—	—	—
Net assets released from restrictions for operations	—	426	537	159	793	5	1	50
Total revenue	153,377	285,292	194,096	134,255	106,169	303,359	56,032	190,031
Expenses:								
Salaries and wages	67,192	100,122	49,413	44,715	35,465	91,712	20,521	65,213
Payroll taxes and fringe benefits	17,890	28,900	14,313	12,501	10,124	25,498	5,130	19,620
Physicians' fees	3	14,926	10,797	4,816	9,084	8,858	1,314	13,161
Supplies	289	49,026	20,920	14,331	12,350	29,650	3,569	22,576
Other	46,360	25,871	10,323	8,780	4,091	10,750	5,197	14,670
Management services	—	23,938	16,750	12,947	10,602	25,386	3,363	16,034
Purchased services	7,508	4,343	4,263	2,263	5,633	16,064	3,408	7,861
Insurance	(563)	(1,303)	4,678	(3,853)	9,217	8,889	(1,868)	1,002
Depreciation and amortization	15,868	5,996	9,099	4,650	4,233	6,540	4,625	5,985
Provision for uncollectible accounts receivable	—	11,844	24,622	24,695	10,045	37,332	3,180	7,721
Interest	—	—	—	—	1,096	—	1,747	—
Assessments and taxes	—	15,227	10,277	8,477	6,639	18,899	4,599	13,974
Total expenses	154,547	278,890	175,455	134,322	118,579	279,578	54,785	187,817
Income (loss) from operations	(1,170)	6,402	18,641	(67)	(12,410)	23,781	1,247	2,214
Nonoperating gains (losses):								
Investment income and other, net	5,440	13,844	4,172	2,574	107	4,002	(3)	11
Unrestricted contributions	—	—	—	—	—	—	—	—
Net nonoperating gains (losses)	5,440	13,844	4,172	2,574	107	4,002	(3)	11
Revenue and gains in excess (deficient) of expenses and losses	4,270	20,246	22,813	2,507	(12,303)	27,783	1,244	2,225
Other changes in unrestricted net assets:								
Net assets released from restrictions for purchases of land, building, and equipment	—	—	203	—	4,190	—	—	—
Change in net unrealized gains and losses on other than trading securities	21,902	—	—	—	—	—	—	—
Designation as trading securities	(10,005)	—	—	—	—	—	—	—
Cumulative effect of a change in accounting principle	—	11,312	—	—	—	—	—	—
Increase (decrease) in unrestricted net assets	$ 16,167	31,558	23,016	2,507	(8,113)	27,783	1,244	2,225

(Continued)

ATTACHMENT 75

Schedule 2

RESURRECTION HEALTH CARE AND AFFILIATES

Consolidating Schedule – Operations and Changes in Unrestricted Net Assets Information

Year ended June 30, 2007

(In thousands)

	West Suburban Medical Center	Resurrection Senior Services	Resurrection Services	Resurrection Behavioral Health	Resurrection Home Health Services	Resurrection Development Foundation	Eliminations	Consolidated
Net service revenue	$ 193,524	118,231	30,127	—	14,745	—	—	1,606,564
Other revenue:								
Auxiliary services	6,939	2,043	23,930	13,483	—	—	(14,968)	60,959
Services provided to affiliates	—	8,337	—	—	—	—	(149,508)	—
Net assets released from restrictions for operations	51	—	—	254	—	—	—	2,276
Total revenue	200,514	128,611	54,057	13,737	14,745	—	(164,476)	1,669,799
Expenses:								
Salaries and wages	59,590	55,138	9,650	6,576	8,402	1,918	—	615,627
Payroll taxes and fringe benefits	16,445	18,478	3,848	2,128	1,800	315	—	176,990
Physicians' fees	11,599	331	6,311	1,340	—	—	—	82,540
Supplies	22,117	17,705	12,262	435	868	1	—	206,099
Other	15,217	15,772	16,965	918	1,167	854	(21,299)	155,636
Management services	13,342	7,360	1,812	878	2,385	43	(134,840)	—
Purchased services	8,104	1,916	1,595	966	43	188	(8,337)	55,818
Insurance	18,265	(2,670)	5,206	112	385	—	—	37,497
Depreciation and amortization	8,712	7,079	7,855	314	247	7	—	81,210
Provision for uncollectible accounts receivable	33,142	2,382	—	—	—	—	—	154,963
Interest	—	1,015	642	—	—	—	(1,096)	3,404
Assessments and taxes	16,473	1,373	—	—	—	—	—	95,938
Total expenses	223,006	125,879	66,146	13,667	15,297	3,326	(165,572)	1,665,722
Income (loss) from operations	(22,492)	2,732	(12,089)	70	(552)	(3,326)	1,096	4,077
Nonoperating gains (losses):								
Investment income and other, net	267	5,502	493	—	352	1,191	(1,096)	36,856
Unrestricted contributions	—	—	—	—	—	1,429	—	1,429
Net nonoperating gains (losses)	267	5,502	493	—	352	2,620	(1,096)	38,285
Revenue and gains in excess (deficient) of expenses and losses	(22,225)	8,234	(11,596)	70	(200)	(706)	—	42,362
Other changes in unrestricted net assets:								
Net assets released from restrictions for purchases of land, building, and equipment	179	3	—	—	—	—	—	4,575
Change in net unrealized gains and losses on other than trading securities	—	—	—	—	—	—	—	21,902
Designation of investments as trading	—	—	—	—	—	—	—	(10,005)
Cumulative effect of a change in accounting principle	—	—	—	—	—	—	—	11,312
Increase (decrease) in unrestricted net assets	$ (22,046)	8,237	(11,596)	70	(200)	(706)	—	70,146

See accompanying independent auditors' report.

ATTACHMENT 75

		2007	2006
Amount recognized in the accompanying consolidated statement of financial position consist of:			
Accrued pension liability	$	(154,757)	(157,599)
Accumulated charge to unrestricted net assets		—	47,008
Net amount recognized	$	(154,757)	(110,591)
Accumulated benefit obligation	$	(274,317)	(253,918)

		2007	2006
Components of net periodic benefit cost:			
Service cost	$	20,828	21,615
Expense load		450	450
Interest cost		15,616	13,297
Expected return on plan assets		(8,652)	(8,663)
Amortization of unrecognized net loss		2,460	4,030
Amortization of unrecognized prior service cost		(650)	(650)
Net periodic benefit cost	$	30,052	30,079
Estimated future benefit payments:			
Fiscal 2008	$	21,247	
Fiscal 2009		20,386	
Fiscal 2010		19,822	
Fiscal 2011		20,517	
Fiscal 2012		20,447	
Fiscal 2013 – 2017		122,433	
Expected contribution during fiscal 2008	$	30,000	
Weighted average assumptions used to determine benefit obligations at June 30:			
Settlement (discount) rate		6.26%	6.25%
Weighted average rate of increase in future compensation levels		4.00	4.00
Weighted average assumptions used to determine net periodic benefit cost for years ended June 30:			
Discount rate		6.25%	5.25%
Expected return on plan assets		8.50	8.50
Rate of compensation increase		4.00	4.00

RHC's overall expected long-term rate of return on assets is 8.5%. The expected long-term rate of return is based on the portfolio as a whole and not on the sum of the returns on individual asset categories. The return is based exclusively on historical returns, without adjustments.

RHC's pension plan weighted average asset allocations at June 30, 2007 and 2006, by asset category are as follows:

Asset category	Plan assets at June 30 2007	2006
Equities	75.5%	80.9%
Fixed income securities and cash equivalents	24.5	19.1

RHC has developed a Plan investment policy, which is reviewed and approved by the RHC Finance Committee and the boards of directors. The policy established goals and objectives of the fund, asset allocations, asset classifications, and manager guidelines. The policy reflects a target of up to 60% for equity securities. Investments are managed by independent advisors who are monitored by management and the Finance Committee. RHC monitors the asset allocation and executes required recalibrations of the portfolio allocation on a regular basis in response to fluctuations in market conditions and the overall portfolio composition.

RHC and Affiliates also have a defined contribution money purchase plan (Defined Contribution Plan). RHC and Affiliates contribute 25% of contributions made by employees to their tax deferred account up to a maximum contribution percentage of 1% of the participant's qualified income. RHC and Affiliates' boards of directors have amended Plan A and the Defined Contribution Plan whereby the employer matching contribution of the Defined Contribution Plan is considered a component of Plan A. Accordingly, this employer matching component has been included as a component of the accrued pension liability of Plan A as determined by the professional consulting actuary.

The WSMC retirement program consists of the West Suburban Health Care Retirement Income Plan (Income Plan), a noncontributory defined benefit pension plan, and the West Suburban Health Care Retirement Savings Plan (Savings Plan), a defined contribution pension plan, for which WSMC's employees are eligible. Effective January 1, 2002, the board of directors of WSMC authorized the curtailment of the Income Plan. As a result of this action, participation in the Income Plan is limited to participants entering on or before January 1, 2002, and no new benefits will accrue to participants subsequent to that date.

The Savings Plan became effective on January 1, 2002 and covers employees on the first day of employment after attaining the age of 21. Under the terms of the Savings Plan, employees may contribute up to 40% of eligible compensation subject to Internal Revenue Code salary deferral limitations. WSMC makes matching payments equal to 50% of a participant's salary deferral contributions up to the first 3%. WSMC also contributes 1.5% of each eligible employee's compensation into the Savings Plan, regardless of whether or not the employee elects to make salary deferrals into the Savings Plan. Participants vest 100% in WSMC contributions after one year of service. WSMC funds the Savings Plan on a current basis.

Effective January 1, 2004, participants of the West Suburban Health Care Retirement Income Plan and the West Suburban Health Care Retirement Savings Plan became participants in the RHC and Affiliates cash balance plans.

A summary of the changes in the projected benefit obligation and plan assets and the resulting funded status of the Income Plan is as follows at June 30, 2007 and 2006 (measurement dates):

		2007	2006
Change in projected benefit obligation:			
Projected benefit obligation at beginning of period	$	(58,676)	(67,050)
Interest cost		(3,510)	(3,477)
Actuarial gain		4,144	10,019
Benefits paid		1,954	1,832
Projected benefit obligation at end of period	$	(56,088)	(58,676)
Change in plan assets:			
Fair value of plan assets at beginning of period	$	43,283	42,473
Actual return on plan assets		8,228	2,642
Employer contributions		4,412	—
Benefits paid		(1,954)	(1,832)
Fair value of plan assets at end of period	$	53,969	43,283
Reconciliation of funded status:			
Funded status	$	(2,119)	(15,393)
Unrecognized net actuarial loss		—	15,909
Net amount recognized	$	(2,119)	516

		2007	2006
Accumulated benefit obligation	$	(56,088)	(58,676)
Amount recognized in the accompanying consolidated statement of financial position:			
Accrued pension liability	$	(2,119)	15,909
Accumulated charge to unrestricted net assets		—	(15,393)
Net amount recognized	$	(2,119)	516
Components of net periodic benefit cost:			
Interest cost	$	3,511	3,477
Expected return on plan assets		(3,743)	(3,533)
Amortization of unrecognized net loss		1,117	2,594
Net periodic benefit cost	$	885	2,538
Estimated future benefit payments:			
Fiscal 2008	$	2,097	
Fiscal 2009		2,356	
Fiscal 2010		2,471	
Fiscal 2011		2,603	
Fiscal 2012		2,827	
Fiscal 2013 – 2017		17,516	
Expected contributions during fiscal 2008:			
Minimum required contribution	$	3,198	
Weighted average assumptions used to determine benefit obligations:			
Settlement (discount) rate		6.43%	6.25%
Weighted average assumptions used to determine net periodic benefit cost:			
Discount rate		6.25%	5.25%
Expected return on plan assets		8.50	8.50

WSMC's overall expected long-term rate of return on assets is 8.5%. The expected long-term rate of return is based on the portfolio as a whole and not on the sum of the returns on individual asset categories. The return is based exclusively on historical returns, without adjustments.

WSMC's pension plan weighted average asset allocations at June 30, 2007 and 2006 by asset category are as follows:

Asset category	Plan assets at June 30 2007	2006
Equities	72.4%	72.0%
Fixed income securities and cash equivalents	27.6	28.0

WSMC has developed a Plan investment policy, which is reviewed and approved by the RHC Finance Committee and the boards of directors. The policy established goals and objectives of the fund, asset allocations, asset classifications, and manager guidelines. The policy dictates a specific asset allocations between equity and fixed income securities. Investments are managed by independent advisors who are monitored by management and the Finance Committee. RHC monitors the asset allocation and executes required recalibrations of the portfolio allocation on a regular basis in response to fluctuations in market conditions and the overall portfolio composition.

(10) Self-Insurance

Professional and General Liability

RHC and affiliates are self-insured for professional and general liability claims up to specified limits arising from incidents occurring after dates of entry into the program, which vary by corporation. Excess insurance coverage was occurrence-based through various dates, at which time all corporations changed to claims made-based coverage.

RHC and Affiliates are involved in litigation arising in the ordinary course of business. Claims alleging malpractice have been asserted against RHC and Affiliates and are currently in various stages of litigation. Provisions for professional and general liability claims include the ultimate cost of known claims and claims incurred but not reported as of the respective consolidated balance sheet dates. It is the opinion of management that the estimated malpractice liabilities accrued at June 30, 2007 and 2006 are adequate to provide for the ultimate cost of potential losses resulting from pending or threatened litigation; however, such estimates may be more or less than the amounts ultimately paid when claims are resolved. Estimated malpractice claims have been discounted at a rate of 5% at June 30, 2007 and 2006. The accrued liability estimated for self-insured professional and general liability claims amounted to $249,502 and $242,309 at June 30, 2007 and 2006, respectively. All self-insured malpractice and general claim liabilities are reported as long-term liabilities as the portion expected to be paid within one year is not readily determinable.

Workers' Compensation

The Hospitals maintain self-insurance programs for workers' compensation coverage. These programs limit the self-insured retention to specific amounts on a per occurrence basis. Coverage from commercial insurance carriers is maintained for claims in excess of the self-insured retention. Accrued workers' compensation claims amounted to $5,985 and $5,242 at June 30, 2007 and 2006, respectively. Management believes the estimated self-insured workers' compensation claims liability

at June 30, 2007 and 2006 is adequate to cover the ultimate liability; however, such estimates may be more or less than the amounts ultimately paid when claims are resolved. The portion of workers' compensation claims expected to be paid beyond one year of the statements of financial position dates is not readily determinable and, therefore, the entire accrual is classified as a current liability included within accounts payable and accrued expenses in the accompanying consolidated balance sheets.

Health Care

RHC and Affiliates also maintains a program of self-insurance for employee health coverage. Stop-loss reinsurance coverage is maintained for claims in excess of stop-loss limits. Accrued self-insured employee health care claims amounted to $4,819 and $6,111 for 2007 and 2006, respectively, and are included with accounts payable and accrued expenses in the accompanying consolidated balance sheets. It is the opinion of management that the estimated health care costs accrued at June 30, 2007 and 2006 are adequate to provide for the ultimate liability; however, final payouts as claims are paid may vary significantly from estimated claim liabilities.

(11) Contingencies

Medicare Reimbursement

For the year ended June 30, 2007, RHC and Affiliates recognized approximately $595,707 of net service revenue from services provided to Medicare beneficiaries. Recent federal legislation have included provisions to reduce Medicare payments to health care providers as well as phase out cost based reimbursement mechanisms to prospective payment methodologies. Changes in Medicare reimbursement as a result of the Health Care Financing Administration's implementation of the provisions of recent Medicare legislation may have an adverse effect on RHC and Affiliates' net service revenues.

Litigation

RHC and Affiliates are involved in litigation and regulatory investigations arising in the normal course of business. In consultation with legal counsel, management estimates that these matters will be resolved without material adverse effect on RHC and Affiliates' financial position or results from operations.

Regulatory Investigations

The U.S. Department of Justice and other federal agencies routinely conduct regulatory investigations and compliance audits of health care providers. RHC and Affiliates are subject to these regulatory efforts. Management is currently unaware of any regulatory matters, which may have a material adverse effect on RHC and Affiliates' financial position or results of operations.

(12) Asbestos Removal Costs

In March 2005, the Financial Accounting Standards Board issued interpretation No. 47, *Accounting for Conditional Asset Retirement Obligations* (FIN 47). FIN 47 requires the current recognition of a liability when a legal obligation exists to perform an asset retirement obligation in which the timing or method of settlement are conditional on a future event that may or may not be under the control of the entity. FIN 47 requires an asset retirement obligation (ARO) liability be recorded at its net present value with recognition of a related long-lived asset in a corresponding amount. The ARO liability is accreted through periodic charges to depreciation expense. The initially capitalized ARO long-lived asset is depreciated over the corresponding long-lived asset's remaining useful life. RHC and Affiliates adopted FIN 47 effective as of June 30, 2006.

RHC and Affiliates are legally liable to remove asbestos from existing buildings prior to future remodeling or demolishing of the existing buildings. The estimated asbestos removal cost at June 30, 2007 and 2006 were $13,418 and $14,121, respectively. The net book value of the ARO long-lived asset at June 30, 2007 and 2006 was $0. The excess of the ARO liability over the net book value of the ARO long-lived asset at June 30, 2006 of $14,121 has been reported as a cumulative effect of a change in accounting principle.

Schedule 1

RESURRECTION HEALTH CARE AND AFFILIATES

Consolidating Schedule – Financial Position Information

June 30, 2007

(In thousands)

Assets	Resurrection Health Care	Resurrection Medical Center	Saint Francis Hospital	Our Lady of the Resurrection Medical Center	Westlake Hospital	Saints Mary and Elizabeth Medical Center	Holy Family Medical Center	Saint Joseph Hospital
Current assets:								
Cash and cash equivalents	$ 2,698	1,119	6,952	387	1,923	5,786	—	—
Assets whose use is limited or restricted – required for current liabilities	17,248	—	—	—	—	—	—	—
Patient and resident accounts receivable, net of allowance for uncollectible accounts of $89,568	—	38,326	23,608	19,879	11,172	31,668	15,640	22,197
Other receivables	2,773	5,609	18,016	3,979	10,925	26,390	2,653	8,090
Inventory of supplies	—	2,170	1,127	847	511	3,111	1,134	3,462
Prepaid expenses and other current assets	14,958	12,953	376	724	114	591	252	406
Due from affiliates	174,433	199,942	—	—	—	—	—	—
Total current assets	212,110	260,119	50,079	25,816	24,645	67,546	19,679	34,155
Assets whose use is limited or restricted:								
By Boards for reinvestment and self-insurance	346,157	266,092	85,231	38,770	—	68,617	1,064	—
Under bond indenture agreements – held by trustee	5,839	—	—	—	—	—	1,169	—
By donors – permanently restricted	—	—	—	—	—	—	—	—
	351,996	266,092	85,231	38,770	—	68,617	2,233	—
Land, buildings, and equipment, net	149,303	22,029	83,718	37,658	40,215	69,465	35,238	71,481
Deferred finance charges	9,523	—	—	—	—	—	1,245	—
Other assets	30,979	3,820	447	13	—	1,688	125	1,721
	$ 753,911	552,060	219,475	102,257	64,860	207,316	58,520	107,357

(Continued)

ATTACHMENT 75

Schedule 1

RESURRECTION HEALTH CARE AND AFFILIATES

Consolidating Schedule – Financial Position Information

June 30, 2007

(In thousands)

Assets	West Suburban Medical Center	Resurrection Senior Services	Resurrection Services	Resurrection Behavioral Health	Resurrection Home Health Services	Resurrection Development Foundation	Eliminations	Consolidated
Current assets:								
Cash and cash equivalents	$ —	8,849	1,200	1,923	9	2,047	—	32,893
Assets whose use is limited or restricted – required for current liabilities	2,627	—	—	—	—	—	—	19,875
Patient and resident accounts receivable, net of allowance for uncollectible accounts of $89,568	22,480	13,007	5,607	1,064	2,383	—	—	207,031
Other receivables	13,889	833	2,043	—	—	6,840	—	102,040
Inventory of supplies	1,737	473	1,304	—	—	—	—	15,876
Prepaid expenses and other current assets	738	500	563	31	—	732	—	32,938
Due from affiliates	—	—	—	—	—	839	(375,214)	—
Total current assets	41,471	23,662	10,717	3,018	2,392	10,458	(375,214)	410,653
Assets whose use is limited or restricted:								
By Boards for reinvestment and self-insurance	—	107,371	—	—	—	19,391	—	932,693
Under bond indenture agreements – held by trustee	—	—	—	—	—	—	—	7,008
By donors – permanently restricted	82	—	—	—	—	13,968	—	14,050
	82	107,371	—	—	—	33,359	—	953,751
Land, buildings, and equipment, net	63,815	127,218	100,215	3,549	269	202	—	804,375
Deferred finance charges	—	—	—	—	—	—	—	10,768
Other assets	342	306	17	—	1,937	—	(28,026)	13,369
	$ 105,710	258,557	110,949	6,567	4,598	44,019	(403,240)	2,192,916

(Continued)

ATTACHMENT 75

Schedule 1

RESURRECTION HEALTH CARE AND AFFILIATES

Consolidating Schedule – Financial Position Information

June 30, 2007

(In thousands)

Liabilities and Net Assets	Resurrection Health Care	Resurrection Medical Center	Saint Francis Hospital	Our Lady of the Resurrection Medical Center	Westlake Hospital	Saints Mary and Elizabeth Medical Center	Holy Family Medical Center	Saint Joseph Hospital
Current liabilities:								
Current installments of long-term debt	$ 13,895	—	—	—	—	—	1,402	—
Accounts payable and accrued expenses	13,998	27,675	8,097	5,377	4,675	18,190	4,516	9,138
Accrued payroll and fringe benefits	—	55,472	—	—	—	148	1,463	1,335
Estimated payables under third-party reimbursement programs	—	22,543	18,660	5,422	6,478	10,833	7,341	29,286
Deferred revenue and refundable deposits	—	—	—	—	—	—	—	—
Due to affiliates	—	—	7,158	2,974	21,139	44,655	40,093	19,361
Total current liabilities	27,893	105,690	33,915	13,773	32,292	73,826	54,815	59,120
Long-term debt, excluding current installments and unamortized bond discount	680,265	—	—	—	28,026	—	40,137	—
Accrued pension liability	—	156,876	—	—	—	—	—	—
Estimated self-insured professional and general liability claims	—	45,177	39,146	13,195	24,097	39,379	8,810	21,288
Asset retirement obligation	13,418	—	—	—	—	—	—	—
Other	—	—	—	—	—	—	—	1,334
Total liabilities	721,576	307,743	73,061	26,968	84,415	113,205	103,762	81,742
Net assets (liabilities):								
Unrestricted	32,335	244,317	146,414	75,289	(19,555)	94,102	(45,242)	25,615
Temporarily restricted	—	—	—	—	—	9	—	—
Permanently restricted	—	—	—	—	—	—	—	—
Total net assets (liabilities)	32,335	244,317	146,414	75,289	(19,555)	94,111	(45,242)	25,615
	$ 753,911	552,060	219,475	102,257	64,860	207,316	58,520	107,357

(Continued)

ATTACHMENT 75

Schedule 1

RESURRECTION HEALTH CARE AND AFFILIATES

Consolidating Schedule – Financial Position Information

June 30, 2007

(In thousands)

Liabilities and Net Assets	West Suburban Medical Center	Resurrection Senior Services	Resurrection Services	Resurrection Behavioral Health	Resurrection Home Health Services	Resurrection Development Foundation	Eliminations	Consolidated
Current liabilities:								
Current installments of long-term debt	$ —	223	—	—	—	—	—	15,520
Accounts payable and accrued expenses	16,684	5,314	5,816	222	141	47	—	119,890
Accrued payroll and fringe benefits	5,298	—	—	—	—	—	—	63,716
Estimated payables under third-party reimbursement programs	1,332	2,605	—	—	—	—	—	104,500
Deferred revenue and refundable deposits	—	45,907	—	119	—	—	—	46,026
Due to affiliates	67,660	52,902	103,028	4,360	11,884	—	(375,214)	—
Total current liabilities	90,974	106,951	108,844	4,701	12,025	47	(375,214)	349,652
Long-term debt, excluding current installments and unamortized bond discount	—	12,787	—	—	—	—	(28,026)	733,189
Accrued pension liability	—	—	—	—	—	—	—	156,876
Estimated self-insured professional and general liability claims	58,410	—	—	—	—	—	—	249,502
Asset retirement obligation	—	—	—	—	—	—	—	13,418
Other	—	—	—	—	—	—	—	1,334
Total liabilities	149,384	119,738	108,844	4,701	12,025	47	(403,240)	1,503,971
Net assets (liabilities):								
Unrestricted	(43,721)	138,819	2,105	1,866	(7,427)	12,012	—	656,929
Temporarily restricted	47	—	—	—	—	17,910	—	17,966
Permanently restricted	—	—	—	—	—	14,050	—	14,050
Total net assets (liabilities)	(43,674)	138,819	2,105	1,866	(7,427)	43,972	—	688,945
	$ 105,710	258,557	110,949	6,567	4,598	44,019	(403,240)	2,192,916

See accompanying independent auditors' report.

ATTACHMENT 75

Schedule 2

RESURRECTION HEALTH CARE AND AFFILIATES

Consolidating Schedule – Operations and Changes in Unrestricted Net Assets Information

Year ended June 30, 2007

(In thousands)

	Resurrection Health Care	Resurrection Medical Center	Saint Francis Hospital	Our Lady of the Resurrection Medical Center	Westlake Hospital	Saints Mary and Elizabeth Medical Center	Holy Family Medical Center	Saint Joseph Hospital
Net service revenue	$ —	280,715	190,659	133,156	103,772	299,033	55,113	187,489
Other revenue:								
Auxiliary services	12,206	4,151	2,900	940	1,604	4,321	918	2,492
Services provided to affiliates	141,171	—	—	—	—	—	—	—
Net assets released from restrictions for operations	—	426	537	159	793	5	1	50
Total revenue	153,377	285,292	194,096	134,255	106,169	303,359	56,032	190,031
Expenses:								
Salaries and wages	67,192	100,122	49,413	44,715	35,465	91,712	20,521	65,213
Payroll taxes and fringe benefits	17,890	28,900	14,313	12,501	10,124	25,498	5,130	19,620
Physicians' fees	3	14,926	10,797	4,816	9,084	8,858	1,314	13,161
Supplies	289	49,026	20,920	14,331	12,350	29,650	3,569	22,576
Other	46,360	25,871	10,323	8,780	4,091	10,750	5,197	14,670
Management services	—	23,938	16,750	12,947	10,602	25,386	3,363	16,034
Purchased services	7,508	4,343	4,263	2,263	5,633	16,064	3,408	7,861
Insurance	(563)	(1,303)	4,678	(3,853)	9,217	8,889	(1,868)	1,002
Depreciation and amortization	15,868	5,996	9,099	4,650	4,233	6,540	4,625	5,985
Provision for uncollectible accounts receivable	—	11,844	24,622	24,695	10,045	37,332	3,180	7,721
Interest	—	—	—	—	1,096	—	1,747	—
Assessments and taxes	—	15,227	10,277	8,477	6,639	18,899	4,599	13,974
Total expenses	154,547	278,890	175,455	134,322	118,579	279,578	54,785	187,817
Income (loss) from operations	(1,170)	6,402	18,641	(67)	(12,410)	23,781	1,247	2,214
Nonoperating gains (losses):								
Investment income and other, net	5,440	13,844	4,172	2,574	107	4,002	(3)	11
Unrestricted contributions	—	—	—	—	—	—	—	—
Net nonoperating gains (losses)	5,440	13,844	4,172	2,574	107	4,002	(3)	11
Revenue and gains in excess (deficient) of expenses and losses	4,270	20,246	22,813	2,507	(12,303)	27,783	1,244	2,225
Other changes in unrestricted net assets:								
Net assets released from restrictions for purchases of land, building, and equipment	—	—	203	—	4,190	—	—	—
Change in net unrealized gains and losses on other than trading securities	21,902	—	—	—	—	—	—	—
Designation as trading securities	(10,005)	—	—	—	—	—	—	—
Cumulative effect of a change in accounting principle	—	11,312	—	—	—	—	—	—
Increase (decrease) in unrestricted net assets	$ 16,167	31,558	23,016	2,507	(8,113)	27,783	1,244	2,225

(Continued)

ATTACHMENT 75

Schedule 2

RESURRECTION HEALTH CARE AND AFFILIATES

Consolidating Schedule – Operations and Changes in Unrestricted Net Assets Information

Year ended June 30, 2007

(In thousands)

	West Suburban Medical Center	Resurrection Senior Services	Resurrection Services	Resurrection Behavioral Health	Resurrection Home Health Services	Resurrection Development Foundation	Eliminations	Consolidated
Net service revenue	$ 193,524	118,231	30,127	—	14,745	—	—	1,606,564
Other revenue:								
Auxiliary services	6,939	2,043	23,930	13,483	—	—	(14,968)	60,959
Services provided to affiliates	—	8,337	—	—	—	—	(149,508)	—
Net assets released from restrictions for operations	51	—	—	254	—	—	—	2,276
Total revenue	200,514	128,611	54,057	13,737	14,745	—	(164,476)	1,669,799
Expenses:								
Salaries and wages	59,590	55,138	9,650	6,576	8,402	1,918	—	615,627
Payroll taxes and fringe benefits	16,445	18,478	3,848	2,128	1,800	315	—	176,990
Physicians' fees	11,599	331	6,311	1,340	—	—	—	82,540
Supplies	22,117	17,705	12,262	435	868	1	—	206,099
Other	15,217	15,772	16,965	918	1,167	854	(21,299)	155,636
Management services	13,342	7,360	1,812	878	2,385	43	(134,840)	—
Purchased services	8,104	1,916	1,595	966	43	188	(8,337)	55,818
Insurance	18,265	(2,670)	5,206	112	385	—	—	37,497
Depreciation and amortization	8,712	7,079	7,855	314	247	7	—	81,210
Provision for uncollectible accounts receivable	33,142	2,382	—	—	—	—	—	154,963
Interest	—	1,015	642	—	—	—	(1,096)	3,404
Assessments and taxes	16,473	1,373	—	—	—	—	—	95,938
Total expenses	223,006	125,879	66,146	13,667	15,297	3,326	(165,572)	1,665,722
Income (loss) from operations	(22,492)	2,732	(12,089)	70	(552)	(3,326)	1,096	4,077
Nonoperating gains (losses):								
Investment income and other, net	267	5,502	493	—	352	1,191	(1,096)	36,856
Unrestricted contributions	—	—	—	—	—	1,429	—	1,429
Net nonoperating gains (losses)	267	5,502	493	—	352	2,620	(1,096)	38,285
Revenue and gains in excess (deficient) of expenses and losses	(22,225)	8,234	(11,596)	70	(200)	(706)	—	42,362
Other changes in unrestricted net assets:								
Net assets released from restrictions for purchases of land, building, and equipment	179	3	—	—	—	—	—	4,575
Change in net unrealized gains and losses on other than trading securities	—	—	—	—	—	—	—	21,902
Designation of investments as trading	—	—	—	—	—	—	—	(10,005)
Cumulative effect of a change in accounting principle	—	—	—	—	—	—	—	11,312
Increase (decrease) in unrestricted net assets	$ (22,046)	8,237	(11,596)	70	(200)	(706)	—	70,146

See accompanying independent auditors' report.

ATTACHMENT 75

EXECUTION COPY

ASSET PURCHASE AGREEMENT

by and among

West Suburban Medical Center, Westlake Community Hospital,
Resurrection Services, and Resurrection Ambulatory Services,
each an Illinois not-for-profit corporation

and

VHS Westlake Hospital, Inc. and
VHS West Suburban Medical Center, Inc.,
each a Delaware corporation

DATED: March 17, 2010

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LIST OF SCHEDULES

Those Schedules provided in the Disclosure Schedules; and:

SCHEDULE	DESCRIPTION
A-1	Retail Pharmacy Operations
A-2	River Forest Facilities
A-3	MOBs
A-4	Related Real Property
A-5	Related Businesses
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1.1(b)	Leased Real Property
1.1(c)	Personal Property
1.1(d)	Licenses
1.1(e)	Leases
1.1(f)	Assumed Contracts
1.1(f)(i)	Multi-Facility Contracts
1.1(f)(ii)	Other Excluded Contracts
1.1(g)	Prepaids
1.1(i)	Equity Interests
1.1(n)	Names
1.1(p)	Practice Support Agreements
1.1(q)	Nurse Education Loans
1.1(s)	Telephone Numbers
1.1(t)	Computer Hardware
1.2(e)	Excluded Proprietary Assets
1.2(j)	Affiliate Contracts
1.2(m)	Catholic Artifacts
1.2(p)	Assets and Membership Interests
1.2(t)	Accounts and Deposits
1.2(y)	Other Excluded Assets
1.3(e)	Tuition Reimbursement
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4.5	Consents
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4.6(b)	Environmental Matters
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SCHEDULE	DESCRIPTION
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11.1(c)	Safety Net Payments
13.1(b)	Allocation of Purchase Price
14.12	Email Duplication Process

ASSET PURCHASE AGREEMENT

This Asset Purchase Agreement (this "**Agreement**") is made and entered into as of the 17th day of March, 2010 (the "**Execution Date**") by and among West Suburban Medical Center, an Illinois not-for-profit corporation ("**West Suburban Corporation**"), Westlake Community Hospital, an Illinois not-for-profit corporation ("**Westlake Corporation**"), Resurrection Services, an Illinois not-for-profit corporation ("**Resurrection Services**") and Resurrection Ambulatory Services, an Illinois not-for-profit corporation ("**RAS**") (West Sub, Westlake, Resurrection Services and RAS are collectively referred to herein as the "**Sellers**"), on the one hand, and VHS Westlake Hospital, Inc., a Delaware corporation ("**VHS Westlake**") and VHS West Suburban Medical Center, Inc., a Delaware corporation ("**VHS West Sub**") (VHS Westlake and VHS West Sub are collectively referred to herein as the "**Purchasers**"), on the other hand. The Sellers and the Purchasers shall each individually be a "**Party**" and all collectively the "**Parties.**"

RECITALS:

A. The Sellers: (i) engage in the business of delivering health care services to the public in connection with the acute care hospitals known as West Suburban Medical Center and Westlake Hospital, including the retail pharmacy operations identified on Schedule A-1 (the "**Hospitals**"); (ii) engage in the business of delivering health care services to the public in connection with the diagnostic and ambulatory care facilities located on an integrated campus in River Forest, Illinois including the cardiac diagnostics, breast center and advanced imaging center services identified on Schedule A-2 (the "**River Forest Facilities**"); (iii) own and operate certain medical office buildings incident to the operation of the Hospitals or River Forest Facilities as specifically identified on Schedule A-3 (the "**MOBs**"); (iv) own certain residential and other real property in areas adjacent to or near the Hospitals or the River Forest Facilities identified on Schedule A-4 (the "**Related Real Property**"); and (v) own and/or operate physician practices and other healthcare businesses or interests in health care related joint ventures incident to the operation of the Hospitals or the River Forest Facilities as specifically identified on Schedule A-5 (the "**Related Businesses**") (the Hospitals, the River Forest Facilities, the MOBs, the Related Real Property and the Related Businesses are referred to in this Agreement collectively as the "**Facilities**").

B. The Purchasers are in the business of owning and operating hospitals and related businesses and desire to purchase from the Sellers, and the Sellers desire to sell to the Purchasers, substantially all of the Acquired Assets (as defined below) used in the operation of the Facilities, for the consideration and upon the terms and conditions contained in this Agreement.

C. The Purchasers are committed to serving the health needs of the residents of Cook County, Illinois, and the communities served by the Facilities, and in furtherance thereof, the Parties have determined that the needs of such communities will be promoted by the Purchasers' acquisition of the Facilities on the terms set forth herein.

NOW, THEREFORE, in consideration of the foregoing premises (which are hereby made a part of this Agreement) and the mutual promises and covenants contained in this

Agreement, the receipt and sufficiency of which are hereby acknowledged, and for their mutual reliance, the Parties agree as follows:

ARTICLE 1

TRANSACTION TERMS

1.1 Transfer of the Sellers Assets. On the Closing Date, except as set forth in Section 1.2, the Sellers shall assign, transfer, convey and deliver to the Purchasers, and the Purchasers shall acquire, effective at the Effective Date, all of Westlake's and West Sub's right, title and interest in and to all of the assets owned or used by them in connection with operation of the Hospitals and all right, title and interest of Resurrection Services or RAS in those assets used exclusively or primarily by them in connection with the operation of the Facilities, including, without limitation, the following assets and properties (collectively, the "**Acquired Assets**"):

(a) all of the real property that is owned by the Sellers and associated or used with respect to the operation of the Facilities, including, without limitation, the real property that is described in Schedule 1.1(a) (such description to include a PIN number and street address), together with all buildings, improvements and fixtures located thereupon and all construction in progress, rights, privileges and appurtenances thereto (collectively, the "**Owned Real Property**");

(b) all leasehold interests of the Sellers related to the operation of the Facilities described in Schedule 1.1(b), together with all buildings, improvements and fixtures located thereupon and all construction in progress, rights, privileges and appurtenances thereto (the "**Leased Real Property**") (the Owned Real Property and the Leased Real Property are collectively referred to in this Agreement as the "**Real Property**");

(c) all of the tangible personal property owned by the Sellers with respect to the operation of the Facilities, including all medical and other equipment, furniture, fixtures, machinery, vehicles, office furnishings, and leasehold improvements (the "**Personal Property**"), including, without limitation, the Personal Property described in Schedule 1.1(c) and the computer hardware and related equipment described in Schedule 1.1(t);

(d) all of the Sellers' rights, to the extent assignable or transferable, to all licenses, provider numbers issued by governmental bodies, permits, approvals, certificates of need or exemption, franchises, accreditations and registrations and other governmental licenses, permits or approvals issued to the Sellers with respect to the ownership of the Acquired Assets and the operation of the Facilities (the "**Licenses**"), including, without limitation, the Licenses described in Schedule 1.1(d);

(e) all of the Sellers' interest, to the extent assignable or transferable, in and to all real property leases for which a Seller is the landlord (the "**Seller Leases**") and the personal property leases (the "**Personal Property Leases**") with respect to the operation of the Facilities (the Seller Leases and the Personal Property Leases are collectively referred to as the "**Leases**") indicated on Schedule 1.1(e) as being assigned to and assumed by the Purchasers;

(f) all of the Sellers' interest, to the extent assignable or transferable, in and to all contracts and agreements (including, but not limited to, purchase orders) with respect to the ownership of the Acquired Assets and the operation of the Facilities indicated on Schedule 1.1(f) as being assigned to and assumed by the Purchasers (collectively, along with the Leases, the "**Assumed Contracts**"); provided, however, the term Assumed Contracts as used in this Agreement shall exclude, subject to Section 11.3: (i) any multi-facility contracts as to which the Facilities and one or more of the Sellers' or the Sellers' affiliates' other acute care hospitals (which are not the Facilities) participate (the "**Multi-Facility Contracts**") except to the extent it is feasible to assign the portion of such contracts pertaining to the applicable Facilities, as more particularly described on Schedule 1.1(f)(i); or (ii) any contracts to which any of the Sellers are a party used in connection with the Acquired Assets and that are identified by Sellers as excluded as set forth on Schedule 1.1(f)(ii) (the "**Other Excluded Contracts**") (the Multi-Facility Contracts and the Other Excluded Contracts collectively are referred to as the "**Excluded Contracts**");

(g) all of those advance payments, prepayments, prepaid expenses (exclusive of prepayments on insurance policies), deposits and the like which exist as of the Closing Date, subject to the prorations provided in Section 2.4 of this Agreement, which were made with respect to the operation of the Facilities (the "**Prepaids**"), the current categories and amounts of which are set forth on Schedule 1.1(g);

(h) except as excluded by Section 1.2(j), all usable inventories of supplies, drugs, food, janitorial and office supplies and other disposables and consumables located at the Facilities, or used with respect to the operation of the Facilities (the "**Inventory**");

(i) all equity or membership interests held by the Sellers that are described on Schedule 1.1(i);

(j) all documents, records, operating manuals, and files with respect to the operation of the Facilities, including, without limitation, all patient records, medical records, employee records related to the Hired Employees (except portions of such records protected by law or contract), financial and billing records with respect to the operation of the Facilities, equipment records, construction plans and specifications, and medical and administrative libraries, but exclusive of any documents and information contained in, or any software or systems to operate, the email system maintained by the Sellers other than emails that are more than twelve (12) months old as of the Effective Date, or contain privileged, competitively sensitive or proprietary information pertaining to the Resurrection Health Care System and not pertinent to the operations of the Facilities after the Closing Date (as set forth in Section 1.2(v));

(k) to the extent assignable, all rights in all warranties of any manufacturer or vendor in connection with the Personal Property;

(l) all goodwill of the businesses evidenced by the Acquired Assets;

(m) all insurance proceeds (after application of Seller deductibles or co-insurance payments) arising in connection with property damage to the Acquired Assets

occurring after the Execution Date and prior to the Effective Date, to the extent not expended on the repair or restoration of the Acquired Assets;

(n) all of the Sellers' rights in the names "West Suburban Medical Center", "Westlake Hospital", "Westlake Community Hospital" and such other names used exclusively with respect to the operation of the Facilities set forth on Schedule 1.1(n) and, with respect to such names, all abbreviations and variations thereof, and the descriptive content used to describe the Facilities on the website maintained by Resurrection Health Care Corporation, an Illinois not-for-profit corporation ("**Resurrection**"), for the system of entities comprising the Resurrection Health Care System;

(o) any current assets of the Sellers with respect to the operation of the Facilities (which are not otherwise specifically described in this Section 1.1) which are included in Net Working Capital, as determined pursuant to Sections 2.1 and 2.3;

(p) except as excluded by Section 1.2 and subject to Section 2.3, all (1) accounts, notes, interest and other receivables of the Sellers, including (A) accounts receivable for health care or other services provided to physicians or their family members and (B) all accounts, notes or other amounts receivable from physicians related to recruitment, income guaranty or similar practice support arrangements for which any of the Sellers has an outstanding potential obligation to loan or advance funds, pursuant to the agreements described at Schedule 1.1(p); and (2) all claims, rights, interests and proceeds related thereto, including all accounts and other receivables, arising from the rendering of services to inpatients and outpatients at the Facilities, billed and unbilled, recorded and unrecorded, for services provided by the Sellers while owners of the Acquired Assets or otherwise to the extent related to the Facilities whether payable by private pay patients, private insurance, third party payors, Medicare, Medicaid, TRICARE, Blue Cross, or by any other source (collectively, the "**Accounts Receivable**"), including any Accounts Receivable related to patient care services that have been written off as bad debt or are related to zero balance accounts;

(q) the balance of any loans that are subject to repayment or forgiveness and that were made to Hired Employees who are nurses at either of the Hospitals in connection with tuition for the West Suburban College of Nursing, as set forth on Schedule 1.1(q) (the "**Nurse Education Loans**");

(r) all claims of Sellers (whether known or unknown, contingent or otherwise) against third parties (other than affiliates of Sellers) with respect to the service and/or maintenance of any tangible Acquired Assets arising after the Execution Date and prior to the Effective Date, other than those claims as to which Sellers have a right to money damages based on a prior expenditure of money with respect to any such tangible Acquired Assets;

(s) telephone numbers used exclusively with respect to the operation of the Facilities set forth on Schedule 1.1(s); and

(t) except as otherwise included in Schedule 1.1(c) or excluded in Section 1.2(e), computer hardware and data processing equipment of the Sellers or the affiliates of Sellers on site at the Facilities or otherwise listed on Schedule 1.1(t) and the licenses to the

software listed on Schedule 1.1(t) solely with respect to the use of such software at the Facilities and to the extent the applicable vendors have consented to the assignment of such licenses;

provided, however, that the Acquired Assets shall not include the Excluded Assets as defined in Section 1.2 below.

1.2 Excluded Assets. Notwithstanding anything to the contrary in Section 1.1, the Sellers shall retain the following assets of the Sellers (collectively, the "**Excluded Assets**"):

(a) cash, cash equivalents, and short-term and long-term investments;

(b) all intercompany receivables of the Sellers with any of the Sellers' affiliates, after any appropriate adjustments to identify assets relating to operation or ownership of the Facilities, which will be included in the calculation of Net Working Capital;

(c) accounts, notes or other amounts receivable from physicians pursuant to a recruitment, income guaranty or similar practice support arrangement, for which none of the Sellers has any remaining potential obligation to loan or advance funds;

(d) any current assets of the Sellers with respect to the operation of the Facilities which are not included in Net Working Capital, including any cost report settlements for periods prior to the Effective Date;

(e) except as otherwise set forth in Section 1.1(t), computer software, programs and hardware or data processing equipment which is (i) proprietary to or owned or licensed by the Sellers and/or the Sellers' affiliates, data processing system manuals and licensed software materials, as more particularly described in Schedule 1.2(e); or (ii) used in connection with the operation of one or more of the Sellers' or the Sellers' affiliates' acute care hospitals other than the Facilities, including the software and systems necessary to operate the electronic ICU monitoring and the email system used by Sellers prior to the Effective Date;

(f) all of the Sellers' or any affiliate of the Sellers' proprietary manuals, policy and procedure manuals, standard operating procedures and data and studies or analyses (but not including policy and procedure manuals and standard operating procedures that relate to or affect employee or patient care and safety (which the Purchasers are entitled to use following the Closing Date, provided that the Purchasers have cooperated with the Sellers in arranging for adequate actions to be taken to indicate that as used, such policies are deemed policies of the Purchasers and provided further that the Sellers do not make any representations or warranties with respect to the content of such policies);

(g) any asset which would revert to the employer upon the termination of any Seller Plan, including assets representing a surplus or overfunding of any Seller Plan;

(h) the Excluded Contracts;

(i) except as otherwise set forth in Section 1.1(n), any and all names, tradenames, trademarks, symbols or world-wide web addresses associated with the Sellers or the Sellers' affiliates, including, but not limited to, "Resurrection", "Resurrection Health Care

Corporation", "RES-Health", "For All of You, All of Your Life", the butterfly design and logo, "Res-Info", "reshealth.org" and the content therein, and, with respect to any of the foregoing, all abbreviations and variations thereof, and trademarks, trade names, service marks, copyrights and any applications therefor, symbols and logos related thereto, together with any promotional material, stationery, supplies or other items of inventory to the extent bearing such names or symbols or abbreviations or variations thereof;

(j) certain contracts between any of the Sellers and any affiliate of the Sellers with respect to the Acquired Assets, as set forth on Schedule 1.2(j);

(k) the portions of Inventory, Prepaids and other Assets disposed of, expended or canceled, as the case may be, by the Sellers after the Execution Date and prior to the Effective Date in the ordinary course of business;

(l) assets owned and provided by vendors of services or goods to the Facilities;

(m) any Catholic artifacts and symbols in or at the Facilities and owned by any of Sellers or their affiliates on the Effective Date, including those set forth on Schedule 1.2(m) (and Sellers will be responsible for repairing damage to the premises caused by the removal of such artifacts), except as set forth on such Schedule 1.2(m);

(n) all claims, rights, interests and proceeds with respect to state or local tax refunds (including but not limited to property tax) resulting from periods prior to the Effective Date, and the right to pursue appeals of same, which are not included in Net Working Capital;

(o) all of the Sellers' corporate record books and minute books;

(p) any assets of, and any membership interests of Sellers in, (i) joint venture entities other than those referenced on Schedule A-5, and, in particular, excluding any interest in joint venture entities of the Alverno Clinical Laboratory joint venture and the Sellers' interests in the limited liability company operating a sleep center at the River Forest campus (except to the extent any interest in such sleep center entity are subsequently made available for purchase by the Purchasers), and (ii) the West Suburban College of Nursing (except for the Real Property currently occupied by the West Suburban College of Nursing at the West Suburban campus), including, but not limited to those assets set forth on Schedule 1.2(p);

(q) all rights in bequests, grants, donor-restricted gifts and other similar assets;

(r) all unclaimed property of any third party which is subject to applicable escheat laws;

(s) all claims, rights, interests and proceeds (whether received in cash or by credit to amounts otherwise due to a third party) with respect to amounts overpaid by the Sellers to any third party with respect to periods prior to the Effective Date (e.g. such overpaid amounts may be determined by billing audits undertaken by the Sellers or the Sellers' consultants), which are not included in Net Working Capital;

(t) all bank, custodial, escrow and investment accounts of the Sellers, and all deposits with governmental entities unrelated to any Assumed Obligations and described on Schedule 1.2(t);

(u) all rights, claims and choses in action of the Sellers and their affiliates with respect to periods prior to the Effective Date, and any payments, awards or other proceeds resulting therefrom, in either case which are not included in Net Working Capital;

(v) all writings and other items that are protected from discovery by the attorney-client privilege, the attorney work product doctrine or any other cognizable privilege or protection, or contain competitively sensitive or proprietary information pertaining to Resurrection Health Care System and not pertinent to the operations of the Facilities after the Closing Date;

(w) any receipts relating to the Seller Cost Reports or Agency Settlements (whether resulting from an appeal by the Sellers or otherwise) which correspond to amounts which the Sellers previously paid to the applicable payor (or which the Sellers paid to the Purchasers as reimbursement for amounts which the Purchasers were required to pay the applicable payor) with respect to time periods prior to the Effective Date;

(x) underpayments determined to be due from Medicare through the conduct of Medicare's Recovery Audit Program and from the State of Illinois through program audits or reviews conducted by the Illinois Department of Health Care and Family Services, to the extent related to services provided in any period prior to the Effective Date; and

(y) any assets of Resurrection or any of its affiliates other than the Sellers that are not specified as included among the Acquired Assets (and which assets are not integral to the operations of the Facilities or reflected on the books of the Sellers), and such other assets identified in Schedule 1.2(y).

1.3 Assumed Obligations. On the Closing Date, the Sellers shall assign, and the Purchasers shall assume and agree to discharge on and after the Effective Date, the following liabilities and obligations of the Sellers and only the following liabilities and obligations (collectively, the "**Assumed Obligations**"):

(a) the Assumed Contracts, but only to the extent of the obligations arising thereunder with respect to events or periods arising on and after the Effective Date;

(b) any and all obligations of the Sellers to the Hired Employees under the Worker Adjustment and Retraining Notification Act (and any state-equivalent statute) (collectively, "**WARN**") with respect to the operation of the Facilities as a result of (i) the consummation of the transaction contemplated by this Agreement (provided that the Sellers have, with respect to the operation of the Facilities, complied with WARN prior to the Effective Date), (ii) the acts of the Purchasers or any affiliate(s) of the Purchasers on and after the Effective Date (taking into account, or otherwise including, any employee terminations prior to the Effective Date) or (iii) the Purchasers' breach of its covenant with respect to the Hired Employees as set forth in Section 7.3;

(c) the accrued paid time off for the Hired Employees, together with the associated employer tax liabilities, e.g. FICA and MHI and other employer withholdings as of the Closing Date ("**Accrued Paid Time Off**") to the extent included in Net Working Capital;

(d) the loan forgiveness obligations associated with the Nurse Education Loans;

(e) the tuition reimbursement commitments to the Hired Employees in existence as of the Closing Date described on Schedule 1.3(e);

(f) all unpaid real and personal property taxes, if any, not past due and attributable to the Acquired Assets prior to the Effective Date, subject to the prorations provided in Section 2.4;

(g) all amounts not past due for all utilities being furnished to the Acquired Assets, subject to the prorations provided in Section 2.4;

(h) all current liabilities of the Sellers with respect to the operation of the Facilities prior to the Effective Date to the extent included in Net Working Capital; and

(i) any other obligations and liabilities identified in Schedule 1.3(k).

1.4 Excluded Liabilities. Notwithstanding anything to the contrary in Section 1.3, the Purchasers shall not assume or become responsible for any of the Sellers' duties, obligations or liabilities that are not assumed by the Purchasers pursuant to the terms of this Agreement, the Bills of Sale or the Real Estate Assignments (the "**Excluded Liabilities**"), and the Sellers shall remain fully and solely responsible for all of the Sellers' debts, liabilities, contract obligations, expenses, obligations and claims of any nature whatsoever related to the Acquired Assets or the Facilities unless assumed by the Purchasers under this Agreement, in the Bills of Sale or in the Real Estate Assignments. The Excluded Liabilities shall include, without limitation:

(a) any current liabilities of the Sellers with respect to the operation the Facilities prior to the Effective Date (i) which are not included in Net Working Capital, and (ii) which are not otherwise specifically included in the Assumed Obligations;

(b) all liabilities of the Sellers arising out of or relating to any act, omission, event or occurrence connected with the use, ownership or operation of the Facilities or any of the Acquired Assets prior to the Effective Date, other than as specifically included in the Assumed Obligations;

(c) all intercompany liabilities of the Sellers with any of the Sellers' affiliates, other than those relating to medical or other direct services provided by Seller or any of Sellers' affiliates on fair market terms or liabilities relating to operation or ownership of the Facilities (such as for Accrued Paid Time Off), but only to the extent included in Net Working Capital;

(d) all liabilities of the Sellers in connection with proceedings, claims, causes of actions, including claims of professional malpractice, general liability, property damage and

workers' compensation, to the extent arising out of or relating to acts, omissions, events or occurrences prior to the Effective Date;

(e) all liabilities of the Sellers relating to the Seller Cost Reports;

(f) all liabilities of the Sellers for violations of any law, regulation or rule to the extent arising from acts or omissions prior to the Effective Date, including, without limitation, those pertaining to Medicare and Medicaid fraud or abuse;

(g) all liabilities and obligations of Sellers in respect of periods prior to the Effective Date arising under the terms of the Medicare, Medicaid, Blue Cross, or other third party payor programs, and any liability of the Sellers arising pursuant to the Medicare, Medicaid, Blue Cross, or any other third party payor programs as a result of the consummation of any of the transactions contemplated under this Agreement;

(h) overpayments determined to be due to Medicare through the conduct of the Medicare's Recovery Audit Contractor program and to the State of Illinois through program audits or reviews conducted by the Illinois Department of Health Care and Family Services, to the extent related to any period prior to the Effective Date;

(i) subject to Section 2.4, all federal, state, foreign or local tax liabilities or obligations of Sellers in respect of periods ending prior to the Effective Date, including, without limitation, any income tax, any franchise tax, any sales and/or use tax, and any FICA, FUTA, workers' compensation and any and all other taxes due and payable as a result of the exercise by the Hired Employees of such employees' right to paid time off benefits accrued while in the employ of the Sellers;

(j) other than as specifically included in the Assumed Obligations, all liability for any and all claims by or on behalf of the Sellers' employees to the extent such liability relates to the period ending prior to the Effective Date, including, without limitation, liability relating to such time period for (i) any pension, profit sharing, deferred compensation or any other employee health and welfare benefit plans, (ii) any EEOC claim, wage and hour claim, unemployment compensation claim or workers' compensation claim, and (iii) all employee wages and benefits, including, without limitation, accrued paid time off benefits and taxes or other liabilities related thereto in respect of the Sellers' employees;

(k) all liabilities and obligations to retired and former employees of the Facilities, including health and welfare benefits;

(l) any and all obligations to the Hired Employees under WARN as a result of the acts of the Sellers or any affiliate(s) of the Sellers on and after the Effective Date;

(m) all liabilities or obligations (without regard to when such liability or obligation is actually due and/or payable by the Sellers) arising out of any breach by the Sellers prior to the Effective Date of any Lease or Assumed Contract, but only with respect to the period from the date of the breach through the Closing Date;

(n) all liabilities of the Sellers under the Excluded Contracts;

(o) all liabilities of the Sellers to the Hired Employees with respect to any pension liabilities and other deferred compensation liabilities as of the Closing Date;

(p) all liabilities of the Sellers under the Seller Plans, and all administrative costs associated with the Seller Plans;

(q) liabilities or obligations arising from any and all indebtedness of Sellers for borrowed money, including all obligations pursuant to or related to any long-term debt instruments pertaining to the Sellers or any Facilities, including tax-exempt debt (the "**Long-Term Debt**");

(r) liabilities or obligations under the Hill-Burton Act or other restricted grant or loan programs with respect to restricted grants or loans made prior to the Effective Date;

(s) all liabilities or obligations arising out of or relating to actions (or alleged actions) of Sellers or any affiliate of Sellers constituting the subject matter of Carol Niewinski, et al. v. Resurrection Health Care Corporation, Circuit Court of Cook County, Illinois, County Department, Chancery Division (case no. 04 CH 15187);

(t) all liabilities of the Sellers for commissions or fees owed to any finder or broker in connection with the transactions contemplated hereunder; and

(u) any other liability, obligation, governmental overpayment, claim against or contract of any Seller, any affiliate of any Seller or any of the Facilities of any kind or nature, whether or not accrued, whether fixed, contingent or otherwise, whether known or unknown, and whether or not recorded on the books and records of any Seller or any affiliate of any Seller, arising out of any event occurring prior to the Effective Date, unless such liability, obligation, claim or contract is expressly assumed by the Purchasers pursuant to the terms of this Agreement, the Bills of Sale or the Real Estate Assignments.

1.5 Disclaimer of Warranties. Except as expressly set forth in Article 4 hereof, the Acquired Assets consisting of Real Property, the Personal Property and the Inventory transferred to the Purchasers will be sold by the Sellers and purchased by the Purchasers in their physical condition at the Effective Date, "AS IS, WHERE IS AND WITH ALL FAULTS AND NONCOMPLIANCE WITH LAWS" WITH NO WARRANTY OF HABITABILITY OR FITNESS FOR HABITATION, with respect to the Real Property, land, buildings and improvements, and WITH NO WARRANTIES, INCLUDING, WITHOUT LIMITATION, THE WARRANTIES OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE, with respect to the physical condition of the Personal Property and Inventory, any and all of which warranties (both express and implied) the Sellers hereby disclaim. All of the foregoing real and personal property shall be further subject to normal wear and tear on the land, buildings, improvements and equipment and normal and customary use of the inventory and supplies in the ordinary course of business up to the Effective Date.

1.6 Risk of Loss. The risk of loss or damage to any of the Acquired Assets shall remain with the Sellers through the Closing Date and the Sellers shall maintain their insurance policies and programs covering the Acquired Assets through the Effective Date.

1.7 Operational Pledges. The Purchasers are committed to continuing the services, outreach, education and advocacy efforts provided by the Facilities in the culturally diverse communities they serve, and supporting the many programs and services currently offered by the Facilities to meet the needs of and improve access to health care in those communities, as of and after the Effective Date. In furtherance of such operational goals, the Purchasers pledge the following:

(a) to adhere to and comply with the charity and indigent care policies and practices in effect as of the Effective Date at the Purchasers' or their affiliates' other hospitals in Illinois, as such policies may be amended or supplemented from time to time to reflect changes in law or governmental policy such as implementation of universal healthcare; and for the first two (2) years after the Effective Date and notwithstanding anything to the contrary in the Purchasers' policies that would preclude such, to assure that each Hospital provides not less than the amount of (a) need-based charity care discounts, and (b) service to Medicaid patients, as set forth on Schedule 1.7(a);

(b) to ensure continuity of care in the community by allowing each Hospital's medical staff members in good standing immediately prior to the Effective Date to maintain medical staff privileges at such Hospital, subject to the Hospital's medical staff bylaws then in effect, as amended from time to time;

(c) to continue to operate the Hospitals as general acute care hospitals and continue to operate the West Suburban facility under the West Suburban Medical Center name, for at least two (2) years after the Effective Date;

(d) to maintain the graduate medical education currently sponsored by West Suburban (which will be transferred by the Sellers to the Purchasers subject to applicable approvals), as set forth on Schedule 1.7(d), through June 30, 2011, and cause Westlake Hospital to participate in the internal medicine residency program rotation sponsored by Resurrection Medical Center, at least through June 30, 2011 (and such program shall be maintained through such period by Resurrection Medical Center);

(e) to comply, and cause the operations of the Facilities to comply, with the core principles of the *Ethical and Religious Directives for Catholic Health Care Services* as approved by the United States Conference of Catholic Bishops and promulgated by the Archbishop of Chicago and in effect from time to time, including operating the Acquired Assets in such matter as to recognize the inherent dignity of each human person and to exhibit respect for life, to prohibit abortions and euthanasia, and to maintain a chaplaincy program at the Facilities designed to meet the spiritual needs of the community served by the Facilities and the employees, patients and patient families of the Facilities, including assuring the availability of needed sacramental services required to be provided by priests through appropriate on-call and contractual arrangements, all in a manner consistent with the historical practices at the Hospitals; and

(f) to establish governance structures for the Hospitals that ensures continued local input on community services provided by the Hospitals, including, through representation on the Hospitals' advisory boards of at least one (1) community representative of each of Oak

Park and Melrose Park with input and recommendation of individuals (i) through March, 31, 2012, by West Suburban Sentinel Corporation for the Oak Park community representative; and (ii) otherwise from representative community organizations based in the communities served by the Hospitals.

Notwithstanding anything to the contrary, the provisions of this Section 1.7 shall not create any legal or other rights or interests in the Sellers, the Sellers' affiliates or any third-party beneficiaries.

ARTICLE 2

CONSIDERATION

2.1 Purchase Price.

(a) Subject to the terms and conditions of this Agreement, the aggregate purchase price to be paid by the Purchasers to the Sellers for the purchase of the Acquired Assets shall be (i) Forty Million Dollars ($40,000,000) (the "**Purchase Price**"), plus or minus (ii) the amount by which Net Working Capital (as defined below) exceeds or is less than, as applicable, the Assumed Net Working Capital (as defined below) on the Closing Date, and minus (iii) the amount of the Sellers' capital lease obligations with respect to the Facilities on the Closing Date, if any, that are assumed by the Purchasers pursuant to Section 1.3 of this Agreement (the sum of (i), (ii) and (iii) being referred to for purposes of this Agreement as the "**Cash Purchase Price**"). The payment of the Cash Purchase Price at Closing shall be governed by Section 3.3(a). The Purchase Price has been determined based upon Net Working Capital of Fifteen Million Dollars ($15,000,000) (the "**Assumed Net Working Capital**").

(b) For purposes of this Agreement, "**Net Working Capital**," as of any date, means an amount equal to the difference between:

(i) the current assets of Sellers with respect to the operation of the Facilities, which for purposes of this calculation shall include only (A) the value of Accounts Receivable; (B) the value of the Prepaids usable by the Purchasers after the Effective Date (exclusive of prepayments for insurance); (C) the value of the Inventory usable by the Purchasers after the Effective Date; and (D) the value of those other categories of current assets usable by the Purchasers after the Effective Date, all of which are further described on Schedule 2.1(b), and

(ii) the following current liabilities of Sellers: (A) Accounts Payable, but only to the extent it is anticipated that the Purchasers will be required to fund the payment of such Accounts Payable after the Effective Date (for example, if a Seller has or will make arrangements for payment of certain portions of the Accounts Payable after the Closing, such portion of the Accounts Payable would not be included in the calculation of Net Working Capital);

(B) Accrued Expenses; (C) Accrued Payroll, together with the associated employer liabilities for FICA and Medicare health insurance employer withholdings; (D) Accrued Paid Time Off; and (E) valid Other Current Liabilities, all of which are further described on Schedule 2.1(b).

All capitalized terms used in this subsection (b) shall mean such terms as used on the Interim Combined Balance Sheet and the Final Combined Balance Sheet, modified (to the extent necessary) to exclude any Excluded Assets or Excluded Liabilities.

(c) At least three (3) calendar days but no more than ten (10) calendar days prior to the Closing Date, the Sellers shall prepare and deliver to the Purchasers an unaudited balance sheet with respect to the operation of the Facilities by the Sellers, on a combined basis, as of the most recent date (not more than two months prior to the Closing Date) for which sufficient financial information is available (the "**Interim Combined Balance Sheet**"). The Interim Combined Balance Sheet shall include a calculation of Net Working Capital, and the amount of the Sellers' capital lease obligations with respect to the Facilities on the Closing Date, if any, that are assumed by the Purchasers pursuant to Section 1.3 of this Agreement. The Interim Combined Balance Sheet shall be attached hereto as Schedule 2.1(c). The amounts set forth in the Interim Combined Balance Sheet shall be subject to adjustment as provided in Sections 2.2 and 2.3 below.

2.2 Inventory. As near in time as possible to the Closing Date and with the results extended and adjusted through the Closing Date, the Sellers shall cause an inventory of those departments of the Hospitals identified on Schedule 2.2 to be taken of the Inventory by employees or representatives of the Sellers. The Sellers shall permit representatives or employees of the Purchasers to observe such inventory process. Sellers shall conduct the inventory in a manner consistent with past practices for all relevant departments, having due regard for the appropriate level of materiality for the size of the Hospitals. The cost of conducting the inventory shall be borne by the Sellers. All inventory items that are not obsolete and that are reasonably usable in the conduct of the Facilities after the Effective Date shall be valued in accordance with GAAP and the Sellers' historical valuation practices consistently applied (except that Sellers have not historically counted inventory in the surgery department). The Parties acknowledge that the inventory to be taken pursuant to this Section 2.2 will not be conducted until immediately prior to the Closing Date and, as such, the results of such inventory will not be available until some time after the Closing Date. Accordingly, the Parties agree that for purposes of the Interim Combined Balance Sheet, Net Working Capital shall include the book value of the Inventory with respect to the operation of the Hospitals as reflected by the latest available unaudited balance sheet of the Sellers. For purposes of the Final Combined Balance Sheet, the portion of Net Working Capital attributable to the Inventory shall be the value of the Inventory as determined pursuant to this Section 2.2.

2.3 Post-Closing Adjustment to Purchase Price.

(a) Within one hundred twenty (120) calendar days after the Closing Date, the Sellers shall prepare and deliver to the Purchasers the final unaudited balance sheet of the Facilities, as developed to reflect the Acquired Assets and Assumed Obligations on the books of

each of the Sellers on a combined basis, as of the Closing Date (the "**Final Combined Balance Sheet**"), which shall include a calculation of Net Working Capital as of the Closing Date, and the amount of the Sellers' capital lease obligations with respect to the Facilities on the Closing Date, if any, that are assumed by the Purchasers pursuant to Section 1.3 of this Agreement. The Purchasers, in connection with its review of the Final Combined Balance Sheet, shall be permitted to review work papers of the Sellers and their affiliates and accountants with respect to the preparation of the Final Combined Balance Sheet and the books and records of the Sellers reasonably related thereto. The Interim Combined Balance Sheet and the Final Combined Balance Sheet shall be prepared in a manner consistent with Sellers' reasonable past practices and that are consistent with GAAP, subject to the provisions of Section 4.10(b). If the Purchasers dispute any entry on the Final Combined Balance Sheet that affects the calculation of Net Working Capital or the capital lease obligations assumed by the Purchasers, the Purchasers shall notify the Sellers in writing (which writing shall contain the Purchasers' determination of the amount of the disputed entry) within thirty (30) days after the Purchasers' receipt of the Final Combined Balance Sheet from the Sellers. If the Purchasers and the Sellers cannot resolve such dispute within thirty (30) business days after the Purchasers notify the Sellers in writing of such dispute, then a mutually agreed-upon national, independent certified public accounting firm (the "**Independent Auditor**"), shall review the matter in dispute and, solely as to disputes relating to accounting issues and acting as an expert and not as an arbitrator, shall promptly decide the proper amounts of such disputed entries (which decision shall also include a final recalculation of the Cash Purchase Price) provided that no change shall be made based on use of a methodology that is different from the methodology used to prepare the Final Combined Balance Sheet, as long as such methodology used was reasonable and consistent with the Sellers' past practices and GAAP. In the event that all or a portion of the dispute at issue involves a legal issue or an interpretation of this Agreement, such legal or interpretative dispute shall first be subject to adjudication by a court or similar tribunal, or by an independent attorney expert in the matter at issue and agreed to by the Purchasers and the Sellers (with the costs thereof to be shared equally by the Parties), with any necessary review by the Independent Auditor under this Section 2.3 occurring following the resolution of such legal dispute. Such decision of the Independent Auditor shall be conclusive and binding as between the Purchasers and the Sellers, and the costs of such review shall be borne by the Sellers, on the one hand, and the Purchasers, on the other hand, in proportion to the relevant amount each Party's determination has been modified.

(b) Within sixty (60) days after the Purchasers' receipt of the Final Combined Balance Sheet from the Sellers or, if disputed by the Purchasers, within five (5) business days after the earlier of (a) the date the Purchasers and the Sellers finally resolve such dispute and recalculate the Cash Purchase Price accordingly, or (b) the date of receipt of a final decision of the Independent Auditor (the "**Post-Closing Adjustment Date**"), either (i) the Sellers shall pay the Purchasers in cash or in other immediately available funds the amount of any decrease in the Cash Purchase Price, or (ii) the Purchasers shall pay the Sellers in cash or in other immediately available funds the amount of any increase in the Cash Purchase Price (as applicable, the "**Post-Closing Adjustment Date Payment Amount**"). If not paid when due, the Post-Closing Adjustment Date Payment Amount paid by the Sellers to the Purchasers, or by the Purchasers to the Sellers, as the case may be, shall be increased by interest at a per annum rate equal to the prime rate reported by the Wall Street Journal under "Money Rates" (the "**Prime Rate**") on the Post-Closing Adjustment Date plus two percent (2%) (or the maximum rate allowed by law,

whichever is less) accruing on the Post-Closing Adjustment Date Payment Amount from the Post-Closing Adjustment Date until the date the Post-Closing Adjustment Date Payment Amount is paid to Sellers or the Purchasers, as the case may be.

2.4 Prorations and Utilities. To the extent not otherwise prorated pursuant to this Agreement, or as reflected in Net Working Capital on the Interim Combined Balance Sheet or the Final Combined Balance Sheet, the Purchasers and the Sellers shall prorate (as of the Effective Date), if applicable, Lease payments (or receipts, as applicable), real estate taxes, assessments and other similar charges against the Real Property, plus all other income and expenses which are normally prorated upon the sale of assets of a going concern. As to power and utility charges, final readings as of the Closing Date shall be ordered from the utility companies; the cost of obtaining such final readings, if any, to be paid for equally by Sellers, on the one hand, and by the Purchasers, on the other hand.

ARTICLE 3

CLOSING

3.1 Closing Date. The consummation of the transactions contemplated by this Agreement (the "**Closing**") shall take place at 9:00 a.m. on June 30, 2010, at the offices of McDermott Will & Emery LLP, 227 W. Monroe Street, Chicago, Illinois 60606, or such other date, time and place as the Parties shall mutually agree ("**Closing Date**"); provided that all conditions precedent and other matters required to be satisfied or completed as of the Closing Date have been or will be so satisfied or completed on such date. The Closing with respect to the Facilities shall be deemed to have occurred and to be effective as between the Parties as of 12:01 a.m. (determined by reference to the local time zone in which the Facilities are located) on the next day after the Closing Date (the "**Effective Date**").

3.2 Items to be Delivered by the Sellers at Closing.

At or before the Closing, the Sellers shall deliver to the Purchasers the following, duly executed by the Sellers where appropriate:

(a) General Assignment, Bill of Sale and Assumption of Liabilities in a form agreed upon by the Parties prior to Closing (the "**Bills of Sale**") and executed motor vehicle titles for all motor vehicles included in the Acquired Assets;

(b) Assignment and Assumption of the Leased Real Property in a form agreed upon by the Parties prior to Closing with respect to each Leased Real Property (the "**Real Estate Assignments**");

(c) Special Warranty Deed(s) in a form agreed upon by the Parties prior to Closing;

(d) A Non-Competition and Non-Solicitation Agreement in a form mutually acceptable to the Parties addressing the protectable interests of the Purchasers related to the Acquired Assets in appropriate scope and duration, as more generally described in a form agreed upon by the Parties prior to Closing (the "**Non-Competition Agreement**");

(e) favorable original certificates of existence (good standing), or comparable status, of the Sellers, issued by the Illinois Secretary of State, dated no earlier than a date which is seven (7) calendar days prior to the Closing Date;

(f) a certificate of the President or any Vice President of the Sellers certifying to the Purchasers (a) the accuracy in all material respects of the representations and warranties set forth in Article 4, and compliance with the Sellers' covenants set forth in this Agreement and (b) that all of the conditions contained in Article 8 have been satisfied except those, if any, waived in writing by the Sellers;

(g) a certificate of the corporate Secretary of the Sellers certifying to the Purchasers (a) the incumbency of the officers of the Sellers on the Execution Date and on the Closing Date and bearing the authentic signatures of all such officers who shall execute this Agreement and any additional documents contemplated by this Agreement and (b) the due adoption and text of the resolutions of the trustees and member(s) of the Sellers authorizing (i) the transfer of the Acquired Assets and Assumed Obligations by the Sellers to the Purchasers and (ii) the execution, delivery and performance of this Agreement and all ancillary documents and instruments by the Sellers, and that such resolutions have not been amended or rescinded and remain in full force and effect on the Closing Date;

(h) as agreed by the Parties, one or more administrative and clinical transition service agreements, in a form agreed upon by the Parties prior to Closing (the "**Transition Service Agreements**");

(i) the Lease Agreement for the West Suburban College of Nursing, which shall be at a mutually agreed upon fair market value rental amount and in a form agreed upon by the Parties prior to Closing (the "**WSCN Lease**");

(j) Limited Power of Attorney for use of DEA and Other Registration Numbers, and DEA Order Forms, in a form agreed upon by the Parties prior to Closing (the "**Power of Attorney**");

(k) copies of all third party consents obtained by the Sellers in connection with the assignment of the Assumed Contracts to the Purchasers; and

(l) such other instruments, certificates, consents or other documents which are reasonably necessary to carry out the transactions contemplated by this Agreement and to comply with the terms hereof.

3.3 Items to be Delivered by the Purchasers at Closing.

At or before the Closing, the Purchasers shall execute and deliver or cause to be delivered to the Sellers the following, duly executed by the Purchasers where appropriate:

(a) payment of the Cash Purchase Price based upon the Interim Combined Balance Sheet (subject to adjustment as described in Section 2.3), as adjusted to reflect the prorations provided in Section 2.4. Such amounts shall be payable by wire transfer of

immediately available funds to the Sellers to the account(s) specified by the Sellers to the Purchasers in writing;

(b) for each Purchaser, a certificate of the President or any Vice President certifying to the Sellers (a) the accuracy in all material respects of the representations and warranties set forth in Article 5, and compliance with the Purchasers' covenants set forth in this Agreement, (b) that the Purchasers have obtained all material licenses, permits, certificates of need and authorizations from governmental agencies or governmental bodies that are necessary or required for completion of the transactions contemplated by this Agreement and (c) that all of the conditions contained in Article 7 have been satisfied except those, if any, waived in writing by the Purchasers;

(c) for each Purchaser, a certificate of the corporate Secretary certifying to the Sellers (a) the incumbency of its officers on the Execution Date and on the Closing Date and bearing the authentic signatures of all such officers who shall execute this Agreement and any additional documents contemplated by this Agreement and (b) the due adoption and text of the resolutions of its Board of Directors authorizing the execution, delivery and performance of this Agreement and all ancillary documents and instruments by the Purchasers, and that such resolutions have not been amended or rescinded and remain in full force and effect on the Closing Date;

(d) favorable original certificates of good standing, or comparable status, of the Purchasers, issued by the Delaware Secretary of State, dated no earlier than a date which is seven (7) calendar days prior to the Closing Date;

(e) the Bills of Sale;

(f) the Real Estate Assignments;

(g) the Transition Service Agreements (along with the payment to the Sellers by wire transfer of immediately available funds of any amounts which must be made by the Purchasers to the Sellers or any affiliate of the Sellers concurrent with the execution thereof);

(h) the Non-Competition Agreement;

(i) the WSCN Lease;

(j) the Power of Attorney; and

(k) such other instruments, certificates, consents or other documents which are reasonably necessary to carry out the transactions contemplated by this Agreement and to comply with the terms hereof.

ARTICLE 4

REPRESENTATIONS AND WARRANTIES OF THE SELLERS

As an inducement to the Purchasers to enter into this Agreement and to consummate the transactions contemplated by this Agreement, the Sellers hereby jointly and severally represent, warrant and covenant to the Purchasers as to the following matters, except as disclosed in the disclosure schedules as of the Execution Date, which schedules may be supplemented, updated and amended through the Closing Date pursuant to Sections 6.13 and 14.5 of this Agreement (the "**Disclosure Schedules**") hereby delivered by the Sellers to the Purchasers. Except as otherwise provided herein, the Sellers shall be deemed to remake all of the following representations, warranties and covenants as of the Closing Date:

4.1 Authorization. Subject to the terms of Section 8.9, each of the Sellers has full corporate power and authority to enter into this Agreement and full power and authority to carry out the transactions contemplated hereby.

4.2 Binding Agreement. Subject to the terms of Section 8.9, (a) all corporate and other actions required to be taken by the Sellers to authorize the execution, delivery and performance of this Agreement, all documents executed by the Sellers which are necessary to give effect to this Agreement, and all transactions contemplated hereby, have been duly and properly taken or obtained by each of the Sellers, (b) no other corporate or other action on the part of the Sellers is necessary to authorize the execution, delivery and performance of this Agreement, all documents necessary to give effect to this Agreement and all transactions contemplated hereby and (c) this Agreement has been duly and validly executed and delivered by each of the Sellers and, assuming due and valid execution by the Purchasers, this Agreement constitutes a valid and binding obligation of each of the Sellers enforceable in accordance with its terms subject to (i) applicable bankruptcy, reorganization, insolvency, moratorium and other laws affecting creditors' rights generally from time to time in effect and (ii) limitations on the enforcement of equitable remedies.

4.3 Organization and Good Standing; No Violation.

(a) Each of the Sellers is a nonprofit corporation duly organized, validly existing and in good standing under the laws of Illinois. Each of the Sellers has full power and authority to own, operate and lease its properties and to carry on its businesses as now conducted.

(b) Neither the execution and delivery by the Sellers of this Agreement nor the consummation of the transactions contemplated hereby by the Sellers nor compliance with any of the material provisions hereof by the Sellers, will violate, conflict with or result in a breach of any material provision of any the Sellers' articles of incorporation or bylaws, respectively.

4.4 Material Contracts.

(a) With the exception of the Excluded Contracts, Schedule 1.1(f) includes a list of those contracts and agreements with respect to the ownership of the Acquired Assets and the operation of the Facilities which:

(i) (A) require the payment by the Sellers during the remaining term of such instrument in excess of Twenty-Five Thousand Dollars ($25,000) on an annualized basis, and (B) either (1) have remaining terms of more than 12 months or (2) cannot be terminated by the applicable Seller (prior to Closing) or Purchaser (after Closing) at any time without cause and without obligation to pay a termination fee or penalty upon notice of ninety (90) calendar days or less;

(ii) are with any of the Facilities' referral sources (as determined by applicable health care laws, rules and regulations), including, without limitation, any physicians on any Hospital's medical staff;

(iii) relate to joint ventures (in the form of partnerships, limited liability companies or corporations) in which any Seller has any investment interest which is an Acquired Asset as set forth herein; or

(iv) contain a covenant not to compete or restrictive covenant which is binding upon any Seller with respect to any of the Acquired Assets. Contracts described in this Section 4.4(a) are referred to herein as "**Material Contracts**".

(b) Each Material Contract is in full force and effect and is the valid and binding obligation of the Seller party to it and, to the knowledge of Sellers, of each other party thereto, except where a failure of the Material Contract to be in full force and effect is not material, individually or in the aggregate, to the operation of the Facilities. The consummation of the transactions contemplated by this Agreement will not result in a breach of any term or provision of, or constitute (with or without notice or lapse of time or both) a default under, any Material Contract to which any Seller is a party, or which is binding on any Seller, or to which the Acquired Assets are subject. The consummation of the transactions contemplated by this Agreement will not give any other party to any such Material Contract a right to cancel or terminate the same, a right to modify or amend the terms thereof, or result in an acceleration of the maturity or performance of any obligation under any such contract. No such breach, default, cancellation, termination, modification or amendment or acceleration described in this Section 4.4 would prevent the Sellers from consummating the transactions contemplated by this Agreement, or would result in the creation of any lien or liability on the Acquired Assets.

4.5 Required Consents. Except as set forth in Schedule 4.5, none of the Sellers is a party to or bound by, nor are any of the Acquired Assets subject to, any mortgage, material lien, deed of trust, or any material order, judgment or decree which (a) requires the consent of another to the execution of this Agreement, or (b) requires the consent of another to consummate the transactions contemplated by this Agreement.

4.6 Compliance With Laws and Contracts.

(a) Except as set forth in Schedule 4.6(a), the Sellers, with respect to the operation of the Facilities, are in compliance with all applicable laws, statutes, ordinances, orders, rules, regulations, policies, guidelines, licenses, certificates, certificates of need, judgments or decrees of all judicial or governmental authorities (federal, state, local, foreign or otherwise), except where the failure to be in such compliance would not have a material adverse effect on the Acquired Assets or the business of the Facilities. Except as set forth in Schedule 4.6(a), none of the Sellers, with respect to the operation of the Facilities, has been charged with or given notice of, and to the knowledge of the Sellers, none of the Sellers, with respect to the operation of the Facilities, is under investigation with respect to, any violation of, or any obligation to take remedial action under, any applicable (i) material law, statute, ordinance, rule, regulation, policy or guideline promulgated, (ii) material license, certificate or certificate of need issued, or (iii) order, judgment or decree entered, by any federal, state, local or foreign court or governmental authority relating to the Facilities or the business of the Facilities. Notwithstanding the foregoing, no provision of this Section 4.6(a) shall be deemed a representation or warranty by the Sellers as to compliance with any Environmental Laws (as defined in Section 4.6(c) below).

(b) Except as set forth in Schedule 4.6(b), the Sellers' ownership and operation of the Facilities and the Acquired Assets are and have been in compliance with all Environmental Laws, except where the failure to be in such compliance would not have a material adverse effect on the Acquired Assets or the business of the Facilities. Except as set forth in Schedule 4.6(b), each of the Sellers has obtained all licenses, permits and approvals necessary or required under all applicable Environmental Laws (the "**Environmental Permits**") for the ownership and operation of the Facilities and the Acquired Assets. Except as set forth in Schedule 4.6(b), all such Environmental Permits are in effect and, to the knowledge of the Sellers, no action to revoke or modify any of such Environmental Permits is pending. Except as set forth in Schedule 4.6(b), there is not now pending or, to the knowledge of the Sellers, threatened, any claim, investigation or enforcement action by any governmental authority (whether judicial, executive or administrative) concerning the Sellers' potential liability under Environmental Laws in connection with the ownership or operation of the Facilities or the Acquired Assets. Except as set forth in Schedule 4.6(b), to the knowledge of the Sellers, there has not been a release or threatened release of any Hazardous Substance at, upon, in, under or from the Facilities or the Acquired Assets at any time. At no time during the Sellers' ownership of the Real Property, and to the Sellers' knowledge at no time during others' ownership of the Real Property, have any Hazardous Substances been present on the Real Property except as may be utilized as a matter of course in Facility operations and in accordance with applicable Environmental Laws.

(c) For the purposes of this Agreement, the term "**Environmental Laws**" shall mean all state, federal or local laws, ordinances, codes or regulations relating to Hazardous Substances or to the protection of the environment, including, without limitation, laws and regulations relating to the storage, treatment and disposal of medical and biological waste. For purposes of this Agreement, the term "**Hazardous Substances**" shall mean (i) any hazardous or toxic waste, substance, or material defined as such in (or for the purposes of) any Environmental Laws, (ii) asbestos-containing material, (iii) medical and biological waste, (iv) polychlorinated

biphenyls, (v) petroleum products, including gasoline, fuel oil, crude oil and other various constituents of such products, and (vi) any other chemicals, materials or substances, exposure to which is prohibited, limited or regulated by any Environmental Laws.

(d) To the knowledge of the Sellers, each of the Sellers has performed all material obligations relating to the Acquired Assets and the business of the Facilities, and is not in breach or default, nor do any circumstances exist which with or without notice or lapse of time, or both, would result in breach or default, nor is there any claim of such breach or default with respect to any obligation to be performed, under any Material Contract, Material Lease, guaranty, indenture or loan agreement relating to the Acquired Assets or the business of the Facilities, which breach or default or its consequences might materially adversely affect the Acquired Assets or the business of the Facilities.

4.7 Title; Sufficiency.

(a) Each of the Sellers has good and marketable fee simple or leasehold title, as the case may be, to its Real Property. Each of the Sellers has good and valid title to its Personal Property.

(b) The Real Property and the Personal Property is held by the Sellers free and clear of all liens, pledges, claims, charges, security interests or other encumbrances, and is not, in the case of the Real Property, subject to any rights-of-way, building or use restrictions, exceptions, variances, reservations or limitations of any nature whatsoever except (i) encumbrances for Taxes not yet due and payable; (ii) liens for inchoate mechanics' and materialmen's liens for construction in progress and workmen's, repairmen's, warehousemen's and carriers' liens arising in the ordinary course of business; (iii) easements, restrictive covenants, rights of way and other similar restrictions of record that do not impair in any material respect the value of the assets or the continued conduct of the business in the manner currently used; (iv) zoning and similar legal restrictions that do not impair in any material respect the value of the asset or the continued conduct of the business in the manner currently used; (v) encumbrances, encroachments and other imperfections of title, licenses or encumbrances, if any, of record that do not impair in any material respect the value of the asset or the continued use of its assets in the manner currently used; (vi) encumbrances arising under original purchase price conditional sales contracts and equipment leases with third parties entered into in the ordinary course of business; and (v) in the case of Leased Real Property, all matters, whether or not of record, affecting the title of the lessor (and any underlying lessor) of the Leased Real Property that do not impair in any material respect the value of the asset or the continued conduct of the business in the manner currently used. The Sellers will convey title to the Real Property free and clear of all liens, pledges, claims, charges, security interests or other encumbrances, and is not, in the case of the Real Property, subject to any rights-of-way, building or use restrictions, exceptions, variances, reservations or limitations of any nature whatsoever except the Permitted Encumbrances. For purposes of this Agreement, "**Permitted Encumbrances**" means (i) encumbrances for Taxes not yet due and payable; (ii) easements, restrictive covenants, rights of way and other similar restrictions of record that do not impair in any material respect the value of the assets or the continued conduct of the business in the manner currently used and that are described in the Title Policies; (iii) zoning and similar municipal restrictions that do not impair in any material respect the value of the asset or the continued conduct of the business in the manner

currently used; and (iv) in the case of Leased Real Property, all matters, whether or not of record, affecting the title of the lessor (and any underlying lessor) of the Leased Real Property that do not impair in any material respect the value of the asset or the continued conduct of the business in the manner currently used.

(c) The Inventory with respect to the Facilities is, and at the Closing Date will be, maintained and accounted for in such qualities and quantities as is consistent with GAAP and such Facilities' historical practices.

(d) The Acquired Assets and the Excluded Assets comprise substantially all of the property and assets used in the conduct of the businesses and operation of the Facilities.

(e) In contemplation of the transactions described by this Agreement specifically or the sale of the Facilities generally, Sellers have made no material reductions to or delayed or deferred the timing of any budgeted routine maintenance and have not failed to make any capital expenditures with respect to the Acquired Assets or the business of the Facilities consistent with its current capital expenditure policies applicable to all of the Sellers and their affiliates.

4.8 Certain Representations With Respect to the Facilities.

(a) All licenses, permits, certificates of need or exemption and other approvals which are necessary to operate the business of the Facilities by the Sellers are valid and in full force and effect, except where the failure to have such licenses, permits and approvals would not have a material adverse effect on the Acquired Assets or the business of the Facilities. Schedule 1.1(d) contains an accurate list of the material licenses, permits, certifications of need and other authorizations which are necessary to operate the businesses of the Facilities by the Sellers, true and complete copies of which have been delivered to the Purchasers.

(b) The Hospitals are duly accredited by the Healthcare Facilities Accreditation Program ("**HFAP**") for the periods set forth in Schedule 4.8(b). Sellers have delivered to the Purchasers true and complete copies of each Hospital's most recent accreditation survey report and deficiency list, if any; the most recent Statement and Deficiencies and Plan of Correction on Form HCFA-2567, if any; the most recent state licensing report and list of deficiencies, if any; the most recent fire marshal's survey and deficiency list, if any, and the corresponding plans of correction or other responses.

(c) The Hospitals and (to the extent required) the other Facilities are certified for participation in the Medicare, Medicaid and TRICARE programs, have current and valid provider contracts with each of such programs, and are in compliance in all material respects with the conditions of participation in such programs. Except as set forth in Schedule 4.8(c), none of the Sellers have received notices from the regulatory authorities which enforce the statutory or regulatory provisions in respect of any of the Medicare, Medicaid or TRICARE programs of any pending or threatened investigations with respect to the operation of the Facilities. No Seller, with respect to the operation of any of the Facilities, has been excluded from the Medicare or Medicaid programs or any state health care program, and there is no

pending or, to Sellers' knowledge, threatened exclusion action against any Seller with respect to the operation of any of the Facilities.

(d) Sellers have delivered to the Purchasers, with respect to the operation of each of the Facilities, true and exact copies of all cost reports which Sellers filed with Medicare, Medicaid and Blue Cross for the last two (2) years, as well as all material correspondence and other material documents relating to any disputes and/or settlements with Medicare, Medicaid or Blue Cross within the last two (2) years. Notices of Program Reimbursement have been issued by the applicable fiscal intermediary with respect to the cost reports of the Facilities for Medicare and Medicaid (if required) through the periods set forth in Schedule 4.8(d) (the "**Audit Periods**"). Each of such reports was timely filed. None of the Sellers has received notice of any material dispute between the Facilities and the applicable governmental agency or private entity, or their intermediaries or representatives, regarding such cost reports for periods subsequent to the periods specified in Schedule 4.8(d) and to the knowledge of the Sellers, there are no pending or threatened claims by any of such programs against the Facilities with respect to the Audit Periods or any period thereafter.

(e) With respect to the operation of the Facilities, none of the Sellers have any outstanding loan, grant or loan guarantee pursuant to the Hill-Burton Act (42 USC Section 291a, et seq.) and the transaction contemplated hereby will not result in any obligation on the part of the Purchasers or any Hospital to repay any such loans, grants, or loan guarantee or provide uncompensated care in consideration thereof.

4.9 Brokers and Finders. Except as described on Schedule 4.9, neither of the Sellers nor any affiliate thereof, nor any officer or director thereof, has engaged any finder or broker in connection with the transactions contemplated hereunder. The Sellers shall be solely responsible for compensating any finder or broker listed on Schedule 4.9.

4.10 Financial Statements.

(a) The following have been or will be prepared from the books and records of the Sellers: (i) unaudited financial statements (consisting of balance sheets, income statements and cash flow statements) of the Hospital Sellers with respect to the operation of the Hospitals as of June 30, 2009 and June 30, 2008, and for the years ended June 30, 2009 and June 30, 2008 (the "**2008 & 2009 Hospital Financials**"); (ii) unaudited financial statements of the Hospital Sellers with respect to the operation of the Hospitals from July 1, 2009 through December 31, 2009 (the "**Hospital Interim Period 2010 Financials**"); (iii) unaudited financial statements of the Sellers with respect to the operation of the Facilities other than the Hospitals as of June 30, 2009 (the "**2009 Non-Hospital Financials**"); (iv) unaudited financial statements of the Sellers with respect to the operation of the Facilities other than the Hospitals as of December 31, 2009 (the ("**Non-Hospital Interim Financials**"); (v) the Interim Combined Balance sheet; and (vi) the Final Combined Balance Sheet (the 2008 & 2009 Hospital Financials, the Hospital Interim Period 2010 Financials, the 2009 Non-Hospital Financials, the Non-Hospital Interim Financials, the Interim Combined Balance Sheet and the Final Combined Balance Sheet are collectively referred to herein as the "**Financial Statements**"). Copies of the 2008 & 2009 Hospital Financials, the Hospital Interim Period 2010 Financials, the 2009 Non-Hospital Financials and

the Non-Hospital Interim Financials have been provided to Purchasers prior to the Execution Date.

(b) The Financial Statements fairly present, or will fairly present when prepared, the financial position and results of operations, as applicable, of the Sellers with respect to the operation of the Facilities as of and for the periods then ended, and with respect to the financial statements for the Hospitals in conformity with GAAP consistently applied during such periods, subject to the following sentence. It is understood and agreed by the Parties that because the Acquired Assets from the non-Hospital Sellers constitute less than substantially all the assets of such Sellers, certain elements of GAAP are unable to be satisfied with respect to the financial information for such assets and associated obligations of the non-Hospital Sellers, but the failure of such elements to satisfy GAAP does not result in a materially misstated financial position of any affected Facility.

(c) Except for liabilities disclosed in the Financial Statements, liabilities incurred in the ordinary course of business since the date of the latest available Hospital Interim Period 2010 Financials or Non-Hospital Interim Financials consistent with past practice or liabilities disclosed in this Agreement, Sellers have no material liabilities or obligations (including without limitation securitization transactions and off-balance sheet arrangements) of any nature with respect to the operation of the Facilities.

4.11 Legal Proceedings. Except as set forth in Schedule 4.11, there are no claims, proceedings or investigations pending or, to the best knowledge of the Sellers, threatened relating to or affecting the Sellers with respect to the operation of the Facilities or any of the Acquired Assets before any court or governmental body (whether judicial, executive or administrative). The Sellers, with respect to the operation of the Facilities, are not subject to any judgment, order, decree or other governmental restriction specifically (as distinct from generically) applicable to them or their assets, including the Acquired Assets, which would have a material adverse effect on the Acquired Assets or the business condition (financial or otherwise) of the Facilities. There is no claim, proceeding or investigation pending or, to the best knowledge of Sellers, threatened, relating to or affecting any Seller with respect to the operation of any Facility before any court or governmental body (whether judicial, executive or administrative) which: (a) materially adversely affects or seeks to prohibit, restrain or enjoin the execution and delivery of this Agreement; (b) materially adversely affects or questions the validity or enforceability of this Agreement; (c) questions the power or authority of any Seller to carry out the transactions contemplated by, or to perform its obligations under, this Agreement; or (d) would result in any change which would materially adversely affect the ability of any Seller to perform any of its obligations hereunder.

4.12 Employee Benefits. Schedule 4.12 contains a list of (i) each pension, profit sharing, bonus, deferred compensation, or other retirement plan or arrangement of the Sellers with respect to the operation of the Facilities, whether oral or written, (ii) each medical, health, disability, insurance or other plan or arrangement of the Sellers with respect to the operation of the Facilities, whether oral or written and (iii) each other employee benefit or perquisite provided by the Sellers with respect to the operation of the Facilities, in which any employee of the Sellers participates in his capacity as such (each, a "**Seller Plan**" and collectively, the "**Seller Plans**").

All required reports and descriptions have been filed or distributed appropriately with respect to each Seller Plan.

4.13 Employees and Labor.

(a) The Sellers have, as of the Execution Date, and shall have, as of the Closing Date, delivered to the Purchasers a complete list (as of the date set forth therein) of names, positions and current annual salaries or wage rates, bonus and other compensation and/or benefit arrangements, the paid time off pay, and period of service credited for vesting as of the date thereof of all full-time and part-time employees of Sellers and their affiliates with respect to the operation of the Facilities and indicating whether such employee is a part-time or full-time employee, the site of such employee's primary workplace and employer.

(b) Except as set forth in Schedule 4.13(b), there are no (a) labor union or collective bargaining agreements in effect with respect to the employees of the Sellers with respect to the operation of the Facilities; (b) labor practice complaints against the Sellers pending, or to the best knowledge of the Sellers threatened, before the National Labor Relations Board; and (c) labor strikes, arbitrations, disputes, slowdowns or stoppages, and no union organizing campaigns, pending, or to the best knowledge of the Sellers threatened, that would materially affect the operation of the Facilities.

(c) Except as set forth in Schedule 4.13(c), there are no outstanding EEOC complaints or Department of Labor investigations of any of the Facilities, and there are no outstanding employment or benefit-related lawsuits or claims.

(d) Sellers have in place employment programs and policies providing for background screens, competence assessments, orientation, health screenings and drug screens of employees and applicants for employment in compliance with all accreditation, licensing and legal requirements, and have complied with such programs, policies and laws with respect to the employees of the Hospitals.

4.14 Insurance. The Sellers maintain, and have maintained, without interruption, at all times during the Sellers' ownership of the Facilities, self-insurance or policies or binders of insurance covering such risks and events, including personal injury, property damage, malpractice and general liability, to provide adequate and sufficient insurance coverage for all the Acquired Assets and operations of the Facilities. Schedule 4.14 contains a list of all such insurance maintained by the Sellers with respect to the operation of the Facilities as of the Execution Date.

4.15 Accounts Receivable. The Financial Statements, with respect to the Sellers' accounts receivable that constitute a part of the Acquired Assets, accurately reflect the amount due to the Sellers as of the date indicated on such applicable Financial Statements with reasonable reserves and allowances. The Accounts Receivable, to the extent uncollected, are valid and existing and represent monies due for goods sold and delivered and services performed in bona fide commercial transactions, have been billed or are billable and are not subject to any right, claims or interest of any other person. To the Sellers' knowledge, there are no refunds, discounts or setoffs payable or assessable that have been determined as of the representation date

with respect to the Accounts Receivable that are not reflected in the Financial Statements. No Accounts Receivable have been sold by Sellers.

4.16 Solvency. Sellers, immediately after Closing and solely as a result of the transactions contemplated hereby, will not be rendered insolvent or otherwise rendered unable to pay their debts as they become due. No Seller has any intention of filing in any court pursuant to any statute either of the United States or of any state a petition in bankruptcy or insolvency or for reorganization or for the appointment of a receiver or trustee of all or any portion of such Seller's property.

4.17 Taxes. Sellers have duly filed all federal, state, foreign and local Tax Returns required to be filed by it (all of which are true and correct in all material respects) and has duly paid or made provision for the payment of all Taxes (including any interest or penalties) which are due and payable, whether or not in connection with such returns. Each Seller, with respect to the operation of the Hospitals, has withheld proper and accurate amounts from its employees' compensation, and made deposits of all such withholdings, in material compliance with all withholding and similar provisions of the Code and any and all other applicable laws. There are no liens for Taxes upon the Acquired Assets, except for statutory liens for current Taxes not yet due and payable or which may hereafter be paid without penalty. Sellers do not and will not have any liability for the Taxes of any Person (other than an affiliate of Seller under Internal Revenue Service regulation 1.1502-6 or any similar provision of state, local or foreign law), as a transferee or successor, by contract or otherwise. No Person (other than the Sellers or any affiliate of Sellers) has limited (expressly or otherwise) Sellers' or their affiliates' ability to disclose the tax treatment or tax structure of, and such advisor's tax strategies with respect to, the transactions contemplated by this Agreement. For purposes of this Agreement, "**Tax**" or "**Taxes**" means any tax of any kind, including, without limitation, all income, unrelated business income, gross receipts, license, payroll, employment, excise, severance, occupation, privilege, premium, net worth, windfall profits, environmental (including taxes under section 59A of the Code), customs duties, capital stock, franchise, profits, withholding, social security, unemployment, disability, real property, personal property, recording, stamp, sales, use, service, service use, transfer, registration, escheat, unclaimed property, value added, alternative or add-on minimum, estimated or other tax, assessment, charge, levy or fee of any kind whatsoever, including payments or services in lieu of Taxes, interest or penalties on and additions to all of the foregoing, which are due or alleged to be due to any governmental authority, whether disputed or not, imposed by the United States or by any foreign country, or by any state, municipality, subdivision or instrumentality of the United States or of any foreign country, or by any other taxing authority. For purposes of this Agreement, "**Tax Return**" means any return, report, information return or amendment or other document (including any related or supporting information) with respect to Taxes. Each Seller is a corporation exempt from federal and state income taxation, and has received a favorable letter of determination from the Internal Revenue Service regarding such Tax status.

4.18 The Sellers Knowledge. References in this Agreement to "**the Sellers' knowledge**" or "**knowledge of the Sellers**" mean the actual knowledge of: (i) with respect to any matter pertaining to the Hospitals: any of the Vice Presidents or the Chief Executive Officer of the applicable Hospital, (ii) with respect to any matter pertaining to any of the Non-Hospital Facilities, the senior-most officer, director or manager responsible for the operations of such

non-Hospital Facility(ies), and (iii) the senior-most officer of Sellers or their affiliates responsible for the applicable subject matter, all without independent investigation. No constructive or imputed knowledge shall be attributed to any such individual by virtue of any position held, relationship to any other Person or for any other reason.

ARTICLE 5

REPRESENTATIONS AND WARRANTIES OF THE PURCHASERS

As an inducement to the Sellers to enter into this Agreement and to consummate the transactions contemplated by this Agreement, the Purchasers hereby jointly and severally represent, warrant and covenant to the Sellers as to the following matters as of the Execution Date and, except as otherwise provided herein, shall be deemed to remake all of the following representations, warranties and covenants as of the Closing Date:

5.1 Authorization. Each Purchaser has the full corporate power and authority to enter into this Agreement and has or by Closing will have full corporate power and authority to carry out the transactions contemplated hereby.

5.2 Binding Agreement. Except as contemplated by Section 9.13, all corporate and other actions required to be taken by the Purchasers to authorize the execution, delivery and performance of this Agreement, all documents executed by the Purchasers which are necessary to give effect to this Agreement, and all transactions contemplated hereby, have been duly and properly taken or obtained by each of the Purchasers. Except as contemplated by Section 9.13, no other corporate or other action on the part of the Purchasers is necessary to authorize the execution, delivery and performance of this Agreement, all documents necessary to give effect to this Agreement and all transactions contemplated hereby. Except as contemplated by Section 9.13, this Agreement has been duly and validly executed and delivered by the Purchasers and, assuming due and valid execution by the Sellers, this Agreement constitutes a valid and binding obligation of the Purchasers enforceable in accordance with its terms subject to (a) applicable bankruptcy, reorganization, insolvency, moratorium and other laws affecting creditors' rights generally from time to time in effect and (b) limitations on the enforcement of equitable remedies.

5.3 Organization and Good Standing. Each of the Purchasers is a corporation duly organized, validly existing and in good standing under the laws of the State of Delaware, and has full corporate power and authority to own, operate and lease its properties and to carry on its business as now conducted.

5.4 No Violation. Neither the execution and delivery by the Purchasers of this Agreement nor the consummation of the transactions contemplated hereby nor compliance with any of the material provisions hereof by the Purchasers will violate, conflict with or result in a breach of any material provision of the Articles of Incorporation, Bylaws or other organizational documents of the Purchasers.

5.5 Brokers and Finders. Except as described on Schedule 5.5, neither of the Purchasers nor any affiliate thereof nor any officer or director thereof has engaged any finder or

broker in connection with the transactions contemplated hereunder. The Purchasers shall be solely responsible for compensating any finder or broker listed on Schedule 5.5.

5.6 Representations of the Sellers. Each of the Purchasers acknowledges that it is purchasing the Acquired Assets on as "AS IS, WHERE IS" basis (as more particularly described in Section 1.5), and that it is not relying on any representation or warranty (expressed or implied, oral or otherwise) made on behalf of the Sellers other than as expressly set forth in this Agreement.

5.7 Legal Proceedings. Except as described on Schedule 5.7, there are no claims, proceedings or investigations pending or, to the best knowledge of the Purchasers, threatened relating to or affecting the Purchasers or any affiliate of the Purchasers before any court or governmental body (whether judicial, executive or administrative) in which an adverse determination would materially adversely affect the ability of the Purchasers to consummate the transactions contemplated hereby. Neither of the Purchasers nor any affiliate of the Purchasers is subject to any judgment, order, decree or other governmental restriction specifically (as distinct from generically) applicable to the Purchasers or any affiliate of the Purchasers which materially adversely affects the ability of the Purchasers to consummate the transactions contemplated hereby.

5.8 Ability to Perform. The Purchasers have the ability to obtain funds in cash in amounts equal to the Cash Purchase Price by means of credit facilities or otherwise and will at the Closing have immediately available funds in cash, which are sufficient to pay the Cash Purchase Price and to pay any other amounts payable to the Sellers at Closing pursuant to this Agreement and to consummate the transactions contemplated by this Agreement.

5.9 Solvency. Neither of the Purchasers is insolvent and will not be rendered insolvent as a result of any of the transactions contemplated by this Agreement. For purposes hereof, the term "**solvency**" means that: (a) the fair salable value of the Purchasers' tangible assets is in excess of the total amount of its liabilities (including for purposes of this definition all liabilities, whether or not reflected on a balance sheet prepared in accordance with generally accepted accounting principles, and whether direct or indirect, fixed or contingent, secured or unsecured, and disputed or undisputed); (b) the Purchasers are able to pay their debts or obligations in the ordinary course as they mature; and (c) the Purchasers have capital sufficient to carry on their businesses and all businesses which they are about to engage.

5.10 The Purchasers Knowledge. References in this Agreement to "**the Purchasers' knowledge**" or "**to the knowledge of the Purchasers**" mean the actual knowledge of: (i) the Chief Executive Officer, Chief Financial Officer and Chief Operating Officer (or the equivalent positions) of each of the Purchasers, and (ii) the senior-most officers or employees of the Purchasers, or affiliates thereof, primarily responsible for the applicable subject matter, as referenced herein, all without independent investigation. No constructive or imputed knowledge shall be attributed to any such individual by virtue of any position held, relationship to any other Person or for any other reason.

ARTICLE 6

COVENANTS OF THE SELLERS

6.1 Access and Information; Inspections. From the Execution Date through the Effective Date, the Sellers shall afford to the officers and agents of the Purchasers (which shall include accountants, attorneys, bankers and other consultants and agents of the Purchasers) full and complete access during normal business hours to and the right to inspect the plants, properties, books, accounts, records and all other relevant documents and information with respect to the Acquired Assets, liabilities and business of the Facilities. From the Execution Date through the Effective Date, the Sellers shall furnish the Purchasers with such additional financial and operating data and other information in the Sellers' possession as to businesses and properties of the Facilities as the Purchasers or their representatives may from time to time reasonably request, without regard to where such information may be located. The Purchasers' right of access and inspection shall be exercised in such a manner as not to interfere unreasonably with the operations of the Facilities. Such access may include consultations with the personnel of the Sellers and consultations and/or contact with physicians on the medical staff at the Facilities. Further, the Purchasers may, at their sole cost and expense (except as otherwise provided in Section 14.12), undertake environmental, mechanical and structural surveys of the Facilities. Notwithstanding the foregoing, all access and inspection activities contemplated by this Section 6.1 shall be with prior reasonable approval of Sellers' representative, John Walton, or his designee.

6.2 Conduct of Business. On and after the Execution Date and prior to the Effective Date, and except as otherwise consented to or approved by an authorized officer of the Purchasers or specifically required by this Agreement, the Sellers shall, with respect to the operation of the Facilities:

(a) carry on their businesses with respect to the operation of the Facilities in substantially the same manner as presently conducted and not make any material change in personnel, operations, finance, accounting policies (unless the Sellers are required to adopt such changes under GAAP or the Sellers' affiliates adopt such changes on a company-wide basis, in which event the Sellers shall give the Purchasers prompt written notice thereof);

(b) maintain the Facilities and all parts thereof and all other Acquired Assets in operating condition in a manner consistent with past practices, ordinary wear and tear excepted, and make all routine, maintenance and other expenditures contemplated by the current budgets and in a manner consistent with past practices;

(c) perform all of its material obligations under agreements relating to or affecting the Facilities, their operations or the Acquired Assets;

(d) keep in full force and effect present insurance policies or other comparable self-insurance;

(e) use their reasonable efforts to maintain and preserve their business organizations intact, retain their present employees at the Facilities and maintain their

relationships with physicians, suppliers, customers and others having business relationships with the Facilities; and

(f) take such actions as are necessary and use their reasonable efforts to cause the efficient transition of business operations and employee relations to the Purchasers as of the Effective Date.

6.3 Negative Covenants. From the Execution Date until the Effective Date, with respect to the operation of the Facilities, the Sellers shall not, without the prior written consent of the Purchasers or except as may be required by law:

(a) amend or terminate any Material Contracts, enter into any new contract, lease or commitment, or incur or agree to incur any liability, except in the ordinary course of business;

(b) increase compensation payable or to become payable or make any bonus payment to or otherwise enter into one or more bonus agreements with any employee, except in the ordinary course of business in accordance with the Sellers' customary personnel policies; provided, however, this Section 6.3(b) shall not apply to (i) agreements or arrangements with any of the officers of the Facilities (collectively, the "**Leadership Team**") in effect on the Execution Date which are consistent with the practices of the affiliates of the Sellers or (ii) any non-recurring payments or proposed non-recurring payments by the Sellers to any of the employees of the Facilities (including any member of the Leadership Team) to provide an incentive to such employees (or to any member of the Leadership Team) to remain employed at the Facilities through the Effective Date;

(c) create, assume or permit to exist any new debt, mortgage, deed of trust, pledge or other lien or encumbrance (other than Permitted Encumbrances) upon any of the Acquired Assets other than those which are terminated on or prior to the Closing Date;

(d) acquire (whether by purchase or lease) or sell, assign, lease, or otherwise transfer or dispose of any Real Property, plant or equipment, except in the ordinary course of business with comparable replacement thereof;

(e) except with respect to previously budgeted expenditures, purchase capital assets or incur costs in respect of construction in progress;

(f) take any action outside the ordinary course of business;

(g) cancel, forgive, release, discharge or waive any Accounts Receivable, except in the ordinary course of business;

(h) sell or factor any Accounts Receivable; or

(i) reduce Inventory except in the ordinary course of business.

For purposes of this Section 6.3, the Sellers shall be deemed to have obtained the Purchasers' prior written consent to undertake the actions otherwise prohibited by this Section 6.3 if the

Sellers gives the Purchasers written notice of a proposed action and the Sellers do not receive from the Purchasers a written notice of objection to such action within five (5) business days after the Purchasers receives the Sellers' written notice. Notwithstanding any provision to the contrary contained in this Agreement, neither Section 6.2 nor this Section 6.3 shall be construed to (i) prohibit the Sellers from engaging in any act which the Sellers reasonably believes is necessary to preserve and protect the continued operation of the Facilities, or (ii) require the Sellers to undertake any action or prohibit the Sellers from engaging in any act which counsel to Sellers has advised Sellers is necessary to comply with federal or state antitrust laws. The Sellers shall give the Purchasers prompt written notice either prior to, or if prior notice is not feasible, subsequent to taking any act described in the immediately preceding sentence.

6.4 Required Consents and Approvals.

(a) Between the Execution Date and the Effective Date, the Sellers shall: (i) use reasonable efforts to obtain, as promptly as practicable, all consents, approvals, authorizations, clearances, certificates of need and licenses required to be obtained by the Sellers to consummate the transactions contemplated by this Agreement (including, without limitation, those of governmental and regulatory authorities), including notification of non-objection of the Attorney General of Illinois to consummate the transactions contemplated hereby; (ii) reasonably cooperate with the Purchasers and their representatives and attorneys in the preparation of any document or other material which may be required by any governmental agency as a predicate to or result of the transactions contemplated in this Agreement; (iii) provide such other information and communications to governmental and regulatory authorities as such governmental and regulatory authorities may reasonably request; and (iv) cooperate with the Purchasers in the Purchasers' obtaining, as soon as practicable, all material consents, approvals, authorizations, clearances, certificates of need and licenses required to be obtained by the Purchasers to consummate the transactions contemplated hereby.

(b) Between the Execution Date and the Effective Date, the Sellers shall request and use reasonable efforts to obtain, as promptly as practicable, all consents and approvals of third parties required to assign to the Purchasers the Assumed Contracts indicated on Schedule 1.1(f) as being assigned to and assumed by the Purchasers.

6.5 Additional Financial Information.

(a) Within thirty (30) calendar days following the end of each calendar month prior to Closing, the Sellers shall deliver to the Purchasers complete copies of unaudited combined balance sheets and related income statements for all of the Facilities on a combined basis for the month then ended, together with corresponding year-to-date amounts, which presentation shall be consistent with the provisions of Section 4.10 which are applicable to the Financial Statements.

(b) The Purchasers have determined that, after Closing, the business of the Facilities acquired by the Purchasers will constitute a "significant subsidiary" under Regulation S-X promulgated under the Securities Exchange Act of 1934, as amended (the "**Exchange Act**"), applying the 20% test for acquisitions. As a result, Purchaser believes that an independent registered public accounting firm must prepare (i) audited financial statements of the Facilities as

of the most recent two fiscal year-end periods with respect to the balance sheets and for the most recent three fiscal year periods with the respect to the statements of operations and cash flows (the "**Audited Financial Statements**"), and (ii) unaudited financial statements of the Facilities for additional periods not covered by the Audited Financial Statements (together with the Audited Financial Statements, the "**Required Financial Statements**"). The Required Financial Statements must be filed with the Securities and Exchange Commission within seventy-five (75) days after Closing. During such period, the Sellers will reasonably cooperate, and cause their affiliates to reasonably cooperate, with the Purchasers and its independent registered public accounting firm to the extent necessary for Seller to prepare the Required Financial Statements, including providing them reasonable access during normal business hours to the financial books and records of the Sellers and their affiliates (wherever located) and answering their questions related specifically to, and to the extent necessary in, the preparation of the Required Financial Statements. The Purchasers shall be responsible for all costs and expenses of the independent accounting firm in conducting the audit and of all reasonable costs incurred by the Sellers and their affiliates in providing the cooperation and assistance required by this Section.

6.6 No-Shop.

(a) From and after the Execution Date until the earlier of the Closing Date or the termination of this Agreement, the Sellers shall not, and shall cause their affiliates, officers, directors, employees, investment bankers and agents to not, without the prior written consent of the Purchasers: (i) offer for sale or lease the Facilities or the Acquired Assets (or any material portion thereof); (ii) solicit offers to buy all or any material portion of the Facilities or the Acquired Assets; (iii) hold discussions with any Person (other than the Purchasers) looking toward such an offer or solicitation; (iv) hold discussions with any Person with respect to a proposed merger, acquisition, consolidation or other business combination (including substitution of members or so-called "virtual merger") having the effect of selling, leasing or otherwise disposing of any of the Facilities or Acquired Assets; or (v) enter into any agreement with any Person (other than the Purchasers) with respect to any transaction described in the foregoing clauses (i), (ii), (iii) and (iv). Notwithstanding the foregoing, this Section 6.6 shall not be construed to prohibit the Sellers or their affiliates from engaging in corporate transactions involving the Sellers' or the Sellers' affiliates' membership interests, including, without limitation, membership substitution transactions, so long as the terms thereof do not contemplate the sale or lease or other disposition of the Facilities or the Acquired Assets and such actions are taken subject to the terms and conditions of this Agreement.

(b) Any reference in this Agreement to an "**affiliate**" shall mean any Person directly or indirectly controlling, controlled by or under common control with a second Person; provided, however, an "affiliate" shall not include any officer or director of any Person. The term "**control**" (including the terms "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a Person, whether through the ownership of voting securities, by contract or otherwise or the right to designate or elect at least a majority of the members of its governing body by contract or corporate membership rights or otherwise. A "**Person**" shall mean any natural person, partnership, corporation, limited liability company, association, trust or other legal entity.

6.7 The Sellers' Efforts to Close. The Sellers shall use their reasonable commercial efforts to satisfy all of the conditions precedent set forth in Articles 8 and 9 to their or the Purchasers' obligations under this Agreement to the extent that the Sellers' action or inaction can control or influence the satisfaction of such conditions.

6.8 Title Matters. As soon as practicable after the Execution Date, the Purchasers shall order (a) a preliminary binder or title commitment(s) (the "**Title Commitment**") sufficient for the issuance of one or more Owner's Title Insurance Policies (ALTA 2006) with respect to the Owned Real Property (the "**Title Policy**"), issued by Chicago Title Insurance Company (the "**Title Company**"), together with true, correct and legible copies of all instruments referred to therein as conditions or exceptions to title (the "**Title Instruments**") and (b) ALTA surveys of all Owned Real Property for which a Title Policy is requested complying with the current Minimum Standard Detail Requirements for ALTA/ACSM Land Title Surveys for the Real Property (the "**Surveys**") and containing a surveyor's certificate in compliance with ALTA/ASCM land title survey requirements. The Sellers shall deliver to the Purchasers copies of the most recent land title surveys of the Facilities in their possession or control. Section 14.12 shall govern which Party or Parties hereto shall bear the costs and expenses of the Title Commitment, the Title Policy and the Surveys.

6.9 Termination of Hired Employees. Upon the Effective Date, the Hired Employees shall cease to be employees of the Sellers and their affiliates. The Sellers and their affiliates shall terminate effective as of the Effective Date the active participation of all of the Hired Employees in all of the Seller Plans, and shall cause each Seller Plan to comply with all applicable laws with respect to any obligations to such Hired Employees. After the Effective Date, the Sellers shall timely make or cause to be made, to the extent applicable, appropriate distributions to, or for the benefit of, all of the Hired Employees in respect of the Seller Plans which are in force and effect with respect to the Hired Employees at the Facilities immediately prior to the Effective Date in accordance with the terms and conditions of the Seller Plans; provided, however, no such distribution shall be required to the extent it is among the Assumed Obligations.

6.10 Hart-Scott-Rodino Act Filings. To the extent required by law, the Sellers will (a) take promptly all actions necessary to make the filings required of the Sellers or the Sellers' affiliates under the Hart-Scott-Rodino Antitrust Improvements Act of 1976 and the rules and regulations promulgated thereunder (the "**HSR Act**"), (b) comply at the earliest practicable date with any request for additional information received by the Sellers or the Sellers' affiliates from the Federal Trade Commission (the "**FTC**") or Antitrust Division of the Department of Justice (the "**DOJ**") pursuant to the HSR Act, and (c) cooperate with the Purchasers in connection with the Purchasers' filings under the HSR Act and in connection with resolving any investigation or other regulatory inquiry concerning the transactions contemplated by this Agreement commenced by either the FTC or the DOJ. All fees and expenses of the Sellers incurred in connection with the Sellers' filing under the HSR Act shall be borne by the Sellers.

6.11 Long-Term Debt. At its sole cost and expense, the Sellers shall do all things necessary, desirable and appropriate so that all liens and mortgages related to the Acquired Assets and securing any of the Long-Term Debt shall be released by the Closing Date.

6.12 Lessor Estoppel Certificates. The Sellers will use commercially reasonable efforts to obtain, prior to the Closing Date, estoppel letters, in a form reasonably acceptable to the Purchasers, for the Leased Real Property described on Schedule 1.1(b).

6.13 Supplements to Disclosure Schedules. From the Effective Date through the Closing Date, the Sellers will promptly notify the Purchasers if the Sellers become aware of any fact or condition that causes or constitutes a breach of any of the Sellers' representations and warranties as of the Effective Date. Should any such fact or condition require any change in the Disclosure Schedules, the Sellers will promptly deliver to the Purchasers a supplement to such Disclosure Schedules specifying such change.

ARTICLE 7

COVENANTS OF THE PURCHASERS

7.1 Purchasers' Efforts to Close. The Purchasers shall use their reasonable commercial efforts to satisfy all of the conditions precedent set forth in Articles 8 and 9 to its or the Sellers' obligations under this Agreement to the extent that the Purchasers' action or inaction can control or influence the satisfaction of such conditions.

7.2 Required Governmental Approvals. Between the Execution Date and the Closing Date, the Purchasers: (a) shall use their reasonable commercial efforts to secure, as promptly as practicable before the Closing Date, all consents, approvals, authorizations, clearances, certificates of need and licenses required to be obtained from governmental and regulatory authorities in order to carry out the transactions contemplated by this Agreement and to cause all of its covenants and agreements to be performed, satisfied and fulfilled, including a certificate of exemption or certificate of need, as applicable, from the Illinois Health Facilities and Services Review Board (the "**IHFSRB**"); and (b) will provide such other information and communications to governmental and regulatory authorities as the Sellers or such authorities may reasonably request. The Purchasers shall cooperate with the Sellers' efforts to obtain all consent and approvals of third parties required for the Sellers to assign to the Purchasers the Assumed Contracts on or before the Closing Date.

7.3 Certain Employee Matters.

(a) As of the Effective Date, Sellers and Purchasers shall have caused the transfer of employment to Purchasers of all Hospital and Hospital-based employees of the Sellers and the Sellers' affiliates, and certain agreed-upon employees of the Sellers or affiliates of the Sellers whose primary responsibilities are to support the Hospitals, the River Forest Facilities, the Related Businesses and/or other Facilities, subject to each such employee's acceptance of such employment, for an initial employment period of at least sixty (60) days after Closing (the "**Transition Period**"). All such employment arrangements will be upon substantially the same terms and conditions with respect to base salaries or wages, job duties, titles and responsibilities provided by the Sellers or affiliates of the Sellers before Closing (subject to employee background checks to the extent required by law and applicable collective bargaining agreements). All employees who accept an offer of employment by the Purchasers shall be referred to collectively in this Agreement as the "**Hired Employees.**" The Purchasers do not

expect to offer employment on the Effective Date to those employees of the Hospitals or other Sellers who as of such date are on short-term disability, until they return to work, or to employees on long-term disability. The Purchasers and the Sellers acknowledge those employees of the Sellers or the Sellers' affiliates working at the Facilities specified on Schedule 7.3 may be retained by such affiliates (the "**Retained Employees**"). After the Transition Period, the Purchasers shall continue to employ the Hired Employees as it reasonably deems necessary and appropriate to support the operations of the Facilities. The Purchasers will give all Hired Employees credit for their Accrued Paid Time Off and for their years of service with the Sellers for purposes of determining eligibility to participate and vesting percentages in the Purchasers' employee pension benefit plans. If the Purchasers terminate any of the Hired Employees following the Transition Period but before one hundred twenty (120) days after Closing, the Purchasers will provide severance to all such terminated employees at least the same extent as would be provided under the Sellers' current severance practice, as set forth in Schedule 7.3(a).

(b) On and after the Effective Date, the Hired Employees shall be eligible for a health plan sponsored by the Purchasers or their affiliates. The Hired Employees shall be given credit for periods of employment with the Sellers or the Sellers' affiliates prior to the Effective Date for purposes of determining eligibility to participate and amount of benefits (including without limitation vesting of benefits), and preexisting condition limitations will be waived with respect to the Hired Employees and their covered dependents unless such preexisting condition limitations were applicable prior to the Effective Date. In addition, if prior to the Effective Date a Hired Employee or his covered dependents paid any amounts towards a deductible or out-of-pocket maximum in the Sellers' or the Sellers' affiliates' medical and health plan's current fiscal year, such amounts shall be applied toward satisfaction of the deductible or out-of-pocket maximum in the current fiscal year of the Purchasers' or the Purchasers' affiliates' medical and health plan that covers the Hired Employees on and after the Effective Date.

(c) The Purchasers shall be responsible to provide continuation coverage pursuant to the requirements of section 4980B of the Internal Revenue Code of 1986, as amended, and Part 6 of Title I of the Employee Retirement Income Security Act of 1974, as amended (COBRA coverage) with respect to each of the Hired Employees (and their dependents) whose qualifying event occurs on or after the Effective Date or later date (with respect to employees on disability) on which such employees become Hired Employees.

(d) After the Closing Date, the Purchasers' human resources department will give reasonable assistance to the Sellers' and their affiliates' human resources department with respect to the Sellers' and the Sellers' affiliates' post-Closing administration of the Sellers' and the Sellers' affiliates' pre-Closing employee pension benefit plans and employee health or welfare benefit plans for the Hired Employees. Within ten (10) days after the Closing Date, the Purchasers shall provide to the Sellers a list of all the employees who were offered employment by the Purchasers but refused such employment.

Notwithstanding anything to the contrary, the provisions of this Section 7.3 shall not create any legal or other rights or interests in the Sellers, the Sellers' affiliates or any third-party beneficiaries.

7.4 Confidentiality. The Purchasers shall, and shall cause their employees, representatives and agents to, hold in strict confidence, unless compelled to disclose by judicial or administrative process or, in the opinion of the Purchasers' counsel, by other requirements of law, all Confidential Information (as hereinafter defined), and the Purchasers shall not disclose the Confidential Information to any person, except as otherwise may be reasonably necessary to carry out the transactions contemplated by this Agreement, including any business or diligence review by or on behalf of the Purchasers. The Purchasers' obligations set forth in the immediately preceding sentence shall apply (a) between the Execution Date and the Effective Date with respect to Confidential Information which is among the Acquired Assets and (b) from and after the Execution Date for all Confidential Information which is not described in subsection (a) above. For the purposes hereof, "**Confidential Information**" shall mean all information of any kind concerning the Sellers or the business of the Facilities, in connection with the transactions contemplated by this Agreement except information (i) ascertainable or obtained from public or published information, (ii) received from a third party not known by the Purchasers to be under an obligation to the Sellers or any affiliate of the Sellers to keep such information confidential, (iii) which is or becomes known to the public (other than through a breach of this Agreement), or (iv) which was in the Purchasers' possession prior to disclosure thereof to the Purchasers in connection herewith. The Parties acknowledge that the restrictions of this Section 7.4 shall not be applicable to any notices to the Attorney General of the State of Illinois, the IHFSRB, any other governmental bodies or agencies in connection with required change of ownership notices or filings for the Facilities, or any bodies or individuals affiliated with the Roman Catholic Church to whom information is provided in connection with approvals required under Roman Catholic canon law. The rights of the Sellers under this Section 7.4 shall be in addition to and not in substitution for the rights of the Sellers and the Sellers' affiliates under that certain Confidentiality Agreement among the Sellers and the Purchasers dated July 21, 2009 (the "**Confidentiality Agreement**"), which Confidentiality Agreement shall survive the Closing.

7.5 Enforceability. The Purchasers hereby acknowledges that the restrictions contained in Section 7.4 above are reasonable and necessary to protect the legitimate interests of the Sellers. The Parties also hereby acknowledge and agree that any breach of Section 7.4 would result in irreparable injury to the Sellers and that any remedy at law for any breach of Section 7.4 would be inadequate. Notwithstanding any provision to the contrary contained in this Agreement, the Parties therefore agree, and the Purchasers hereby specifically consent that, without necessity of proof of actual damage, the Sellers may be granted temporary or permanent injunctive relief, that the Sellers shall be entitled to an equitable accounting of all earnings, profits and other benefits arising from such breach, and that the Sellers shall be entitled to recover its reasonable fees and expenses, including attorneys' fees, incurred by the Sellers in enforcing the restrictions contained in Section 7.4.

7.6 Waiver of Bulk Sales Law Compliance. The Purchasers hereby waive compliance by the Sellers with the requirements, if any, of Article 6 of the Uniform Commercial Code as in force in any state in which the Acquired Assets are located and all other similar laws applicable to bulk sales and transfers. Notwithstanding the foregoing, the Sellers shall notify the Illinois Department of Revenue and Chicago Department of Revenue of the transaction, as applicable, and obtain a receipt or confirmation showing that the Taxes have been paid or that no taxes are due.

7.7 Hart-Scott-Rodino Act Filings. To the extent required by law, the Purchasers shall (a) take promptly all actions necessary to make the filings required of the Purchasers or their affiliates under the HSR Act, (b) comply at the earliest practicable date with any request for additional information received by the Purchasers or their affiliates from the FTC or the DOJ pursuant to the HSR Act, and (c) cooperate with the Sellers in connection with the Sellers' or the Sellers' affiliates' filings under the HSR Act and in connection with resolving any investigation or other regulatory inquiry concerning the transactions contemplated by this Agreement commenced by either the FTC or the DOJ. All filing fees imposed in connection with the Purchasers' filings under the HSR Act shall be borne by the Purchasers.

ARTICLE 8

CONDITIONS PRECEDENT TO OBLIGATIONS OF THE SELLERS

The Sellers' obligation to sell the Acquired Assets and to close the transactions as contemplated by this Agreement shall be subject to the satisfaction of each of the following conditions on or prior to the Closing Date unless specifically waived in writing by the Sellers in whole or in part at or prior to the Closing.

8.1 Signing and Delivery of Instruments. The Purchasers shall have executed and delivered all documents, instruments and certificates required to be executed and delivered pursuant to the provisions of this Agreement. The Purchasers acknowledge that the Purchasers shall not satisfy the condition precedent set forth in this Section 8.1 (as it relates to the delivery of the amount set forth in Section 2.1) unless the Purchasers initiate the wire transfer of the amount set forth in Section 2.1 to the Sellers, and provide to the Sellers a Federal Reserve wire reference number with respect thereto, on or before 5:00 p.m. (Central time) on the Closing Date.

8.2 Unfavorable Action or Proceeding. On the Closing Date, no orders, decrees, judgments or injunctions of any court or governmental body shall be in effect, and no claims, actions, suits, proceedings, arbitrations or investigations shall be pending or threatened, which challenge or seek to challenge, or which could prevent or cause the rescission of, or the consummation of the transactions contemplated in this Agreement.

8.3 Performance of Covenants. The Purchasers shall have in all material respects performed or complied with each and all of the obligations, covenants, agreements and conditions required to be performed or complied with by it on or prior to the Closing Date.

8.4 Opinion of the Purchasers' Counsel. The Sellers shall have received the favorable opinion of the Purchasers' counsel (which may be in-house counsel), dated the Closing Date, in form agreed upon by the Parties prior to Closing.

8.5 Hart-Scott-Rodino Filings. Any and all filings required to be made and notices required to be given pursuant to the HSR Act shall have been made, all approvals or consents required thereby shall have been obtained and the waiting periods required thereby, if any, shall have expired or terminated.

8.6 Governmental Authorizations. The Parties shall have obtained all material licenses, permits, certificates of need and authorizations from governmental agencies or

governmental bodies that are necessary or required for completion of the transactions contemplated by this Agreement, including, without limitation, approval from the IHFSRB, the expression of a no objection position by the Attorney General of Illinois regarding the purchase and sale of the Acquired Assets by the Purchasers and the Sellers, and reasonable assurances that any other material licenses, permits, certificates of need and authorizations not actually issued as of the Closing will be issued following Closing (which may include oral assurances from appropriate governmental agencies or bodies).

8.7 Schedules. The provisions of the Schedules attached to this Agreement that were supplemented, updated or amended after the Execution Date, if any, shall be acceptable to the Sellers in their sole discretion.

8.8 Warranties True and Correct. The representations and warranties made by the Purchasers in Article 5 shall be true and correct in all material respects when made and as of the Closing Date.

8.9 Approval of Roman Catholic Church. The Sellers shall have received all required approvals of the Roman Catholic Church required to be obtained by the Sellers or any affiliate of the Sellers under canon law, regarding the Sellers' execution of this Agreement and the consummation of the transactions contemplated hereunder.

ARTICLE 9

CONDITIONS PRECEDENT TO OBLIGATIONS OF THE PURCHASERS

The Purchasers' obligation to purchase the Acquired Assets and to close the transactions contemplated by this Agreement shall be subject to the satisfaction of each of the following conditions on or prior to the Closing Date unless specifically waived in writing by the Purchasers in whole or in part at or prior to the Closing.

9.1 Signing and Delivery of Instruments. The Sellers shall have executed and delivered all documents, instruments and certificates required to be executed and delivered pursuant to all of the provisions of this Agreement.

9.2 Unfavorable Action or Proceeding. On the Closing Date, no orders, decrees, judgments or injunctions of any court or governmental body shall be in effect, and no claims, actions, suits, proceedings, arbitrations or investigations shall be pending or threatened, which challenge or seek to challenge, or which could prevent or cause the rescission of, the consummation of the transactions contemplated in this Agreement.

9.3 Performance of Covenants. The Sellers shall have in all material respects performed or complied with each and all of the obligations, covenants, agreements and conditions required to be performed or complied with by the Sellers on or prior to the Closing Date.

9.4 Opinion of Sellers' Counsel. The Purchasers shall have received the favorable opinion of the Sellers' counsel (which may be in-house counsel), dated the Closing Date, in a form agreed upon by the Parties prior to Closing.

9.5 Hart-Scott-Rodino Filings. Any and all filings required to be made and notices required to be given pursuant to the HSR Act shall have been made, all approvals or consents required thereby shall have been obtained and the waiting periods required thereby, if any, shall have expired or terminated.

9.6 Governmental Authorizations. The Parties shall have obtained all material licenses, permits, certificates of need and authorizations from governmental agencies or governmental bodies that are necessary or required for completion of the transactions contemplated by this Agreement, including, without limitation, approval from the IHFSRB, the expression of a no objection position by the Attorney General of Illinois regarding the purchase and sale of the Acquired Assets by the Purchasers and the Sellers, and reasonable assurances that any other material licenses, permits, certificates of need and authorizations not actually issued as of the Closing will be issued following Closing (which may include oral assurances from appropriate governmental agencies or bodies).

9.7 Assumed Contract Consents; Payor Contracts. The Sellers shall have obtained the Material Consents. "**Material Consents**" mean consents for those Material Contracts listed on Schedule 9.7.

9.8 Title Insurance Policy. The Purchasers shall have received a fully effective Title Policy issued to the Purchasers by the Title Company covering the Owned Real Property in the aggregate amount allocated to the Owned Real Property in Schedule 9.8, which may be in the form of a marked Title Commitment (or pro forma Title Policy) binding the Title Company to issue the final Title Policy (the "**Marked Commitment**"). With delivery of the Marked Commitment, the Title Company is confirming to the Purchasers that (i) all of the conditions of Schedule B – Section I of the Title Commitment to the issuance of the final Title Policy have been fully satisfied, except for payment of the Purchaser Price and (ii) except for payment of the Purchase Price, there are no other unsatisfied conditions, qualifications or reservations to the effectiveness of the Marked Commitment, and that the Title Company is otherwise unconditionally obligated and prepared to issue the final title policy to the Purchaser in the form required by the Marked Commitment. The Title Policy shall show fee simple title to the Owned Real Property vested in the Purchasers, subject only to the Permitted Encumbrances, other than those intended to be paid off or discharged by Sellers pursuant to Section 4.7(b)(ii) and (vi). The Title Policy shall include policy modification endorsement 4 ("extended coverage" endorsement) deleting general policy exception numbers 1-5 of Schedule B of the Title Policy.

9.9 Schedules. The provisions of the Disclosure Schedules that were supplemented, updated or amended by the Sellers after the Execution Date, if any, shall be acceptable to the Purchasers in their reasonable discretion, and the provisions of any other Schedules that were supplemented, updated or amended after the Execution Date, if any, shall be acceptable to the Purchasers in their sole discretion.

9.10 Warranties True and Correct. The representations and warranties made by the Sellers in Article 4 shall be true and correct in all material respects when made and as of the Closing Date.

9.11 Approval of Roman Catholic Church. The Sellers shall have received all required approvals of the Roman Catholic Church required to be obtained by the Sellers or any affiliate of the Sellers under canon law, regarding the Sellers' execution of this Agreement and the consummation of the transactions contemplated hereunder.

9.12 Environmental and Other Reports. The Purchasers shall have received environmental and engineering reports with respect to the Facilities prepared by Persons acceptable to the Purchasers and the scope, findings and conclusions of such reports shall be reasonably satisfactory to the Purchasers.

9.13 Approval of Purchasers' Boards of Directors. The boards of directors of the Purchasers shall have ratified the execution of this Agreement and approved the consummation of the transactions contemplated herein, subject to the satisfaction of all Closing conditions applicable to the Purchasers.

9.14 No Material Adverse Change. Since the Execution Date, no Material Adverse Change shall have occurred and no events or circumstances have occurred that, individually or in the aggregate, could reasonably be expected to result in a Material Adverse Change in the reasonable discretion of the Purchasers. As used in this Agreement, "**Material Adverse Change**" means any condition, change, event, violation, inaccuracy, circumstance or effect that individually or in the aggregate, could reasonably be expected to result in a material adverse effect on the assets, results of operation or the financial condition of either of the Hospitals or of the Facilities as a whole. Notwithstanding anything to the contrary, "Material Adverse Change" shall not include: (i) changes in the financial or operating performance due to or caused by the announcement of the transactions contemplated by this Agreement or seasonal changes; (ii) changes or proposed changes to any applicable law, reimbursement rates or policies of governmental agencies or bodies that are generally applicable to hospitals or healthcare facilities; (iii) requirements, reimbursement rates, policies or procedures of third party payors or accreditation commissions or organizations that are generally applicable to hospitals or healthcare facilities; (iv) general business, industry or economic conditions, including such conditions related to the business of the Sellers, taken as a whole, or the Purchasers, taken as a whole, that do not disproportionately affect the applicable entities; (v) local, regional, national or international political or social conditions, including the engagement by the United States in hostilities, whether or not pursuant to the declaration of a national emergency or war, or the occurrence of any military or terrorist attack, that do not disproportionately affect the Sellers, taken as a whole, or the Purchasers, taken as a whole; (vi) changes in financial, banking or securities markets (including any disruption thereof and any decline in the price of any security or any market index) that do not disproportionately affect the Sellers, taken as a whole, or the Purchasers, taken as a whole; or (vii) changes in GAAP.

ARTICLE 10

TERMINATION

10.1 Termination. This Agreement may be terminated at any time prior to Closing:

(a) by the mutual written consent of the Parties;

(b) by the Sellers if a material breach of this Agreement has been committed by the Purchasers and such breach has not been (i) waived in writing by the Sellers or (ii) cured by the Purchasers to the reasonable satisfaction of the Sellers within fifteen (15) business days after service by the Sellers upon the Purchasers of a written notice which describes the nature of such breach;

(c) by the Purchasers if a material breach of this Agreement has been committed by the Sellers and such breach has not been (i) waived in writing by the Purchasers or (ii) cured by the Sellers to the reasonable satisfaction of the Purchasers within fifteen (15) business days after service by the Purchasers upon the Sellers of a written notice which describes the nature of such breach;

(d) by the Purchasers if any of the conditions in Article 9 have not been satisfied as of the Closing Date or if satisfaction of any condition in Article 9 is or becomes impossible and the Purchasers has not waived such condition in writing on or before the Closing Date (provided that the failure to satisfy the applicable condition or conditions has occurred by reason other than through the failure of the Purchasers to comply with its obligations under this Agreement);

(e) by the Sellers if any of the conditions in Article 8 have not been satisfied as of the Closing Date or if satisfaction of any such condition in Article 8 is or becomes impossible and the Sellers have not waived such condition in writing on or before the Closing Date (provided that the failure to satisfy the applicable condition or conditions has occurred by reason other than through the failure of the Sellers to comply with their obligations under this Agreement);

(f) by either the Purchasers or the Sellers if the Closing has not occurred (other than through the failure of any Party seeking to terminate this Agreement to comply fully with its obligations under this Agreement) on or before August 30, 2010; or

(g) by Purchaser if, prior to the Effective Date, any of Hospitals or the River Forest Facilities is substantially destroyed, or if, prior to the Effective Date, one or more of such Facilities is substantially damaged by fire, theft, vandalism or other cause or casualty and, as a result, the Sellers are unable to provide twenty-five percent (25%) or more (on a net revenue basis) of the health care services provided by that Facility immediately before the casualty for a period of more than thirty (30) days; provided, however, the Purchasers cannot terminate this Agreement pursuant to this Section if the Sellers otherwise commit to commencing and completing such repairs prior to Closing in such a manner that the services lost because of the damage are operational again and the Parties agree to extend the Closing Date so that the repairs can be completed by the Sellers prior to Closing.

10.2 Termination Consequences. If this Agreement is terminated pursuant to Section 10.1, (a) all further obligations of the Parties under this Agreement shall terminate, except that the obligations in Sections 7.4 (Confidentiality), 14.3 (Governing Law), 14.8 (Confidentiality and Publicity), and 14.12 (Expenses and Attorneys' Fees) shall survive, (b) each Party shall pay the costs and expenses incurred by it in connection with this Agreement, except as provided in Section 14.12, and (c) nothing shall prevent any Party hereto from pursuing any of

its legal rights or remedies that may be granted to any such Party by law against any other Party to this Agreement, except that no Party shall be entitled to obtain Consequential Damages.

ARTICLE 11

POST-CLOSING MATTERS

11.1 Post-Closing Receipt of Assets or Excluded Assets.

(a) Any asset or any liability, all other remittances and all mail and other communications that is an Excluded Asset or an Excluded Liability (i) pursuant to the terms of this Agreement or (ii) as otherwise determined by the Parties' mutual written agreement, and which comes into the possession, custody or control of the Purchasers (or their respective successors-in-interest, assigns or affiliates) shall within ten (10) business days following receipt be transferred, assigned or conveyed by the Purchasers (and their respective successors-in-interest, assigns and affiliates) to the Sellers at the Sellers' cost. Until such transfer, assignment and conveyance, the Purchasers (and their respective successors-in-interest, assigns and affiliates) shall not have any right, title or interest in or obligation or responsibility with respect to such asset or liability except that the Purchasers shall hold such asset in trust for the benefit of the Sellers. The Purchasers (and their respective successors-in-interest, assigns and affiliates) shall have neither the right to offset amounts payable to the Sellers under this Section 11.1(a) against, nor the right to contest its obligation to transfer, assign and convey to the Sellers because of, outstanding claims, liabilities or obligations asserted by the Purchasers against the Sellers including but not limited to pursuant to the post-Closing Cash Purchase Price adjustment of Section 2.3 and the indemnification provisions of Section 12.2. If the Purchasers do not remit any payments or remittances due to the Sellers under this Section 11.1(a) in accordance with the first sentence of this Section 11.1(a), such payments or remittances shall bear interest at the Prime Rate in effect on the calendar day upon which such payment was required to be made to the Sellers (the "**Seller Payment Due Date**") plus two percent (2%) per annum (or the maximum rate allowed by law, whichever is less), such interest accruing after the Seller Payment Due Date until payment, including all interest thereon, is made to the Sellers. The terms of this Article 11 shall not be subject to the time limitations contained in Section 12.1 of this Agreement.

(b) If the Sellers or any of their affiliates receive any funds paid in respect of any Acquired Assets, Assumed Obligations or services rendered by or on behalf of the Facilities from and after the Effective Date, the Sellers shall remit such funds to the Purchasers within ten (10) business days after receipt thereof, and if the Purchasers or any of their affiliates receive any funds paid in respect of Excluded Assets or Excluded Liabilities, the Purchasers shall remit such funds to the Sellers within ten (10) business days after receipt thereof. Any other asset or liability, and all other remittances, mail and other communications that are Acquired Assets or Assumed Obligations that come into the possession, custody or control of the Sellers (or their successors-in-interest, assigns or affiliates) shall within ten (10) business days following receipt be transferred, assigned or conveyed by the Sellers (and its respective successors-in-interest, assigns and affiliates) to the Purchasers. Until such transfer, assignment and conveyance, the Sellers (and their respective successors-in-interest, assigns and affiliates) shall not have any right, title or interest in or obligation or responsibility with respect to such asset or liability except that the Sellers shall hold such asset in trust for the benefit of the Purchasers. The Sellers

(and their respective successors-in-interest, assigns and affiliates) shall have neither the right to offset amounts payable to the Purchasers under this Section 11.1(b) against, nor the right to contest its obligation to transfer, assign and convey to the Purchasers because of, outstanding claims, liabilities or obligations asserted by the Sellers against the Purchasers including but not limited to pursuant to the post-Closing Cash Purchase Price adjustment of Section 2.3 and the indemnification provisions of Section 12.3. If the Sellers do not remit any payments or remittances due to the Purchasers under this Section 11.1(b) in accordance with the first sentence of this Section 11.1(b), such payments or remittances shall bear interest at the Prime Rate in effect on the calendar day upon which such payment was required to be made to the Purchasers (the "**Purchasers Payment Due Date**") plus two percent (2%) per annum (or the maximum rate allowed by law, whichever is less), such interest accruing after the Purchasers Payment Due Date until payment, including all interest thereon, is made to the Purchasers.

(c) Notwithstanding the foregoing, the Parties acknowledge that certain disproportionate share payments or other governmental, safety net or similar programs, including those identified in Schedule 11.1(c) (the "**Safety Net Payments**") are determined and paid by the governmental program or payor in a particular governmental fiscal year based on data taken from a prior governmental fiscal year. If after the Effective Date a Party receives one or more such payments during a governmental fiscal year that includes the Effective Date, the payment shall be apportioned between the Sellers and the Purchasers based on the number of months in the year in which the payment is made (pro-rated for any partial months as necessary) prior to the Effective Date (in the case of the Sellers) and after the Effective Date (in the case of the Purchasers) the Sellers and the Purchasers each owned the Facilities; provided, however, that to the extent Safety Net Payments due in one governmental fiscal year are paid in a subsequent governmental fiscal year, the Safety Net Payments will be apportioned among the Parties as if they had been made in the governmental fiscal year such payments were due.

(d) To the extent that Medicare, Medicaid, Blue Cross and other third party payors offset any amounts owing to the Purchasers for periods from and after the Effective Date, or require the Purchasers to pay any amounts to such third parties for periods from and after the Effective Date, in each case, as a result of any amounts owing (or allegedly owing) to such third parties by the Sellers in respect of periods prior to the Effective Date (the "**Purchaser Offset Amounts**"), the Purchasers shall promptly notify the Sellers of the same and, within fifteen (15) business days of receipt of such notice, the Sellers shall reimburse the Purchasers the amount that has been offset or the amount that the Purchasers are required to pay, as applicable. Without limiting the Sellers' obligations contained in this Section 11.1(d), upon reimbursement or payment of the amount due to the Purchasers, (i) the Sellers shall have the right to dispute with the applicable payor any such offsets or amounts alleged to be owed to such payor, (ii) the Sellers and the Purchasers shall reasonably cooperate with each other in connection with the Sellers' pursuit of such dispute and (iii) if the Purchasers subsequently receive any refund from the applicable payor of any amount which the Sellers have paid to the Purchasers pursuant to this Section 11.1(d), the Purchasers shall, within fifteen (15) business days after receipt thereof, pay such amount to the Sellers. To the extent that Medicare, Medicaid, Blue Cross and other third party payors offset any amounts owing to the Sellers for periods prior to the Effective Date, or require the Sellers to pay any amounts to such third parties for periods prior to the Effective Date, in each case, as a result of any amounts owing (or allegedly owing) to such third parties by the Purchasers in respect of periods on or after the Effective Date (the "**Seller Offset**

Amounts"), the Sellers shall promptly notify the Purchasers of the same and, within fifteen (15) business days of receipt of such notice, the Purchasers shall reimburse the Sellers the amount that has been offset or the amount that the Sellers are required to pay, as applicable. Without limiting the Purchasers' obligations contained in this Section 11.1(d), upon reimbursement or payment of the amount due to the Sellers, (i) the Purchasers shall have the right to dispute with the applicable payor any such offsets or amounts alleged to be owed to such payor, (ii) the Purchasers and the Sellers shall reasonably cooperate with each other in connection with the Purchasers' pursuit of such dispute and (iii) if the Sellers subsequently receive any refund from the applicable payor of any amount which the Purchasers have paid to the Sellers pursuant to this Section 11.1(d), the Sellers shall, within fifteen (15) business days after receipt thereof, pay such amount to the Purchasers.

11.2 Preservation and Access to Records After the Closing.

(a) From the Closing Date until seven (7) years after the Closing Date or such longer periods as are legally required (including in connection with any known or threatened governmental investigation or proceeding, or known or threatened civil or criminal proceeding of which the Sellers shall have notified the Purchasers with respect to document retention; provided that such notice identifies the applicable documentation or other records required to be retained with reasonable specificity) (the "**Document Retention Period**"), the Purchasers shall keep and preserve all medical records, patient records, employee records, medical staff records and other books and records which are among the Acquired Assets as of the Effective Date, but excluding any records which are among the Excluded Assets. If, after the expiration of the Document Retention Period but prior to the expiration of applicable statues of limitation or other legal record retention requirements, the Purchaser intends to destroy or otherwise dispose of any medical records for periods prior to the Effective Date, the Purchaser shall provide written notice to the Sellers of the Purchasers intention no later than forty-five (45) days prior to the date of such intended destruction or disposal and the Sellers shall have the right, at their sole cost, to take possession of such medical records during such period.

(b) The Purchasers will afford to the representatives of the Sellers, including their counsel and accountants, full and complete access to, and copies (including, electronic and color copies) of, such records (including electronic and color records) with respect to time periods prior to the Effective Date (including access to records of patients treated at the Facilities prior to the Effective Date) during normal business hours after the Effective Date, to the extent reasonably needed by the Sellers or the Sellers' affiliates for proper business purposes, subject to reasonable restrictions pertaining to the time and place of such access.

(c) With respect to any electronic or other records which are among the Excluded Assets but relate to the Acquired Assets or Assumed Obligations, the Sellers will afford to the representatives of the Purchasers, including their counsel and accountants, full and complete access to, and copies of (including electronic and color copies), such records with respect to time periods prior to the Effective Date, during normal business hours after the Effective Date, to the extent related to the Acquired Assets or Assumed Obligations and reasonably needed by the Purchasers for proper business purposes, subject to reasonable restrictions pertaining to the time and place of such access.

(d) The Purchasers shall give reasonable cooperation to the Sellers, the Sellers' affiliates and their insurance carriers in respect of the defense of claims by third parties against the Sellers or any affiliate of the Sellers, in respect of events occurring prior to the Effective Date with respect to the operation of the Facilities. Such cooperation shall include, without limitation, making the Hired Employees available for interviews, depositions, hearings and trials. Such cooperation shall also include making all of their employees available to assist in the securing and giving of evidence and in obtaining the presence and cooperation of witnesses. In addition, the Sellers and the Sellers' affiliates shall be entitled to remove from the Facilities originals of any such records, but only for purposes of pending litigation involving the Persons to whom such records refer, as certified in writing prior to removal by counsel retained by the Sellers or any of the Sellers' affiliates in connection with such litigation. Any records so removed from the Facilities shall be promptly returned to the Purchasers following the Sellers' or its applicable affiliate's use of such records.

(e) For the purpose of (i) transitioning the Facilities to the Purchasers pursuant to the transaction contemplated by this Agreement, (ii) granting the Sellers' access to the Excluded Assets, (iii) enabling the Sellers to satisfy its obligations under the Excluded Liabilities and (iv) enabling the Sellers to prepare the Final Combined Balance Sheet pursuant to Section 2.3, the Purchasers shall after the Effective Date give the Sellers, the Sellers' affiliates and their respective representatives access during normal business hours to the Purchasers' books, accounts and records and all other relevant documents and information with respect to the Acquired Assets, Excluded Liabilities and pre-Closing business of the Facilities as representatives of the Sellers and the Sellers' affiliates may from time to time reasonably request, all in such manner as not to unreasonably interfere with the operations of the Facilities. The Sellers acknowledge that they shall coordinate their activities contemplated by this Section 11.2(e) through Rob Jay, or his designee or successor.

(f) The Purchasers and their representatives shall be given access by the Sellers during normal business hours to the extent reasonably needed by the Purchasers for business purposes to all documents, records, correspondence, work papers and other documents retained by the Sellers pertaining to any of the Acquired Assets or with respect to the operation of the Facilities prior to the Effective Date, all in such manner as to not interfere unreasonably with the Sellers' business. Such documents and other materials shall be, at the Sellers' option, either (i) copied in hard copy or electronic form by the Sellers for the Purchasers, or (ii) removed by the Purchasers from the premises, copied by the Purchasers and promptly returned to the Sellers.

(g) To the maximum extent permitted by law, if any Person requests or demands, by subpoena or otherwise, any documents relating to the Excluded Liabilities, including without limitation, documents relating to the operations of the Facilities or any of the Facilities' committees prior to the Effective Date, prior to any disclosure of such doeuments, the Purchasers shall notify the Sellers and shall provide the Sellers with the opportunity to object to, and otherwise coordinate with respect to, such request or demand.

(h) No Party shall be entitled to compensation for any cooperation described in Section 11.2(b) through Section 11.2(g) other than reimbursement for its reasonable out-of-pocket expenses.

11.3 Provision of Benefits of Certain Contracts. If, as of the Effective Date, the Sellers are unable to obtain any consent to the assignment of the Sellers' interest in a Material Contract, or if after reasonable effort the Purchasers are unable to enter into a new contract or partial assignment of a contract with respect to an Excluded Multi-Facility Contract that but for being excluded would have been a Material Contract, with respect to one or more of the Facilities, until such consent, partial assignment or new contract is obtained, the Sellers shall use reasonable commercial efforts to provide the Purchasers the benefits of any such Material Contract and, in the case of an Excluded Multi-Facility Contract, the Facilities' portion of any Excluded Multi-Facility Contract not to exceed twelve (12) months in length, by cooperating in any reasonable and lawful arrangement designed to provide such benefits to the Purchasers, and allow the Purchasers to directly enforce such Assumed Contract against the applicable third parties thereto. The Purchasers shall use reasonable commercial efforts to perform, on behalf of the Sellers, the obligations of the Sellers thereunder or in connection therewith arising on and after the Effective Date, with respect to the Acquired Assets, but only to the extent that such action would not result in a material default thereunder or in connection therewith and such obligation would have been, in the case of a Material Contract, an obligation of the Purchasers had it entered into a new contract on substantially similar terms.

11.4 Use of Business Names. Except for the names included as part of the Acquired Assets, the Purchasers covenant that they and their affiliates shall not use directly, indirectly or in any way that implies that the Facilities continue to be affiliated with Resurrection in their respective trades or businesses including any of the Excluded Assets, names, tradenames, trademarks, symbols or world-wide web addresses associated with the Sellers or the Sellers' affiliates, and with respect to any of the foregoing, all abbreviations and variations thereof, and trademarks, trade names, service marks, copyrights and any applications therefor, symbols and logos related thereto, together with any promotional material, stationery, supplies or other items of inventory bearing such names or symbols or abbreviations or variations thereof.

11.5 Removal of Excluded Assets. After the Closing Date, the Purchasers shall provide to the Sellers reasonable access to the Facilities to remove any Excluded Assets at the Facilities on and after the Effective Date, without imposing any charge on the Sellers for the Purchasers' storage or holding of same on and after the Effective Date. Any Excluded Assets not so removed by the Sellers within one hundred twenty (120) days after the Effective Date shall be deemed abandoned by the Sellers and may be retained or disposed of by the Purchasers as they see fit in their sole discretion. The Purchasers shall have no responsibility for such Excluded Assets and the Sellers shall repair any damage to the premises caused by their removal of the Excluded Assets. Notwithstanding the foregoing, any Excluded Assets that are required to remain at the Facilities to enable the Sellers to provide services under the Transition Services Agreement (or pursuant to any other agreement between the Sellers and the Purchasers) shall not be deemed abandoned and shall be permitted to remain at the Facilities during the term of the Transition Services Agreement (or such other agreement between the Sellers and the Purchasers).

ARTICLE 12

SURVIVAL AND INDEMNIFICATION

12.1 Survival. Except as expressly set forth in this Agreement to the contrary, all representations and warranties of the Purchasers and the Sellers, respectively, contained in this Agreement or in any certificate delivered pursuant hereto shall continue to be fully effective and enforceable following the Closing Date for eighteen (18) months and shall thereafter be of no further force and effect, except that the representations and warranties contained in Sections 4.1 and 5.1 shall continue to be fully effective and enforceable following the Closing Date without any time limitation; provided, however, that if there is an outstanding notice of a claim at the end of any such applicable period in compliance with the terms of Section 12.4, such applicable period shall not end in respect of such claim until such claim is resolved. All other covenants, agreements and indemnifications contained in this Agreement or any documents to be delivered hereunder shall survive in accordance with the terms set forth herein or therein.

12.2 Indemnification of the Purchasers by the Sellers.

12.2.1 Indemnification. The Sellers shall keep and save the Purchasers, their affiliates, and their respective directors, officers, employees, agents and other representatives, forever harmless from and shall indemnify and defend the Purchasers and such other Persons against any and all obligations, judgments, liabilities, penalties, violations, fees, fines, claims, losses, costs, demands, damages, liens, encumbrances and expenses including reasonable attorneys' fees (collectively, "**Damages**"), to the extent connected with or arising or resulting from (a) any breach of any representation or warranty of the Sellers under this Agreement (subject to the survival period set forth in Section 12.1), (b) any breach or default by the Sellers of any covenant or agreement of the Sellers under this Agreement, (c) the Excluded Liabilities, (d) the Excluded Assets, (e) all Taxes relating to the Sellers (the "**Seller Tax Claims**"), (f) any professional liability claim arising out of the business operations of the Facilities prior to the Effective Date and (g) any act, conduct or omission of the Sellers that has accrued, arisen, occurred or come into existence at any time prior to the Effective Date. The Sellers' obligations under this Section 12.2.1 shall remain subject to, and shall be limited by, the provisions contained in Section 1.5. No provision in this Agreement shall prevent the Sellers from pursuing any of their legal rights or remedies that may be granted to the Sellers by law against any Person other than the Purchasers.

12.2.2 Indemnification Limitations. (a) Notwithstanding any provision to the contrary contained in this Agreement, the Sellers shall be under no liability to indemnify the Purchasers under Section 12.2.1 and no claim under Section 12.2.1 of this Agreement shall:

(i) be made unless notice thereof shall have been given by or on behalf of the Purchasers to the Sellers in the manner provided in Section 12.4, unless failure to provide such notice in a timely manner does not materially impair the Sellers' ability to defend their rights, mitigate damages, seek indemnification from a third party or otherwise protect their interests;

(ii) be made to the extent that any loss may be recovered under a policy of insurance in force on the date of loss; provided, however, that this Section 12.2.2(a)(ii) shall not apply to deductibles or copayments, any self-insurance program or insurance provided by captive affiliates, or to the extent that coverage under the applicable policy of insurance is denied by the applicable insurance carrier;

(iii) be made to the extent that such claim relates to a liability arising out of or relating to any act, omission, event or occurrence connected with:

(A) the use, ownership or operation of the Facilities, or

(B) the use, ownership or operation of any of the Acquired Assets,

on and after the Effective Date (without regard to whether such use, ownership or operation is consistent with the Sellers' policies, procedures and/or practices prior to the Effective Date); other than as specifically included in the Excluded Liabilities;

(iv) be made under Section 12.2.1(a) to the extent that such claim (or the basis therefor) is set forth in the Disclosure Schedules or any Schedule to this Agreement;

(v) be made if and to the extent that proper provision or reserve was made for the matter giving rise to the claim in, or noted in, or taken account of in Net Working Capital;

(vi) be made to the extent such claim relates to an obligation or liability for which the Purchasers have agreed to indemnify the Sellers pursuant to Section 12.3;

(vii) be made to the extent such claim seeks Damages which are consequential in nature (as opposed to direct), including, without limitation, loss of future revenue or income or loss of business reputation or opportunity (collectively, "**Consequential Damages**"); provided, however, the limitation contained in this Section 12.2.2(a)(vii) shall not apply to the extent (A) of any payments which the Purchasers or other indemnified Person is required to make to a third party (other than any third party which is an affiliate of either of the Purchasers) which are in the nature of Consequential Damages;

(viii) be made under Section 12.2.1(a) to the extent that such claim relates to the Purchasers' ability to collect the Accounts Receivable; provided, however, the limitation contained in this Section 12.2.2(a)(viii) shall not apply to any breach by any of the Sellers of its representation and warranty contained in Section 4.15; and

(ix) accrue under Section 12.2.1(a) to the benefit of the Purchasers unless and only to the extent that (A) the actual liability of the Sellers to the Purchasers in respect of any single claim under Section 12.2.1(a) exceeds Ten Thousand Dollars ($10,000) (the "**Relevant Claim Amount**") and (B) the total actual liability of the Sellers to the Purchasers in respect of all Relevant Claims in the aggregate exceeds Fifty

Thousand Dollars ($50,000) (the "**Aggregate Amount**"), in which event the Purchasers or other indemnified Person shall be entitled to seek indemnification under Section 12.2.1(a) for all claims for Damages which exceed the Aggregate Amount.

(b) Notwithstanding any provision to the contrary contained in this Agreement, the maximum aggregate liability of the Sellers to the Purchasers and other indemnified Persons for claims brought under Section 12.2.1(a) shall not exceed an amount equal to fifty percent (50%) of the Cash Purchase Price.

(c) If the Purchasers are entitled to recover any sum (whether by payment, discount, credit or otherwise) from any third party (other than an insurance provider or another Person entitled to indemnification by the Sellers hereunder) in respect of any matter for which a claim of indemnity could be made against the Sellers hereunder, the Purchasers shall use their reasonable endeavors to recover such sum from such third party and any sum recovered will reduce the amount of the claim. If the Sellers pays to the Purchasers an amount in respect of a claim, and the Purchasers subsequently recover from a third party (other than an insurance provider or another Person entitled to indemnification by the Sellers hereunder) a sum which is referable to that claim, the Purchasers shall forthwith repay to the Sellers so much of the amount paid by it as does not exceed the sum recovered from the third party less all reasonable costs, charges and expenses incurred by the Purchasers in obtaining payment in respect of that claim and in recovering that sum from the third party.

12.3 Indemnification of the Sellers by the Purchasers.

12.3.1 Indemnification. The Purchasers shall keep and save the Sellers, and the Sellers' respective directors, officers, employees, agents and other representatives, forever harmless from and shall indemnify and defend the Sellers and such other Persons against any and all Damages, to the extent connected with or arising or resulting from (a) any breach of any representation or warranty of the Purchasers under this Agreement, (b) any breach or default by the Purchasers under any covenant or agreement of the Purchasers under this Agreement, (c) the Assumed Obligations, (d) any professional liability claim arising out of the business operations of the Facilities on or after the Effective Date; and (e) any act, conduct or omission of the Purchasers related to the Acquired Assets, Assumed Obligations or operations of the Facilities that has accrued, arisen, occurred or come into existence at any time on or after the Effective Date. No provision in this Agreement shall prevent the Purchasers from pursuing any of its legal rights or remedies that may be granted to the Purchasers by law against any Person other than the Sellers or any affiliate of the Sellers.

12.3.2 Indemnification Limitations. (a) Notwithstanding any provision to the contrary contained in this Agreement, the Purchasers shall be under no liability to indemnify the Sellers under Section 12.3.1 and no claim under Section 12.3.1 of this Agreement shall:

(i) be made unless notice thereof shall have been given by or on behalf of the Sellers to the Purchasers in the manner provided in Section 12.4, unless failure to provide such notice in a timely manner does not materially impair the Purchasers' ability to defend its rights, mitigate damages, seek indemnification from a third party or otherwise protect its interests;

(ii) be made to the extent that any loss may be recovered under a policy of insurance in force on the date of loss; provided, however, that this Section 12.3.2(a)(ii) shall not apply to deductibles or copayments, any self-insurance program or insurance provided by captive affiliates, or to the extent that coverage under the applicable policy of insurance is denied by the applicable insurance carrier;

(iii) be made to the extent that such claim relates to a liability of the Sellers arising out of or relating to any act, omission, event or occurrence connected with:

(A) the use, ownership or operation of the Facilities, or

(B) the use, operation or ownership of any of the Acquired Assets,

prior to the Effective Date, other than as specifically included in the Assumed Obligations;

(iv) be made to the extent such claim relates to an obligation or liability for which the Sellers have agreed to indemnify the Purchasers pursuant to Section 12.2;

(v) be made to the extent such claim seeks Consequential Damages; provided, however, the limitation contained in this Section 12.3.2(a)(v) shall not apply to the extent of any payments which the Sellers or any affiliate of the Sellers is required to make to a third party which are in the nature of Consequential Damages; and

(vi) accrue under Section 12.3.1(a) to the benefit of the Sellers unless and only to the extent that (A) the actual liability of the Purchasers to the Sellers in respect of any claim under Section 12.3.1(a) exceeds the Relevant Claim Amount and (B) the total actual liability of the Purchasers in respect of all Relevant Claims exceeds the Aggregate Amount, in which event Sellers and other indemnified Persons shall be entitled to seek indemnification under Section 12.3.1(a) for all claims for Damages which exceed the Aggregate Amount.

(b) Notwithstanding any provision to the contrary contained in this Agreement, the maximum aggregate liability of the Purchasers to Sellers and other indemnified Persons for claims brought under Section 12.3.1(a) shall not exceed an amount equal to fifty percent (50%) of the Cash Purchase Price.

(c) If the Sellers are entitled to recover any sum (whether by payment, discount, credit or otherwise) from any third party in respect of any matter for which a claim of indemnity could be made against the Purchasers hereunder, the Sellers shall use reasonable endeavors to recover such sum from such third party and any sum recovered will reduce the amount of the claim. If the Purchasers pays to the Sellers an amount in respect of a claim, and the Sellers subsequently recovers from a third party a sum which is referable to that claim, the Sellers shall forthwith repay to the Purchasers so much of the amount paid by it as does not exceed the sum recovered from the third party less all reasonable costs, charges and expenses incurred by the Sellers in obtaining payment in respect of that claim and in recovering that sum from the third party.

12.4 Method of Asserting Claims. All claims for indemnification by any person entitled to indemnification (the "**Indemnified Party**") under this Article 12 will be asserted and resolved as follows:

(a) In the event any claim or demand, for which a party hereto (an "**Indemnifying Party**") would be liable for the Damages to an Indemnified Party, is asserted against or sought to be collected from such Indemnified Party by a person other than the Sellers, the Purchasers or their affiliates (a "**Third Party Claim**"), the Indemnified Party shall deliver a notice of its claim (a "**Claim Notice**") to the Indemnifying Party within thirty (30) calendar days after the Indemnified Party receives written notice of such Third Party Claim; provided, however, that notice shall be provided to the Indemnifying Party within fifteen (15) calendar days after receipt of a complaint, petition or institution of other formal legal action by the Indemnified Party. If the Indemnified Party fails to provide the Claim Notice within such applicable time period after the Indemnified Party receives written notice of such Third Party Claim and thereby materially impairs the Indemnifying Party's ability to protect its interests, the Indemnifying Party will not be obligated to indemnify the Indemnified Party with respect to such Third Party Claim. The Indemnifying Party will notify the Indemnified Party within thirty (30) calendar days after receipt of the Claim Notice (the "**Notice Period**") whether the Indemnifying Party desires, at the sole cost and expense of the Indemnifying Party, to defend the Indemnified Party against such Third Party Claim.

(i) If the Indemnifying Party notifies the Indemnified Party within the Notice Period that the Indemnifying Party desires to defend the Indemnified Party with respect to the Third Party Claim pursuant to this Section 12.4(a), then subject to the immediately succeeding sentence the Indemnifying Party will have the right to defend, at its sole cost and expense, such Third Party Claim by all appropriate proceedings, which proceedings will be prosecuted by the Indemnifying Party to a final conclusion or will be settled at the discretion of the Indemnifying Party. To the extent the Third Party Claim is solely for money damages, the Indemnifying Party will have full control of such defense and proceedings, including any compromise or settlement thereof. Notwithstanding the foregoing, the Indemnified Party may, at its sole cost and expense, file during the Notice Period any motion, answer or other pleadings that the Indemnified Party may deem necessary or appropriate to protect its interests or those of the Indemnifying Party and which is not prejudicial, in the reasonable judgment of the Indemnifying Party, to the Indemnifying Party. Except as provided in Section 12.4(a)(ii) hereof, if an Indemnified Party takes any such action that is prejudicial and causes a final adjudication that is adverse to the Indemnifying Party, the Indemnifying Party will be relieved of its obligations hereunder with respect to the portion of such Third Party Claim prejudiced by the Indemnified Party's action. If requested by the Indemnifying Party, the Indemnified Party agrees, at the sole cost and expense of the Indemnifying Party, to cooperate with the Indemnifying Party and its counsel in contesting any Third Party Claim that the Indemnifying Party elects to contest, or, if appropriate and related to the Third Party Claim in question, in making any counterclaim against the person asserting the Third Party Claim, or any cross-complaint against any person (other than the Indemnified Party or any of its affiliates). The Indemnified Party may participate in, but not control, any defense or settlement of any Third Party Claim controlled by the Indemnifying Party pursuant to this Section 12.4(a)(i), and except as specifically provided in this

Section 12.4(a)(i), the Indemnified Party will bear its own costs and expenses with respect to such participation.

(ii) If the Indemnifying Party fails to notify the Indemnified Party within the Notice Period that the Indemnifying Party desires to defend the Indemnified Party pursuant to this Section 12.4(a), or if the Indemnifying Party gives such notice but fails to prosecute diligently or settle the Third Party Claim, or if the Indemnifying Party fails to give any notice whatsoever within the Notice Period, then the Indemnified Party will have the right to defend, at the sole cost and expense of the Indemnifying Party, the Third Party Claim by all appropriate proceedings, which proceedings will be promptly and reasonably prosecuted by the Indemnified Party to a final conclusion or will be settled at the discretion of the Indemnified Party. The Indemnified Party will have full control of such defense and proceedings, including any compromise or settlement thereof; provided, however, that if requested by the Indemnified Party, the Indemnifying Party agrees, at the sole cost and expense of the Indemnifying Party, to cooperate with the Indemnified Party and its counsel in contesting any Third Party Claim which the Indemnified Party is contesting, or, if appropriate and related to the Third Party Claim in question, in making any counterclaim against the person asserting the Third Party Claim, or any cross-complaint against any person (other than the Indemnifying Party or any of its affiliates). Notwithstanding the foregoing provisions of this Section 12.4(a)(ii), if the Indemnifying Party has notified the Indemnified Party with reasonable promptness that the Indemnifying Party disputes its liability to the Indemnified Party with respect to such Third Party Claim and if such dispute is resolved in favor of the Indemnifying Party, the Indemnifying Party will not be required to bear the costs and expenses of the Indemnified Party's defense pursuant to this Section 12.4(a)(ii) or of the Indemnifying Party's participation therein at the Indemnified Party's request, and the Indemnified Party will reimburse the Indemnifying Party in full for all reasonable costs and expenses incurred by the Indemnifying Party in connection with such litigation. Subject to the above terms of this Section 12.4(a)(ii), the Indemnifying Party may participate in, but not control, any defense or settlement controlled by the Indemnified Party pursuant to this Section 12.4(a)(ii), and the Indemnifying Party will bear its own costs and expenses with respect to such participation. The Indemnified Party shall give sufficient prior notice to the Indemnifying Party of the initiation of any discussions relating to the settlement of a Third Party Claim to allow the Indemnifying Party to participate therein.

(b) In the event any Indemnified Party should have a claim against any Indemnifying Party hereunder that either (i) does not involve a Third Party Claim being asserted against or sought to be collected from the Indemnified Party or (ii) is a the Seller Tax Claim, the Indemnified Party shall deliver an Indemnity Notice (as hereinafter defined) to the Indemnifying Party. (The term "**Indemnity Notice**" shall mean written notification of a claim for indemnity under Article 12 hereof (which claim does not involve a Third Party Claim or is a the Seller Tax Claim) by an Indemnified Party to an Indemnifying Party pursuant to this Section 12.4, specifying the nature of and specific basis for such claim and the amount or the estimated amount of such claim.) The failure by any Indemnified Party to give the Indemnity Notice shall not impair such party's rights hereunder except to the extent that an Indemnifying Party demonstrates that it has been prejudiced thereby.

(c) If the Indemnifying Party does not notify the Indemnified Party within thirty (30) calendar days following its receipt of a Claim Notice or an Indemnity Notice that the Indemnifying Party disputes its liability to the Indemnified Party hereunder, such claim specified by the Indemnified Party will be conclusively deemed a liability of the Indemnifying Party hereunder and the Indemnifying Party shall pay the amount of such liability to the Indemnified Party on demand, or on such later date (i) in the case of a Third Party Claim, as the Indemnified Party suffers the Damages in respect of such Third Party Claim, (ii) in the case of an Indemnity Notice in which the amount of the claim is estimated, when the amount of such claim becomes finally determined or (iii) in the case of a the Seller Tax Claim, within fifteen (15) calendar days following final determination of the item giving rise to the claim for indemnity. If the Indemnifying Party has timely disputed its liability with respect to such claim, as provided above, the Indemnifying Party and the Indemnified Party agree to proceed in good faith to negotiate a resolution of such dispute, and if not resolved through negotiations, such dispute will be resolved by adjudication by a court or similar tribunal.

(d) The Indemnified Party agrees to give the Indemnifying Party reasonable access to the books and records and employees of the Indemnified Party in connection with the matters for which indemnification is sought hereunder, to the extent the Indemnifying Party reasonably deems necessary in connection with its rights and obligations hereunder.

(e) The Indemnified Party shall assist and cooperate with the Indemnifying Party in the conduct of litigation, the making of settlements and the enforcement of any right of contribution to which the Indemnified Party may be entitled from any person or entity in connection with the subject matter of any litigation subject to indemnification hereunder. In addition, the Indemnified Party shall, upon request by the Indemnifying Party or counsel selected by the Indemnifying Party (without payment of any fees or expenses to the Indemnified Party or an employee thereof), attend hearings and trials, assist in the securing and giving of evidence, assist in obtaining the presence or cooperation of witnesses, and make available its own personnel; and shall do whatever else is necessary and appropriate in connection with such litigation. The Indemnified Party shall not make any demand upon the Indemnifying Party or counsel for the Indemnifying Party in connection with any litigation subject to indemnification hereunder, except a general demand for indemnification as provided hereunder. If the Indemnified Party shall fail to perform such obligations as Indemnified Party hereunder or to cooperate fully with the Indemnifying Party in Indemnifying Party's defense of any suit or proceeding, such cooperation to include, without limitation, attendance at all depositions and the provision of all documents (subject to appropriate privilege) relevant to the defense of any claim, then, except where such failure does not have materially impair the Indemnifying Party's defense after notice to the Indemnified Party and ten (10) days to cure, the Indemnifying Party shall be released from all of its obligations under this Agreement with respect to that suit or proceeding and any other claims which had been raised in such suit or proceeding.

(f) Following indemnification as provided for hereunder, the Indemnifying Party shall be subrogated to all rights of the Indemnified Party with respect to all persons or entities relating to the matter for which indemnification has been made; provided, however, that the Indemnifying Party shall have no subrogation rights to seek reimbursement through or from the Indemnified Party's insurance policies, program, coverage, carriers or beneficiaries.

12.5 Exclusive. Other than claims for fraud or equitable relief (which equitable relief claims are nevertheless subject to Section 12.1), any claim arising under this Agreement or in connection with or as a result of the transactions contemplated by this Agreement or any Damages or injury alleged to be suffered by any party as a result of the actions or failure to act by any other party shall, unless otherwise specifically stated in this Agreement, be governed solely and exclusively by the provisions of this Article 12. If the Sellers and the Purchasers cannot resolve such claim by mutual agreement, such claim shall be determined by adjudication by a court or other tribunal subject to the provisions of this Article 12.

ARTICLE 13

TAX AND COST REPORT MATTERS

13.1 Tax Matters; Allocation of Purchase Price.

(a) After the Closing Date, the Parties shall cooperate fully with each other and shall make available to each other, as reasonably requested, all information, records or documents relating to tax liabilities or potential tax liabilities attributable to the Sellers with respect to the operation of the Facilities for all periods prior to the Effective Date and shall preserve all such information, records and documents at least until the expiration of any applicable statute of limitations or extensions thereof. The Parties shall also make available to each other as reasonably required, and at the reasonable cost of the requesting party (for out-of-pocket costs and expenses only), personnel responsible for preparing or maintaining information, records and documents in connection with tax matters.

(b) The Purchase Price shall be allocated among each category of the Acquired Assets in accordance with Schedule 13.1(b). The Sellers and the Purchasers hereby agree to allocate the Purchase Price in accordance with Schedule 13.1(b), to be bound by such allocations, to account for and report the purchase and sale of the Acquired Assets contemplated hereby for federal and state tax purposes in accordance with such allocations, and not to take any position (whether in tax returns, tax audits, or other tax proceedings), which is inconsistent with such allocations without the prior written consent of the other Parties.

13.2 Cost Report Matters.

(a) After the Effective Date, the Sellers shall timely file all Medicare, Medicaid, TRICARE, Blue Cross and any other termination cost reports required to be filed as a result of the consummation of (a) the transfer of the Acquired Assets to the Purchasers and (b) the transactions contemplated by this Agreement (the "**Seller Cost Reports**"). All such termination cost reports shall be filed by the Sellers in a manner that is consistent with the then current laws, rules and regulations. The Sellers will be solely responsible, financially and otherwise, for the contents of all such termination cost reports (and related claims and documentation) and shall retain the right to control the appeal of any Medicare, Medicaid or Blue Cross determinations relating to any of the Seller Cost Reports. The Sellers recognize that the Blue Cross cost reports filed by the Sellers will affect Blue Cross reimbursement to the Purchasers in periods after Closing. Therefore, the Sellers will provide to the Purchasers a reasonable opportunity to review the Sellers' Blue Cross cost reports prior to the filing thereof

and will consider in good faith the Purchasers' comments that may affect their reimbursement in future periods.

(b) The Purchasers shall forward to the Sellers any and all correspondence relating to the Seller Cost Reports or rights to settlements and retroactive adjustments on the Seller Cost Reports ("**Agency Settlements**") within fifteen (15) business days after receipt by the Purchasers. The Purchasers will forward any demand for payments with respect to the Agency Settlements or the Seller Cost Reports within fifteen (15) business days after receipt by the Purchasers.

(c) Upon reasonable notice and during normal business office hours, the Purchasers will cooperate with the Sellers in regard to the preparation and filing of the Seller Cost Reports. Upon reasonable notice and during normal business office hours, the Purchasers will cooperate with the Sellers in connection with any cost report disputes and/or other claim adjudication matters relative to governmental program reimbursement. Such cooperation shall include, at Sellers' cost, obtaining files at the Facilities and the Purchasers' provision to the Sellers of data and statistics, and the coordination with the Sellers pursuant to reasonable notice of Medicare, Medicaid and Blue Cross exit conferences or meetings.

ARTICLE 14

MISCELLANEOUS PROVISIONS

14.1 Further Assurances and Cooperation. The Sellers shall execute, acknowledge and deliver to the Purchasers any and all other assignments, consents, approvals, conveyances, assurances, documents and instruments reasonably requested by the Purchasers at any time and shall take any and all other actions reasonably requested by the Purchasers at any time for the purpose of more effectively assigning, transferring, granting, conveying and confirming to the Purchasers, the Acquired Assets. After consummation of the transaction contemplated in this Agreement, the Parties agree to cooperate with each other and take such further actions as may be necessary or appropriate to effectuate, carry out and comply with all of the terms of this Agreement, the documents referred to in this Agreement and the transactions contemplated hereby.

14.2 Successors and Assigns. All of the terms and provisions of this Agreement shall be binding upon and shall inure to the benefit of and be enforceable by the respective successors and assigns of the Parties hereto; provided, however, that no party hereto may assign any of its rights or delegate any of its duties under this Agreement without the prior written consent of the other Parties, except that the Purchasers may assign any of their rights or delegate any of their duties under this Agreement to any wholly-owned subsidiary of the Purchasers upon the Sellers' receipt of the Purchasers' guaranty of such wholly-owned subsidiary's obligations, in a form reasonably acceptable to the Sellers. The Purchasers may designate one or more affiliates to take title to some of the Acquired Assets or to assume some of the Assumed Obligations upon the Sellers' receipt of evidence that such affiliates have agreed to assume all of the Purchasers' obligations hereunder related to such assets or obligations and the Purchasers and the affiliates have complied with applicable laws and regulations governing the transfer of such assets or obligations, in a form reasonably acceptable to the Sellers.

14.3 Governing Law. This Agreement shall be governed by and construed and enforced in accordance with the laws of the State of Illinois as applied to contracts made and performed within the State of Illinois. The Parties hereby waive their right to claim in any proceeding involving this Agreement that the law of any jurisdiction other than the State of Illinois shall apply to such dispute; and the Parties hereby covenant that they shall assert no such claim in any dispute arising under this Agreement.

14.4 Amendments. This Agreement may not be amended other than by written instrument signed by the Parties.

14.5 Schedules and Disclosure Schedules. The Disclosure Schedules and Schedules referred to in this Agreement shall be attached hereto and are incorporated by reference herein. From the Execution Date until the Closing, the Sellers shall update the Disclosure Schedules that are attached to this Agreement as of the Effective Date if and to the extent required by Section 6.13, and the Parties may mutually agree to update any other Schedules. With respect to any Disclosure Schedules or other Schedules that have been completed and attached to the Agreement, such Schedules will be prepared and attached to this Agreement at such time as the Parties agree. Until all such Schedules are final and acceptable to the Parties and attached to this Agreement, any Party may terminate this Agreement for any reason upon notice to the other Parties without penalty or liability for breach or default. Any matter disclosed in this Agreement or in the Disclosure Schedules with reference to any Section of this Agreement shall be deemed a disclosure in respect of all sections to which such disclosure may apply.

14.6 Notices. Any notice, demand or communication required, permitted, or desired to be given hereunder shall be deemed effectively given when personally delivered, when received by telegraphic or other electronic means (including facsimile) or overnight courier, or five (5) calendar days after being deposited in the United States mail, with postage prepaid thereon, certified or registered mail, return receipt requested, addressed as follows:

If to the Sellers:	Resurrection Health Care Corporation 7435 W. Talcott Avenue Chicago, IL 60631 Attention: Sandra Bruce, President and CEO Facsimile No.: Available upon request
With a copy to:	Resurrection Health Care Corporation 7435 W. Talcott Avenue Chicago, IL 60631 Attention: Jeannie C. Frey, Esq., Senior Vice President and General Counsel Facsimile No.: Available upon request
With a copy to:	McDermott Will & Emery LLP 227 W. Monroe Street Suite 4700

Chicago, IL 60606
Attention: Kerrin B. Slattery
Facsimile No.: 312.984.7700

If to the Purchasers: Vanguard Health Management, Inc.
20 Burton Hills Boulevard, Suite 100
Nashville, Tennessee 37215
Attention: Senior Vice President – Development
Facsimile No.: 615.665.6181

With a copy to: Vanguard Health Management, Inc.
20 Burton Hills Boulevard, Suite 100
Nashville, TN 37215
Attention: General Counsel
Facsimile No. 615.665.6197

or at such other address as one party may designate by notice hereunder to the other Parties.

14.7 Headings. The section and other headings contained in this Agreement and in the Disclosure Schedules and Schedules to this Agreement are included for the purpose of convenient reference only and shall not restrict, amplify, modify or otherwise affect in any way the meaning or interpretation of this Agreement or the Disclosure Schedules and Schedules hereto.

14.8 Confidentiality and Publicity. The Parties hereto shall hold in confidence the information contained in this Agreement, and all information related to this Agreement, which is not otherwise known to the public, shall be held by each party hereto as confidential and proprietary information and shall not be disclosed without the prior written consent of the other Parties. Accordingly, the Purchasers and the Sellers shall not discuss with, or provide nonpublic information to, any third party (except for such party's attorneys, accountants, directors, officers and employees, the directors, officers and employees of any affiliate of any party hereto, and other consultants and professional advisors) concerning this transaction prior to the Effective Date, except: (a) as required by law or in governmental filings or judicial, administrative or arbitration proceedings, including without limitation any filings to be made by the Parties with respect to the HSR Act, to the IHFSRB, the Attorney General of Illinois, or other governmental agencies or bodies, and the authorities or individuals associated with the Roman Catholic Church; provided, however, each party shall consult with the other party prior to making any such filings and the applicable party shall modify any portion thereof if the other party reasonably objects thereto, unless the same may be required by applicable law; (b) pursuant to public announcements made with the prior written approval of the Sellers and the Purchasers, or (c) to enforce its rights under this Agreement. The rights of the Sellers under this Section 14.8 shall be in addition and not in substitution for the rights of the Sellers and the Sellers' affiliates under the Confidentiality Agreement, which shall survive Closing.

14.9 Fair Meaning. This Agreement shall be construed according to its fair meaning and as if prepared by all Parties hereto.

14.10 Gender and Number; Construction. All references to the neuter gender shall include the feminine or masculine gender and vice versa, where applicable, and all references to the singular shall include the plural and vice versa, where applicable. Unless otherwise expressly provided, the word "including" followed by a listing does not limit the preceding words or terms and shall mean "including, without limitation."

14.11 Third Party Beneficiary. None of the provisions contained in this Agreement are intended by the Parties, nor shall they be deemed, to confer any benefit on any person not a party to this Agreement.

14.12 Expenses and Attorneys' Fees. Except as otherwise provided in this Agreement, each party shall bear and pay its own costs and expenses relating to the preparation of this Agreement and to the transactions contemplated by, or the performance of or compliance with any condition or covenant set forth in, this Agreement, including without limitation, the disbursements and fees of their respective attorneys, accountants, advisors, agents and other representatives, incidental to the preparation and carrying out of this Agreement, whether or not the transactions contemplated hereby are consummated. The Parties expressly agree further that all documentary transfer taxes, stamp taxes and recording charges in connection with the conveyance of the Acquired Assets to the Purchasers shall be shared equally by the Sellers, on the one hand, and by the Purchasers, on the other hand. The Parties expressly agree further that the following costs and expenses shall be borne by the Sellers: (a) all costs of the Title Commitment and the Title Policy (in an amount not to exceed the cost of a standard owners' policy of title insurance); and (b) all costs and expenses associated with obtaining any required consents, including, without limitation, any fees payable to the Attorney General of Illinois as required in connection with obtaining approval of the transactions contemplated by this Agreement. The Parties expressly agree further that the following costs and expenses shall be borne by the Purchasers: (w) all costs of the Title Commitment and the Title Policy in excess of the cost of a standard owners' policy of title insurance or in excess of the mutually agreed amount, and all endorsements thereto; (x) all costs of the Surveys and the Purchasers' environmental and engineering reports; (y) all reasonable costs incurred by Sellers in connection with transferring email records pursuant to Section 1.1(j), as further described on Schedule 14.12; and (z) auditor engagement fees, auditor fees and costs, and the hourly rate for hours worked by senior finance staff of the Sellers or its affiliates (as documented and supported by the auditing firm) incurred by the Sellers related to the audits required by the Purchasers under Section 6.5(b). If any action is brought by any party to enforce any provision of this Agreement, the prevailing party shall be entitled to recover its court costs and reasonable attorneys' fees.

14.13 Counterparts. This Agreement may be executed in any number of counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same Agreement, binding on all of the Parties hereto. The Parties agree that facsimile copies of signatures shall be deemed originals for all purposes hereof and that a Party may produce such copies, without the need to produce original signatures, to prove the existence of this Agreement in any proceeding brought hereunder.

14.14 Entire Agreement. This Agreement, the Disclosure Schedules and Schedules, and the documents referred to in this Agreement contain the entire understanding between the Parties with respect to the transactions contemplated hereby and supersede all prior or contemporaneous

agreements, understandings, representations and statements, oral or written, between the Parties on the subject matter hereof (the "**Superseded Agreements**"), which Superseded Agreements shall be of no further force or effect.

14.15 No Waiver. Any term, covenant or condition of this Agreement may be waived at any time by the party which is entitled to the benefit thereof but only by a written notice signed by the party expressly waiving such term or condition. The subsequent acceptance of performance hereunder by a party shall not be deemed to be a waiver of any preceding breach by any other party of any term, covenant or condition of this Agreement, other than the failure of such other party to perform the particular duties so accepted, regardless of the accepting party's knowledge of such preceding breach at the time of acceptance of such performance. The waiver of any term, covenant or condition shall not be construed as a waiver of any other term, covenant or condition of this Agreement.

14.16 Severability. If any term, provision, condition or covenant of this Agreement or the application thereof to any party or circumstance shall be held to be invalid or unenforceable to any extent in any jurisdiction, then the remainder of this Agreement and the application of such term, provision, condition or covenant in any other jurisdiction or to persons or circumstances other than those as to whom or which it is held to be invalid or unenforceable, shall not be affected thereby, and each term, provision, condition and covenant of this Agreement shall be valid and enforceable to the fullest extent permitted by law.

14.17 Mediation. If the Parties are unable to resolve any dispute between them after using good faith efforts to do so for a period of at least thirty (30) days, either Party may request that the dispute be resolved by non-binding mediation upon terms and conditions to be agreed by the Parties at the time of submission. Compliance with this Section 14.17 is a condition precedent to instituting formal legal proceedings in any court of law. Nothing in this Section shall prevent a Party from seeking injunctive or other equitable relief against the other Party.

14.18 Time is of the Essence. Time is of the essence for all dates and time periods set forth in this Agreement and each performance called for in this Agreement.

14.19 Definitions. The terms listed below are defined elsewhere in this Agreement and, for ease of reference, the section containing the definition of each such term is set forth opposite such term.

Term	**Section**
2008 & 2009 Hospital Financials	§4.10(a)
2009 Non-Hospital Financials	§4.10(a)
Accounts Receivable	§1.1(p)
Accrued Paid Time Off	§1.3(c)
Acquired Assets	§1.1
affiliate	§6.6(b)
Agency Settlements	§13.2(b)
Aggregate Amount	§12.2.2(a)(ix)
Agreement	Preamble
Assumed Contracts	§1.1(f)

Term	Section
Assumed Net Working Capital	§2.1(a)
Assumed Obligations	§1.3
Audit Periods	§4.8(d)
Audited Financial Statements	§6.5(b)
Bills of Sale	§3.2(a)
Cash Purchase Price	§2.1(a)
Claim Notice	§12.4(a)
Closing	§3.1
Closing Date	§3.1
Confidential Information	§7.4
Confidentiality Agreement	§7.4
Consequential Damages	§12.2.2(a)(vii)
control	§6.6(b)
Damages	§12.2.1
Disclosure Schedules	§4
Document Retention Period	§11.2(a)
DOJ	§6.10
Effective Date	§3.1
Environmental Laws	§4.6(c)
Environmental Permits	§4.6(b)
Excluded Contracts	§1.1(f)
Exchange Act	§6.5(b)
Excluded Assets	§1.2
Excluded Liabilities	§1.4
Execution Date	Preamble
Facilities	Recitals
Final Combined Balance Sheet	§2.3(a)
Financial Statements	§4.10(a)
FTC	§6.10
Hazardous Substances	§4.6(c)
HFAP	§4.8(b)
Hired Employees	§7.3(a)
Hospitals	Recitals
Hospital Interim Period 2010 Financials	§4.10(a)
HSR Act	§6.10
IHFSRB	§7.2
Indemnified Party	§12.4
Indemnifying Party	§12.4(a)
Indemnity Notice	§12.4(b)
Independent Auditor	§2.3(a)
Interim Combined Balance Sheet	§2.1(c)
Inventory	§1.1(h)
knowledge of the Purchasers	§5.10
knowledge of the Sellers	§4.18
Leadership Team	§6.3(b)

Term	Section
Leased Real Property	§1.1(b)
Leases	§1.1(e)
Licenses	§1.1(d)
Long-Term Debt	§1.4(q)
Marked Commitment	§9.8
Material Adverse Change	§9.14
Material Consents	§9.7
Material Contracts	§4.4(a)(iv)
MOBs	Recitals
Multi-Facility Contracts	§1.1(f)
Net Working Capital	§2.1(b)
Non-Competition Agreement	§3.2(d)
Non-Hospital Interim Financials	§4.10(a)
Notice Period	§12.4(a)
Nurse Education Loans	§1.1(q)
Other Excluded Contracts	§1.1(f)
Owned Real Property	§1.1(a)
Parties	Preamble
Party	Preamble
Permitted Encumbrances	§4.7(b)
Person	§6.6(b)
Personal Property	§1.1(c)
Personal Property Leases	§1.1(e)
Post-Closing Adjustment Date	§2.3(b)
Post-Closing Adjustment Date Payment Amount	§2.3(b)
Power of Attorney	§3.2(j)
Prepaids	§1.1(g)
Prime Rate	§2.3(b)
Purchase Price	§2.1(a)
Purchaser Offset Amounts	§11.1(d)
Purchasers	Preamble
Purchasers' knowledge	§5.10
Purchasers Payment Due Date	§11.1(b)
RAS	Preamble
Real Estate Assignments	§3.2(b)
Real Property	§1.1(b)
Related Businesses	Recitals
Related Real Property	Recitals
Relevant Claim Amount	§12.2.2(a)(ix)
Resurrection	§1.1(n)
Resurrection Services	Preamble
Retained Employees	§7.3(a)
Required Financial Statements	§6.5(b)
River Forest Facilities	Recitals
Safety Net Payments	§11.1(c)

Term	Section
Seller Cost Reports	§13.2(a)
Seller Leases	§1.1(e)
Seller Offset Amounts	§11.1(d)
Seller Payment Due Date	§11.1(a)
Seller Plans	§4.12
Seller Tax Claims	§12.2.1(e)
Sellers	Preamble
Sellers' knowledge	§4.18
Solvency	§5.9
Superseded Agreements	§14.14
Surveys	§6.8
Tax	§4.17
Tax Return	§4.17
Taxes	§4.17
Third Party Claim	§12.4(a)
Title Commitment	§6.8
Title Company	§6.8
Title Instruments	§6.8
Title Policy	§6.8
Transition Period	§7.3(a)
Transition Service Agreements	§3.2(h)
VHS West Sub	Preamble
VHS Westlake	Preamble
WARN	§1.3(b)
West Suburban Corporation	Preamble
Westlake Corporation	Preamble
WSCN Lease	§3.2(i)

[Signatures on following page]

IN WITNESS WHEREOF, this Agreement has been entered into as of the day and year first above written.

SELLERS:

West Suburban Medical Center

Signature: Sandra Bruce
Printed Name: Sandra Bruce
Title: President

Westlake Community Hospital

Signature: Sandra Bruce
Printed Name: Sandra Bruce
Title: President

Resurrection Services

Signature: Sandra Bruce
Printed Name: Sandra Bruce
Title: President

Resurrection Ambulatory Services

Signature: Sandra Bruce
Printed Name: Sandra Bruce
Title: President

PURCHASERS:

VHS West Suburban Medical Center, Inc.

Signature: _____
Printed Name: _____
Title: _____

VHS Westlake Hospital, Inc.

Signature: _____
Printed Name: _____
Title: _____

IN WITNESS WHEREOF, this Agreement has been entered into as of the day and year first above written.

SELLERS:

West Suburban Medical Center

Signature:_____
Printed Name:_____
Title:_____

Westlake Community Hospital

Signature:_____
Printed Name:_____
Title:_____

Resurrection Services

Signature:_____
Printed Name:_____
Title:_____

Resurrection Ambulatory Services

Signature:_____
Printed Name:_____
Title:_____

PURCHASERS:

VHS West Suburban Medical Center, Inc.

Signature: [signature]
Printed Name: H. H. PILGRIM
Title: SR. VICE PRES

VHS Westlake Hospital, Inc.

Signature: [signature]
Printed Name: H. H. PILGRIM
Title: SR. VICE PRES

Project Overview

Vanguard Health Systems and Resurrection Health Care Corporation propose a change of ownership that will allow two hospitals to continue providing vital services to patients and their families and anchor their respective communities as centers of employment and public service.

This Project Overview supplements the Narrative Description provided in Section I.3 of the Certificate of Need application, and highlights features and issues related to the proposed change in ownership from the Resurrection Health Care System to Vanguard Health Systems. While separate Certificate of Need applications are being filed for each of the hospitals, this overview addresses the transaction that would result in the two hospitals' changes in ownership.

The proposed transaction would affect two hospitals affiliated with Resurrection Health Care Corporation (Resurrection): Westlake Hospital in Melrose Park and West Suburban Medical Center in Oak Park. Westlake Hospital joined the Resurrection system in 1998; West Suburban Medical Center joined in 2004. Westlake Hospital is owned and operated by an Illinois not-for-profit corporation known as Westlake Community Hospital. West Suburban Medical Center is owned and operated by an Illinois not-for-profit corporation known as West Suburban Medical Center. Resurrection Health Care Corporation is the sole member of each of the two hospital corporations.

About Vanguard Health Systems

Vanguard Health Systems owns two hospitals in the Chicago area, MacNeal Hospital (MacNeal), which joined the Vanguard family in 2000, and Louis A. Weiss Memorial Hospital (Weiss), which joined in 2002. These hospitals have long-standing reputations of serving their respective communities—Berwyn and the north side of Chicago—thoughtfully and responsibly.

Under Vanguard's ownership, Weiss and MacNeal have maintained their reputations of providing high-quality health care services, with solid scores on Medicare "core measures" as well as innovative outreach programs to the communities they serve.

Both Weiss and MacNeal provide Medicaid and Medicare services on par with not-for-profit hospitals in their respective markets. Approximately 55 percent of the patients admitted to Weiss are Medicare recipients, and 21 percent are Medicaid recipients. Approximately 35 percent of the patients admitted to MacNeal are Medicare recipients, and 20 percent are Medicaid recipients.

Vanguard is committed to ensuring that its hospitals provide levels of charity care that meet the needs of individual communities served. Vanguard subscribes to a sliding scale that qualifies patients with a household income of up to 500 percent of the Federal Poverty Level for financial assistance, with full write-offs provided at 200 percent of the Federal Poverty Level.

Innovation in reaching the underserved in need is a hallmark of the Vanguard family—from school-based health centers and prenatal care clinics to domestic violence shelters and multi-cultural and social services that expand the concept of the health care safety net.

For example, Weiss is located in an area that is home to many senior citizens; the hospital serves this population beyond hospital stays through social services, education and wellness, right in the heart of the community. And, through a partnership with Alivio Medical Center, MacNeal Hospital has expanded services to neighboring areas. For example, many patients in Cicero and other towns consider Alivio their "medical home". The MacNeal-Alivio collaboration opens up a world of access to Spanish-speaking, predominantly Mexican immigrants who are uninsured or underinsured.

Vanguard is also known for a supportive work environment as well as encouraging the development and advancement of employees. At MacNeal Hospital, for example, job candidates undergo a rigorous recruitment process that helps to ensure that successful candidates fit the culture of quality standards, engagement and service to community. The hospital also has a well-received employee recognition program, offers employees training to enhance opportunities for advancement, and promotes healthy lifestyle programs that extend to employee families.

Vanguard's hospitals operate under an investor-owned business model that marries the principles of not-for-profit health care with private-sector business acumen. Vanguard hospitals operate with a core set of values and principles, particularly with respect to quality of care and the provision of a broad spectrum of services appropriate to local community needs. Each year, a portion of the compensation to a local hospital management team is tied directly to quantitative measurements of quality of care. This fosters a culture of achievement on behalf of patients.

Vanguard successfully operates faith-based hospitals in San Antonio, Texas and Worcester, Massachusetts while maintaining the values and mission of the founders of these facilities. As a result, Vanguard is particularly well positioned to assume responsibility as the new owner of Westlake Hospital and West Suburban Medical Center.

About The Resurrection Health Care System

The Resurrection Health Care System grew from a single hospital, now known as Resurrection Medical Center, established by the Sisters of the Resurrection in northwest Chicago in the early 1950s. A second hospital, Our Lady of the Resurrection Medical Center, was added in 1988. During the period from late 1997 through 2001, six more hospitals joined the Resurrection system, including Westlake Hospital in 1998. West Suburban Medical Center joined the system in 2004. During the same period, eight Chicago area licensed long-term care facilities, three retirement communities, a home care agency, an ambulatory surgery center, and numerous freestanding outpatient facilities became part of the Resurrection Health Care System.

All of the facilities have operated under the tenants of Resurrection Health Care's not-for-profit mission, providing significant levels of service to uninsured and Medicaid patients, as well as other health care services and programs of community benefit.

Structure of the Transaction and Commitments

Vanguard, through one or more subsidiary entities, proposes to acquire the assets of Westlake and West Suburban hospitals, as well as an ambulatory care campus located in River Forest. The College of Nursing, located at West Suburban, is not included in the proposal. Also excluded from the proposal are religious symbols and artifacts, as well as any outstanding charitable bequests, grants or donations held by or for the benefit of the two hospitals.

In keeping with its track record, Vanguard is committed to making sure that hospital employees keep their accrued vacation and seniority levels. In addition, in recognition of community interests and existing patient care standards, Vanguard has pledged to the following: maintain both hospitals as acute care facilities for a minimum of two years; maintain existing medical residency programs and rotations in effect for at least two years; operate the hospitals consistently with the care principles of the Ethical and Religious Directives for Catholic Health Care Services; provide community representation in hospital governance through at least March, 2012; continue charity care and Medicaid services at a minimum of the level they are currently being provided; and provide pastoral and spiritual care at levels appropriate to meet patient needs.

In addition to approval of this transaction by the IHFSRB, under Roman Catholic canon law, Resurrection must also receive approval of the sale from the leaders of the Catholic Church in Rome and a "no objection" ruling from Francis Cardinal George, O.M.I., the Archbishop of Chicago.

Resurrection's decision to divest

Resurrection's decision to sell two of its eight hospitals to Vanguard resulted from a thorough evaluation by its management, Board of Directors, and religious sponsors.

Ongoing financial challenges for the two hospitals and the Resurrection system were central to the decision. As part of a lengthy mission discernment process, the impact of the proposed sale, along with possible alternatives, was evaluated with respect to key shareholder groups – including hospital employees, physicians and community members – as well as the Resurrection's overall mission. The proposed sale of the two hospitals was determined necessary to ensure the viability of remaining components of the Resurrection system – including six other hospitals, skilled nursing facilities, retirement homes, ambulatory care centers, home health services and physician offices. In addition, Resurrection believes that the sale of the two hospitals and related assets is in the best interest of the communities served by these hospitals, not only as an alternative to closure or discontinuation of services that might otherwise need to be considered for financial reasons, but also by assuring that the hospitals have access to capital support for the hospitals' facilities and service lines.

Financial Considerations

For many years the Resurrection system as a whole, and in particular Westlake Hospital and West Suburban Medical Center, has experienced serious financial challenges. In fact, the two hospitals suffered operational losses totaling $166 million over the past five years, constituting a significant portion of the system's overall losses for those years.

Such losses over multiple years are not sustainable. After careful due diligence, Resurrection determined that it could no longer support losses at Westlake and West Suburban without serious risk to the entire system and its ability to continue to fulfill its health care mission. Resurrection, its Board of Directors and religious Sponsors therefore determined that it would be in the best interest of these two hospitals, and the system as a whole, to seek a new owner for Westlake Hospital and West Suburban Medical Center.

Search for Potential Purchasers

Prior to entering into a Letter of Intent with Vanguard, Resurrection sought out not-for-profit buyers, both Catholic and non-Catholic, without success. In contrast, Vanguard emerged as the most viable prospective owner of the two hospitals, by virtue of its track record in Illinois and other states, as described above.

Summary

The proposed change in ownership of West Suburban Medical Center and Westlake Hospital will ensure that these two vital institutions continue to serve their patients, employees, and communities. Without a change in ownership, the two hospitals would be imperiled. Vanguard Health Systems, the prospective new owner, has a track record of delivering quantifiable, quality health care, a commitment to charity care that meets or exceeds that of not-for-profit hospitals, and best practices in employee relations and innovative community service tailored to local needs.

Illinois Department of
PUBLIC HEALTH

Pat Quinn, Governor
Damon T. Arnold, M.D., M.P.H., Director

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.idph.state.il.us

March 18, 2010

CORRECTED
CERTIFIED MAIL
RETURN RECEIPT REQUESTED
Lori Wright, Senior CON Specialist
Fresenius Medical Care North America
One Westbrook Corporate Center, Tower One Suite 1000
Westchester, Illinois 60154

RE: **Completeness Requirements Met**
Health Facilities Planning Act
PROJECT: 10-012 Fresenius Medical Care River Forest
APPLICANT(S): Fresenius Medical Care River Forest, LLC
Fresenius Medical Care Ventures, LLC
Fresenius Medical Care Ventures Holding Co. Inc.
Fresenius Medical Care Holdings, Inc.
National Medical Care, Inc.

Dear Ms. Wright:

This is to acknowledge receipt of your application for permit under the Illinois Health Facilities Planning Act. Your application, received on March 11, 2010, was deemed complete as of March 11, 2010, and is considered a non-substantive project.

We have received your check in the amount of $2,500.00. The balance of your fee has been determined to be $9,475.92 **and payment must be made to the Illinois Department of Public Health within thirty (30) days of your receipt of this notice.**

Only EMERGENCY CON projects are charged no fee. Please make the check out for the exact amount, as rounding off dollar amounts complicates our records unnecessarily.

It is possible that a public hearing may be requested on your project pursuant to the provisions of Part 1130.910. If so, you will be contacted regarding the time and place for the public hearing.

A review of your project will be conducted by the State Agency and a report of findings will be submitted to the State Board. You will have an opportunity to review a copy of the report and appear before the State Board to answer any questions that members may have.
The State Agency Report and related materials for this project will be posted on the State Board website 14 days before the State Board meeting.

Consideration by the State Board has been tentatively scheduled for the **June 8-9, 2010 State Board Meeting**

Should you have any questions regarding your application, please contact our office at (217) 782-3516 or TTY (800) 547-0466 for hearing impaired only.

Sincerely,

Mike Constantino
Supervisor, Project Review Section

Enclosure

NOTICE OF REVIEW AND OPPORTUNITY FOR PUBLIC HEARING AND WRITTEN COMMENT

In accordance with the requirements of the Illinois Health Facilities Planning Act, notice is given of receipt to establish a 20-station End Stage Renal Dialysis (ESRD) Facility, and discontinue 20 stations at a nearby ESRD facility. Project 10-012, Fresenius Medical Care, River Forest. Applicants: Fresenius Medical Care River Forest, LLC, Fresenius Medical Care Ventures, LLC, Fresenius Medical Care Ventures Holding Co. Inc., Fresenius Medical Care Holdings, Inc., and National Medical Care, Inc. The applicants propose to establish a 20-station ESRD at 103 Forest Avenue, River Forest, and discontinue 20 ESRD stations at Fresenius Oak Park Dialysis Center. Project cost: $5,443,600.

The application was declared complete on March 11, 2010. A copy of the application may be viewed at the Illinois Health Facilities and Services Review Board Office, at the address below. To obtain a copy of an application, please call the office for details and copying fees, at the number listed below. Consideration by the State Board has been tentatively scheduled for the June 8-9, 2010 State Board Meeting. Any person wanting a public hearing on the proposed project must submit a written request for a hearing to:

Mike Constantino, Supervisor, Project Review Section
Illinois Health Facilities and Services Review Board
525 West Jefferson Street (2nd Floor)
Springfield, Illinois 62761
(217) 782-3516
(TTY# 800-547-0466 for hearing impaired only)

Requests for hearings must be received by this Agency no later than **March 25, 2010**. Any person wanting to submit written comments on this project must submit these comments by **May 19, 2010**.

The Illinois Department of Public Health will post its findings in a State Agency Report, and the report will be made available via the internet on **May 25, 2010**. The public may submit written responses in support of or in opposition to the findings of the Illinois Department of Public Health. The public will have until **9:00 am, June 1, 2010.** The internet address used to access this report is:

www.idph.state.il.us/about/hfpb/sars.htm