ORIGINAL

10-081

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

RECEIVED

DEC 17 2010

HEALTH FACILITIES & SERVICES REVIEW BOARD

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	Holy Cross Hospital		
Street Address:	2701 West 68th Street		
City and Zip Code:	Chicago, IL 60629		
County: Cook		Health Service Area: VI	Health Planning Area: A-03

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

Exact Legal Name:	Vanguard Health Systems, 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

Type of Ownership of Applicant/Co-Applicant

	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.

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

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:	615/665-5161
E-mail Address:	tpilgrim@vanguardhealth.com
Fax Number:	

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

Name:	none
Title:	
Company Name:	
Address:	
Telephone Number:	
E-mail Address:	
Fax Number:	

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
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County: Cook	Health Service Area: VI	Health Planning Area: A-03	

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

Exact Legal Name:	Vanguard Health Management, Inc.
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Name of Chief Executive Officer:	Charles N. Martin, Jr.
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Title:	Chief Development Officer
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E-mail Address:	tpilgrim@vanguardhealth.com
Fax Number:	

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

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ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
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SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

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Facility/Project Identification

Facility Name:	Holy Cross Hospital
Street Address:	2701 West 68th Street
City and Zip Code:	Chicago, IL 60629
County: Cook	Health Service Area: VI — Health Planning Area: A-03

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

Exact Legal Name:	Vanguard Health Financial Company, 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
Telephone Number:	615/665-6000

Type of Ownership of Applicant/Co-Applicant

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Primary Contact
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Name:	Trip Pilgrim
Title:	Chief Development Officer
Company Name:	Vanguard Health Systems
Address:	20 Burton Hills Blvd. Nashville, TN 37212
Telephone Number:	615/665-5161
E-mail Address:	tpilgrim@vanguardhealth.com
Fax Number:	

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

Name:	none
Title:	
Company Name:	
Address:	
Telephone Number:	
E-mail Address:	
Fax Number:	

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	Holy Cross Hospital
Street Address:	2701 West 68th Street
City and Zip Code:	Chicago, IL 60629
County: Cook	Health Service Area: VI — Health Planning Area: A-03

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

Exact Legal Name:	Hospital Development Company Number 2, 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

Type of Ownership of Applicant/Co-Applicant

	Non-profit Corporation	☐	Partnership		
X	For-profit Corporation	☐	Governmental		
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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:	615/665-5161
E-mail Address:	tpilgrim@vanguardhealth.com
Fax Number:	

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

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Title:	
Company Name:	
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ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
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City and Zip Code:	Chicago, IL 60629
County: Cook	Health Service Area: VI Health Planning Area: A-03

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

Exact Legal Name:	Holy Cross Hospital
Address:	2701 West 68th Street Chicago, IL 60629
Name of Registered Agent:	
Name of Chief Executive Officer:	Wayne Lerner
CEO Address:	2701 West 68th Street Chicago, IL 60629
Telephone Number:	773/471-8000

Type of Ownership of Applicant/Co-Applicant

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

- Corporations and limited liability companies must provide an **Illinois certificate of good standing.**
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Company Name:	Vanguard Health Systems
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Fax Number:	

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

Name:	none
Title:	
Company Name:	
Address:	
Telephone Number:	
E-mail Address:	
Fax Number:	

Post Permit Contact

[Person to receive all correspondence subsequent to permit issuance-**THIS PERSON MUST BE EMPLOYED BY THE LICENSED HEALTH CARE FACILITY AS DEFINED AT 20 ILCS 3960**

Name:	Trip Pilgrim
Title:	Chief Development Officer
Company Name:	Vanguard Health Systems
Address:	20 Burton Hills Blvd. Nashville, TN 37212
Telephone Number:	615/665-5161
E-mail Address:	tpilgrim@vanguardhealth.com
Fax Number:	

Site Ownership-----please see attached

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Holy Cross Hospital

Address of Site Owner: 2701 West 68th Street Chicago, IL 60629

Street Address or Legal Description of Site: 2701 West 68th Street Chicago, IL 60629

Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statement, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease or a lease.

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: Hospital Development Company Number 2, Inc.

Address: 20 Burton Hills Blvd. Nashville, TN 37212

☐	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.
- **Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.**

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

Organizational Relationships

Provide (for each co-applicant) an organizational chart containing the name and relationship of any person or entity who is related (as defined in Part 1130.140). If the related person or entity 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-4, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Flood Plain Requirements — not applicable

[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.hfsrb.illinois.gov)**.

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

Historic Resources Preservation Act Requirements — not applicable

[Refer to application instructions.]

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

APPEND DOCUMENTATION AS ATTACHMENT-6, 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. 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.

Vanguard Health Systems, Inc. ("VHS") through its subsidiary entity Hospital Development Company Number 2, Inc., will, through an Asset Purchase Agreement ("APA") (attached) acquire essentially all of the assets of Holy Cross Hospital.

Following acquisition, Holy Cross Hospital will continue to operate as a Catholic hospital, consistent with the "Stewardship Agreement" developed jointly by VHS and the Sisters of St. Casimir, the sponsors of the hospital. VHS has agreed to operate Holy Cross Hospital as a licensed acute care hospital for a minimum of five years, contingent upon government support payments which in the aggregate provide an annual level of support to the hospital that is consistent with that received during the year ending June 30, 2010 (see § 5.21 of APA). VHS has also agreed to form a local advisory board, to include local physicians and community representatives, with one-third of the membership to be named by the Sisters of St. Casimir.

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.

NOTE ON ASSET PURCHASE AGREEMENT

Holy Cross Hospital ("HCH"), Hospital Development Company Number 2, Inc. and Vanguard Health Systems, Inc. (collectively, "Vanguard") executed an Asset Purchase Agreement on December 15, 2010 ("Asset Purchase Agreement"). As part of the transactions contemplated by the Asset Purchase Agreement, Vanguard is purchasing substantially all of the assets owned or leased by HCH in connection with the operation of the hospital. The Asset Purchase Agreement contains various conditions precedent to Vanguard's obligation to close the transactions contemplated by the Asset Purchase Agreement, including without limitation, that there has been no material adverse change with respect to HCH, that Vanguard's board of directors shall have approved the closing of the transactions contemplated by the Asset Purchase Agreement, and that HCH shall have concluded a voluntary self-disclosure process with the Centers for Medicare and Medicaid Services and the Illinois Attorney General with respect to a review of HCH's physician arrangements. In addition, both HCH and Vanguard acknowledge that closure of the transaction will not occur prior to the receipt of the necessary approvals from the Illinois Health Facilities and Services Review Board in connection with this change of ownership.

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-reviewable components that are not related to the provision of health care, complete the second column of the table below. Note, the use and sources of funds must equal.

Project Costs and Sources of Funds			
USE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**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	$700,000		$700,000
Movable or Other Equipment (not in construction contracts)			
Bond Issuance Expense (project related)			
Negotiated Purchase Price of Hospital Pursuant to Asset Purchase Agreement	$18,655,000		$18,655,000
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	**$19,355,000**		**$19,355,000**
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities	$19,355,000		$19,355,000
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	**$19,355,000**		**$19,355,000**

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 ☐ Yes ☐ No **included in acquisition cost of the hospital**

Purchase Price: $_____

Fair Market Value: $_____

The project involves the establishment of a new facility or a new category of service

☐ 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): August 31, 2011

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.

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

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

Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.

Cost Space Requirements

not applicable

Provide in the following format, the department/area **DGSF** or the building/area **BGSF** and cost. The type of gross square footage either **DGSF** or **BGSF** must be identified. 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**
REVIEWABLE							
Medical Surgical							
Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical							
NON REVIEWABLE							
Administrative							
Parking							
Gift Shop							
Total Non-clinical							
TOTAL							

APPEND DOCUMENTATION AS ATTACHMENT-9, 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. Include observation days in the patient day totals for each bed service.** Any bed capacity discrepancy from the Inventory will result in the application being deemed **incomplete**.

FACILITY NAME: Holy Cross Hospital		**CITY: Chicago**			
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	204	8,317	38,646	none	204
Obstetrics	16	0	0	none	16
Pediatrics					
Intensive Care	20	1,828	6,021	none	20
Comprehensive Physical Rehabilitation	34	456	4,782	none	34
Acute/Chronic Mental Illness					
Neonatal Intensive Care					
General Long Term Care					
Specialized Long Term Care					
Long Term Acute Care					
Other ((identify)					
TOTALS:	274	10,142	49,449	none	274

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 Systems, 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

Harold Pilgrim

PRINTED NAME

Sr. Vice President

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 14th day of September, 2010

Signature of Notary

Seal

SIGNATURE

Kent H. Wallace

PRINTED NAME

President + COO

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 14th day of September, 2010

Signature of Notary

Seal

JEAN P. LORTON
STATE OF TENNESSEE
NOTARY PUBLIC
DAVIDSON COUNTY
COMM. EXP. 11-7-11

*Insert EXACT legal name of the applicant

CERTIFICATION

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SIGNATURE

HAROLD PILGRIM

PRINTED NAME

SR. VICE PRESIDENT

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 14th day of September, 2010

Signature of Notary

Seal

JEAN P. LORTON
STATE OF TENNESSEE
NOTARY PUBLIC
DAVIDSON COUNTY
COMM. EXP. 11-7-11

SIGNATURE

Kent H. Wallace

PRINTED NAME

President + COO

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 14th day of September, 2010

Signature of Notary

Seal

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STATE OF TENNESSEE
NOTARY PUBLIC
DAVIDSON COUNTY
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- in the case of a sole proprietor, the individual that is the proprietor.

This Application for Permit is filed on the behalf of Hospital Development Company Number 2, 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.

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Harold Pilgrim

PRINTED NAME

Sr. Vice President

PRINTED TITLE

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this 14th day of September, 2010

Signature of Notary

Seal

STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY
COMM. EXP. 11-7-11

SIGNATURE

Kent H. Wallace

PRINTED NAME

President and COO

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 14th day of September, 2010

Signature of Notary

Seal

STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY
COMM. EXP. 11-7-11

*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:

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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);
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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.

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Harold Pilgrim
PRINTED NAME

Sr. Vice President
PRINTED TITLE

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Subscribed and sworn to before me
this 14th day of September, 2010

Signature of Notary

Seal

JEAN P. LORTON
NOTARY PUBLIC
STATE OF TENNESSEE
DAVIDSON COUNTY
COMM. EXP. 11-7-11

SIGNATURE

Kent H. Wallace
PRINTED NAME

President + COO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 14th day of September, 2010

Signature of Notary

Seal

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NOTARY PUBLIC
STATE OF TENNESSEE
DAVIDSON COUNTY
COMM. EXP. 11-7-11

*Insert EXACT legal name of the applicant

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- 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 Financial Company, LLC__* 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

HAROLD PILGRIM

PRINTED NAME

SR. VICE PRESIDENT

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 14th day of September, 2010

Signature of Notary

Seal

SIGNATURE

Kent H. Wallace

PRINTED NAME

President + COO

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 14th day of September, 2010

Signature of Notary

Seal

JEAN P. LORTON
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY
COMM. EXP. 11-7-11

*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 ____Holy Cross Hospital_____* 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.

Sister M. Immaculata Wendt
SIGNATURE

Sister M Immaculata Wendt
PRINTED NAME

General Superior
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 9th day of September 2010

Beverly Lodato
Signature of Notary

Seal

OFFICIAL SEAL
BEVERLY LODATO
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 1-28-2014

Sister Regina Dubickas
SIGNATURE

Sister Regina Dubickas
PRINTED NAME

Secretary of HCH Board
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 9th day of September, 2010

Beverly Lodato
Signature of Notary

Seal

OFFICIAL SEAL
BEVERLY LODATO
NOTARY PUBLIC STATE OF ILLINOIS
MY COMMISSION EXPIRES 1-28-2014

*Insert EXACT legal name of the applicant

SECTION III – BACKGROUND, PURPOSE OF THE PROJECT, 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 – Background, Purpose of the Project, 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, and certification 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-11, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-4) MUST BE IDENTIFIED IN ATTACHMENT 11.

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 as appropriate.

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

NOTE: Information regarding the "Purpose of the Project" will be included in the State Agency Report.

APPEND DOCUMENTATION AS ATTACHMENT-12, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-6) MUST BE IDENTIFIED IN ATTACHMENT 12.

ALTERNATIVES

1) Identify **ALL** of the alternatives to the proposed project:

Alternative options **must** 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

D) Provide the reasons why the chosen alternative was selected.

2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of total costs, 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. **FOR EVERY ALTERNATIVE IDENTIFIED THE TOTAL PROJECT COST AND THE REASONS WHY THE ALTERNATIVE WAS REJECTED MUST BE PROVIDED.**

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

APPEND DOCUMENTATION AS ATTACHMENT-13, 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.

NOTE: For all projects involving a change of ownership THE TRANSACTION DOCUMENT must be submitted with the application for permit. The transaction document must be signed dated and contain the appropriate contingency language.

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-19, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

The following Sections DO NOT need to be addressed by the applicants or co-applicants responsible for funding or guaranteeing the funding of the project if the applicant has a bond rating of A- or better from Fitch's or Standard and Poor's rating agencies, or A3 or better from Moody's (the rating shall be affirmed within the latest 18 month period prior to the submittal of the application):

- **Section 1120.120 Availability of Funds – Review Criteria**
- **Section 1120.130 Financial Viability – Review Criteria**
- **Section 1120.140 Economic Feasibility – Review Criteria, subsection (a)**

VIII. - 1120.120 - Availability of Funds

The applicant shall document that financial resources shall be available and be equal to or exceed the estimated total project cost plus any related project costs by providing evidence of sufficient financial resources from the following sources, as applicable: **Indicate the dollar amount to be provided from the following sources:**

$19,355,000	a)	Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to: 1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and 2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion; **please see attached Audited financial Statements**
_____	b)	Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.
_____	c)	Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts;
_____	d)	Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including: 1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated; 2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate; 3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.; 4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment; 5) For any option to lease, a copy of the option, including all terms and conditions.
_____	e)	Governmental Appropriations – 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, a copy of a resolution or other action of the governmental unit attesting to this intent;
_____	f)	Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt;
_____	g)	All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
$19,355,000	**TOTAL FUNDS AVAILABLE**	

APPEND DOCUMENTATION AS ATTACHMENT-39, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

IX. 1120.130 - Financial Viability

All the applicants and co-applicants shall be identified, specifying their roles in the project funding or guaranteeing the funding (sole responsibility or shared) and percentage of participation in that funding.

Financial Viability Waiver

not applicable, no debt financing

The applicant is not required to submit financial viability ratios if:

1. **All of the projects capital expenditures are completely funded through internal sources**
2. **The applicant's current debt financing or projected debt financing is insured or anticipated to be insured by MBIA (Municipal Bond Insurance Association Inc.) or equivalent**
3. **The applicant provides a third party surety bond or performance bond letter of credit from an A rated guarantor.**

See Section 1120.130 Financial Waiver for information to be provided

APPEND DOCUMENTATION AS ATTACHMENT-40, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

The applicant or co-applicant that is responsible for funding or guaranteeing funding of the project shall provide viability ratios for the latest three years for which **audited financial statements are available and for the first full fiscal year at target utilization, but no more than two years following project completion.** When the applicant's facility does not have facility specific financial statements and the facility is a member of a health care system that has combined or consolidated financial statements, the system's viability ratios shall be provided. If the health care system includes one or more hospitals, the system's viability ratios shall be evaluated for conformance with the applicable hospital standards.

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

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.

2. Variance

Applicants not in compliance with any of the viability ratios shall document that another organization, public or private, shall assume the legal responsibility to meet the debt obligations should the applicant default.

APPEND DOCUMENTATION AS ATTACHMENT 41, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

X. 1120.140 - Economic Feasibility

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

A. Reasonableness of Financing Arrangements

The applicant shall document the reasonableness of financing arrangements by submitting a notarized statement signed by an authorized representative that attests to one of the following:

1) That the total estimated project costs and related costs will be funded in total with cash and equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation; or

2) That the total estimated project costs and related costs will be funded in total or in part by borrowing because:

   A) A portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or

   B) 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. Conditions of Debt Financing

not applicable, no debt financing

This criterion is applicable only to projects that involve debt financing. The applicant shall document that the conditions of debt financing are reasonable by submitting a notarized statement signed by an authorized representative that attests to the following, as applicable:

1) That the selected form of debt financing for the project will be at the lowest net cost available;

2) That the selected form of debt financing will not be at the lowest net cost available, but is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional indebtedness, term (years), financing costs and other factors;

3) That the project involves (in total or in part) the leasing of equipment or facilities and that the expenses incurred with leasing a facility or equipment are less costly than constructing a new facility or purchasing new equipment.

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

D. **Projected Operating Costs**

The applicant shall provide the projected direct annual operating costs (in current dollars per equivalent patient day or unit of service) for the first full fiscal year at target utilization but no more than two years following project completion. Direct cost means the fully allocated costs of salaries, benefits and supplies for the service.

E. **Total Effect of the Project on Capital Costs**

The applicant shall provide the total projected annual capital costs (in current dollars per equivalent patient day) for the first full fiscal year at target utilization but no more than two years following project completion.

APPEND DOCUMENTATION AS ATTACHMENT -42, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

XII. Charity Care Information

Charity Care information MUST be furnished for ALL projects.

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.

2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.

3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

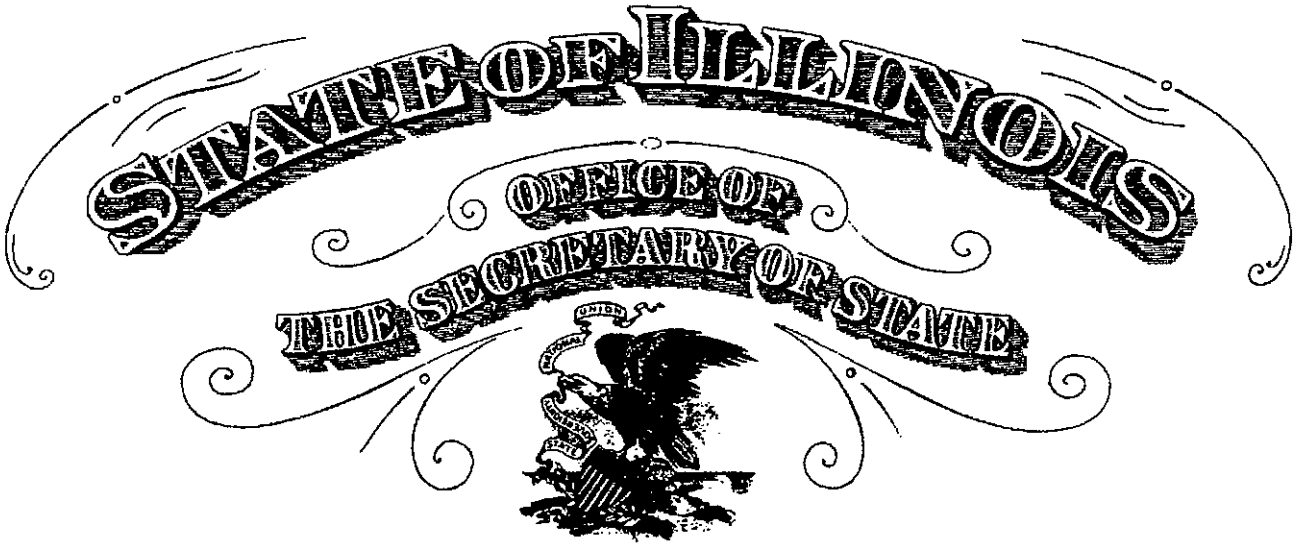
Charity care" means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer. (20 ILCS 3960/3) Charity Care must be provided at cost.

A table in the following format must be provided for all facilities as part of Attachment 44.

CHARITY CARE			
	2007	**2008**	**2009**
Net Patient Revenue	**109,110,687**	**111,142,732**	**101,697,666**
Amount of Charity Care (charges)	9,240,623	9,938,806	10,435,701
Cost of Charity Care	2,319,396	2,807,713	2,974,175

APPEND DOCUMENTATION AS ATTACHMENT-44, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

File Number 6724-421-4



To all to whom these Presents Shall Come, Greeting:

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

HOSPITAL DEVELOPMENT COMPANY NUMBER 2, INC., INCORPORATED IN DELAWARE AND LICENSED TO TRANSACT BUSINESS IN THIS STATE ON AUGUST 17, 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 #: 1023001588

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* 18TH *day of* AUGUST *A.D.* 2010 .

Jesse White

SECRETARY OF STATE

ATTACHMENT 1

File Number 6402-314-4

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 SYSTEMS, INC., INCORPORATED IN DELAWARE AND LICENSED TO TRANSACT BUSINESS IN THIS STATE ON FEBRUARY 02, 2005, 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* 24TH *day of* MARCH *A.D.* 2010 .

Jesse White

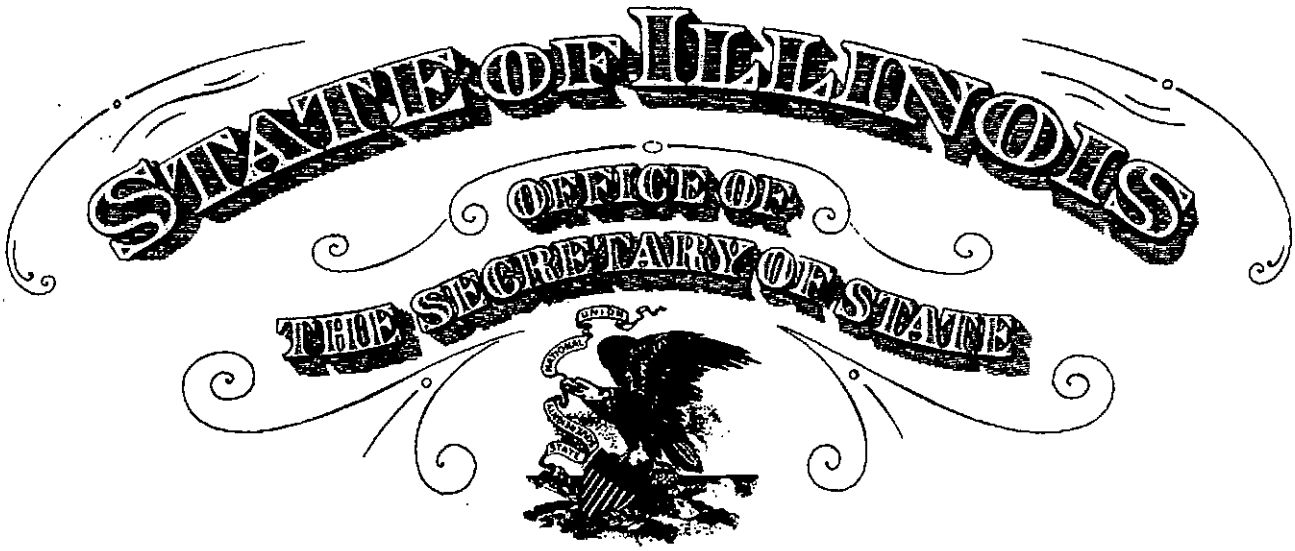
SECRETARY OF STATE

Authentication #: 1008301872

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

ATTACHMENT 1

File Number 6087-292-9



To all to whom these Presents Shall Come, Greeting:

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

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.

Authentication #: 1005702452

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* 26TH *day of* FEBRUARY *A.D.* 2010 .

Jesse White

SECRETARY OF STATE

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 2073-273-3

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

HOLY CROSS HOSPITAL, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON OCTOBER 10, 1929, 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* 16TH *day of* AUGUST *A.D.* 2010 .

Jesse White

SECRETARY OF STATE

Authentication #: 1022601668

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

ATTACHMENT 1

COMMITMENT FOR TITLE INSURANCE

Chicago Title Insurance Company

CHICAGO TITLE INSURANCE COMPANY, a Nebraska corporation, herein called the Company, for valuable consideration, commits to issue its policy or policies of title insurance, as identified in Schedule A, in favor of the Proposed Insured named in Schedule A, as owner or mortgagee of the estate or interest in the Land described or referred to in Schedule A, upon payment of the premiums and charges and compliance with the Requirements; all subject to the provisions of Schedule A and B and to the Conditions of this Commitment.

This Commitment shall be effective only when the identity of the Proposed Insured and the amount of the policy or policies committed for have been inserted in Schedule A by the Company.

All liability and obligation under this Commitment shall cease and terminate 6 months after the Effective Date or when the policy or policies committed for shall issue, whichever first occurs, provided that the failure to issue the policy or policies is not the fault of the Company.

The Company will provide a sample of the policy form upon request.

IN WITNESS WHEREOF, Chicago Title Insurance Company has caused its corporate name and seal to be affixed by its duly authorized officers on the date shown in Schedule A.

Issued By:

CHICAGO TITLE INSURANCE COMPANY
171 N. CLARK STREET
CHICAGO, IL 60601

Refer Inquiries To:

(312)223-3025

CHICAGO TITLE INSURANCE COMPANY

By

Authorized Signatory

Commitment No.: 1401 008823092 D1

ATTACHMENT 2

CHICAGO TITLE INSURANCE COMPANY

COMMITMENT FOR TITLE INSURANCE

SCHEDULE A

YOUR REFERENCE: HOLY CROSS HOSPITAL ORDER NO.: 1401 008823092 D1

EFFECTIVE DATE: AUGUST 5, 2010

1. POLICY OR POLICIES TO BE ISSUED:

   OWNER'S POLICY: ALTA OWNERS 2006
   AMOUNT: $100,000.00
   PROPOSED INSURED:

2. THE ESTATE OR INTEREST IN THE LAND DESCRIBED OR REFERRED TO IN THIS COMMITMENT IS FEE SIMPLE, UNLESS OTHERWISE NOTED.

3. TITLE TO THE ESTATE OR INTEREST IN THE LAND IS AT THE EFFECTIVE DATE VESTED IN:
   HOLY CROSS HOSPITAL, A CORPORATION OF ILLINOIS

ATTACHMENT 2

CHICAGO TITLE INSURANCE COMPANY

COMMITMENT FOR TITLE INSURANCE

SCHEDULE A (CONTINUED)

ORDER NO.: 1401 008823092 D1

4A. LOAN POLICY 1 MORTGAGE OR TRUST DEED TO BE INSURED:

NONE

4B. LOAN POLICY 2 MORTGAGE OR TRUST DEED TO BE INSURED:

NONE

ATTACHMENT 2

5. THE LAND REFERRED TO IN THIS COMMITMENT IS DESCRIBED AS FOLLOWS:

PARCEL 1:

BLOCKS 5 AND 6 EXCEPT THE EAST 150 FEET OF BLOCK 6 AND EXCEPT THE WEST 35 FEET OF THE EAST 185 FEET OF THE SOUTH 180 FEET OF BLOCK 6 IN HIRSH AND YOUNGS SUBDIVISION OF THE NORTHWEST QUARTER OF THE SOUTHEAST QUARTER OF SECTION 24, TOWNSHIP 38 NORTH, RANGE 13 EAST FO THE THIRD PRICIPAL MERIDIAN, AND ALSO THAT PART OF VACATED WEST 68TH STREET LYING EASTERLY OF THE EAST LINE OF SOUTH CALIFORNIA AVENUE AND WESTERLY OF THE WEST LINE OF SOUTH WASHTENAW AVENUE EXCEPT THE EAST 150 FEET OF THE SOUTH ONE HALF THEREOF, LYING NORTH OF AND ADJOINING BLOCK 6 IN HIRSH AND YOUNG'S SUBDIVISON OF THE NORTHWEST QUARTER OF THE SOUTHEAST QUARTER OF SECTION 24, TOWNSHIP 38 NORTH, RANGE 13 EAST OF THE THIRD PRINCIPAL MERIDIAN, ALL IN COOK COUNTY, ILLINOIS.

PARCEL 2:

VACATED PART OF SOUTH FAIRFIELD AVENUE EAST OF AND ADJOINING THE EAST LINE OF BLOCK 5 AND WEST OF AND ADJOINING THE WEST LINE OF BLOCK 6, IN HIRSH AND YOUNG'S SUBDIVISION OF THE NORTHWEST QUARTER OF THE SOUTHEAST QUARTER OF SECTION 24, TOWNSHIP 38 NORTH, RANGE 13, EAST OF THE THIRD PRINCIPAL MERIDIAN, IN COOK COUNTY, ILLINOIS, THAT PART OF SAID STREET BEING OTHERWISE COMMONLY DESCRIBED AS THAT PART OF SOUTH FAIRFIELD AVENUE BETWEEN THE SOUTH LINE OF WEST 68TH STREET AND THE NORTH LINE OF WEST 69TH STREET, CHICAGO IN COOK COUNTY, ILLINOIS.

PARCEL 3:

LOTS 13, 14, 15 AND 16 IN WILLIAM H BRITTIGAN'S RESUBDIVISON OF LOTS 1-11 BOTH INCLUSIVE, IN BLOCK 1 AND LOTS 1 TO 11 BOTH INCLUSIVE IN BLOCK 2 IN CS THORNTONS SUBDIVISION OF THE WEST HALF OF THE SOUTHWEST QUARTER OF THE SOUTHEAST QUARTER OF SECTION 24, TOWNSHIP 38 NORTH RANGE 13 EAST OF THE THIRD PRINCIPAL MERIDIAN IN COOK COUNTY, ILLINOIS.

PARCEL 4:

LOTS 9 AND 10 IN WILLIAM BRITTIGAN'S RESUBDIVISON OF LOT 1 TO 11 BOTH INCLUSIVE, IN BLOCK 1 AND LOTS 1 TO 11 BOTH INCLUSIVE IN BLOCK 2, IN CS THORNTON'S SUBDIVISON OF THE WEST HALF OF THE SOUTHWEST QUARTER OF THE SOUTHEAST QUARTER OF SECTION 24 TOWNSHIP 38 NORTH RANGE 13 EAST OF THE THIRD PRINCIPAL MERIDIAN IN COOK COUNTY, ILLINOIS.

PARCEL 5:

LOTS 11 AND 12 IN WILLIAM BRITTIGAN'S RESUBDIVISON OF LOT 1 TO 11 BOTH INCLUSIVE, IN BLOCK 1 AND LOTS 1 TO 11 BOTH INCLUSIVE IN BLOCK 2, IN CS THORNTON'S SUBDIVISON OF THE WEST HALF OF THE SOUTHWEST QUARTER OF THE SOUTHEAST QUARTER OF SECTION 24 TOWNSHIP 38 NORTH RANGE 13 EAST OF THE THIRD PRINCIPAL MERIDIAN IN COOK COUNTY, ILLINOIS.

ATTACHMENT 2

File Number 6724-421-4

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

HOSPITAL DEVELOPMENT COMPANY NUMBER 2, INC., INCORPORATED IN DELAWARE AND LICENSED TO TRANSACT BUSINESS IN THIS STATE ON AUGUST 17, 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.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 18TH *day of* AUGUST *A.D.* 2010 .

Jesse White

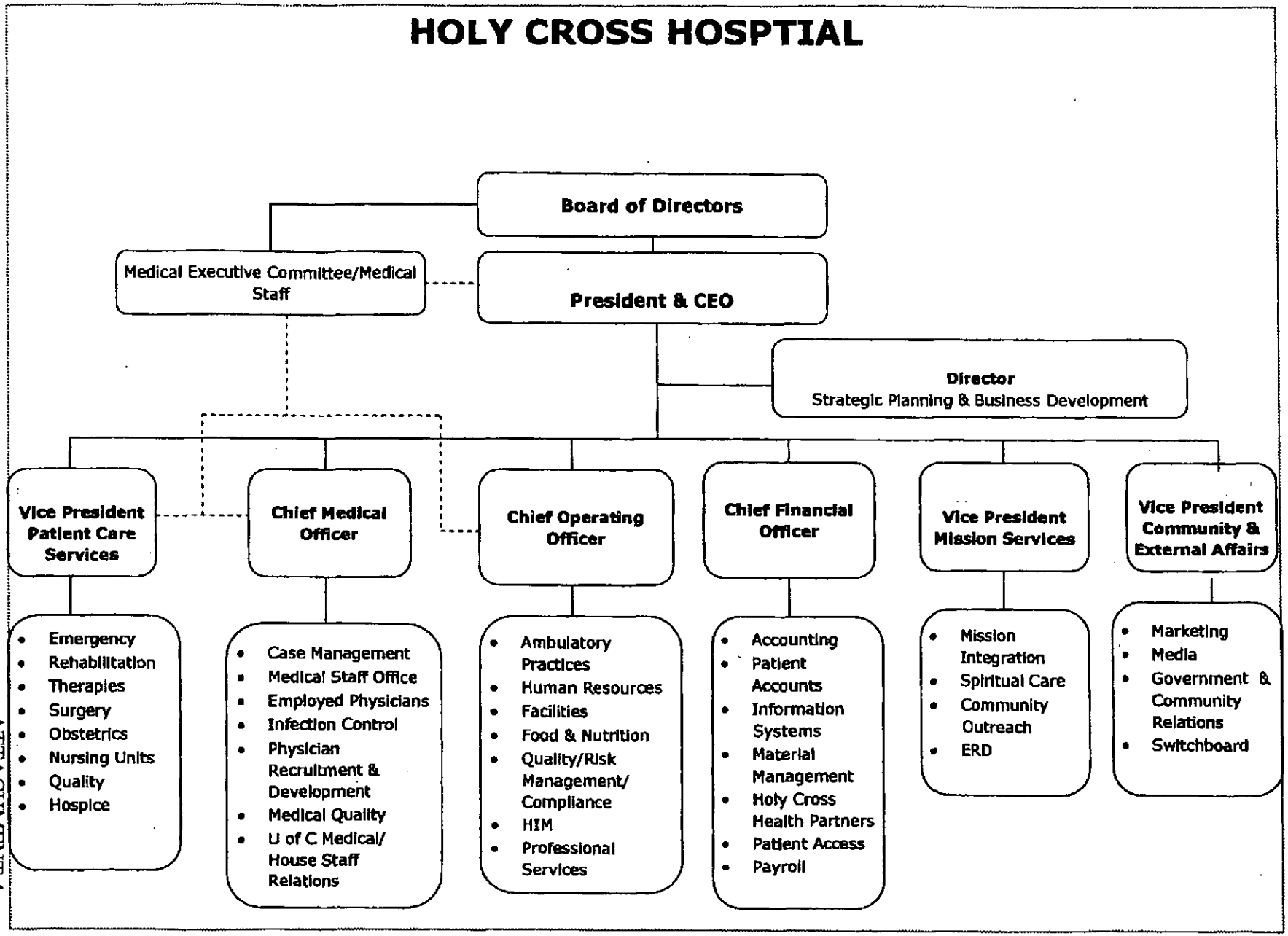
SECRETARY OF STATE

Authentication #: 1023001588

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

ATTACHMENT 3

HOLY CROSS HOSPTIAL

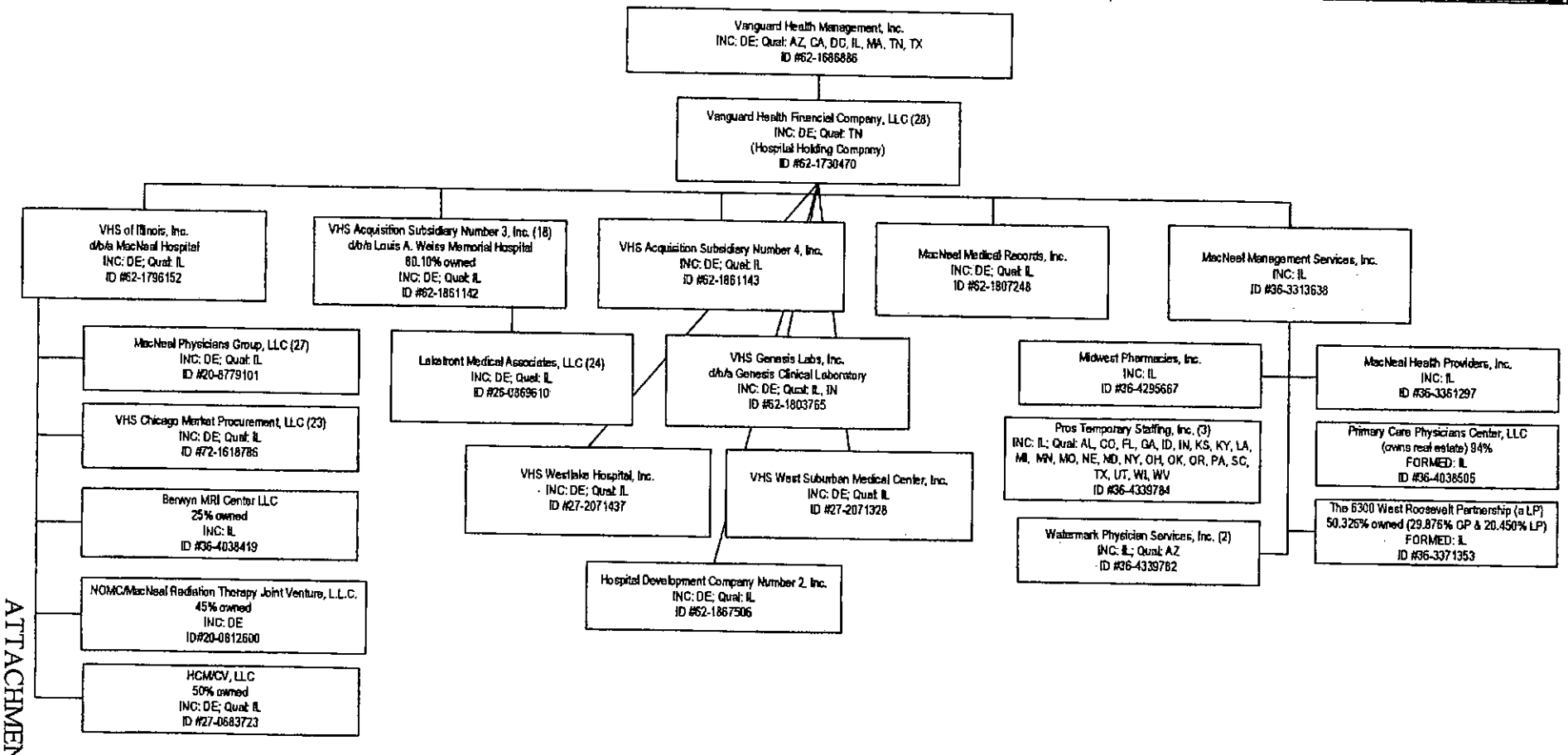


ATTACHMENT 4

VANGUARD HEALTH SYSTEMS

ILLINOIS

Wednesday, August 25, 2010



ATTACHMENT 4

PROJECT COSTS

Purchase Price ($18,655,000)

Negotiated purchase price for the hospital and related assets as described in the Asset Purchase Agreement.

Consulting and Other Fees ($700,000)

Estimate of transaction-related costs, including the CON review fee ($43,000), consulting and legal fees related to the CON process and the review by the Attorney General's office ($250,000), community relations activities ($100,000), contract development ($250,000), and miscellaneous costs ($57,000).

BACKGROUND

Vanguard Health Systems, Inc. owns and operates the following licensed health care facilities in Illinois:

- West Suburban Medical Center, Oak Park (#0005694)
- Westlake Hospital, Melrose, Park (#0005702)
- Louis A. Weiss Memorial Hospital, Chicago (#0005249)
- MacNeal Hospital, Berwyn (#0005082).

In addition to the four Illinois hospitals identified above, Vanguard owns and operates the following hospitals in Arizona, Texas and Massachusetts:

- Arrowhead Hospital, Glendale, Arizona
- Paradise Valley Hospital, Phoenix
- Maryvale Hospital, Phoenix
- Phoenix Valley Hospital, Phoenix
- West Valley Hospital, Phoenix
- St. Vincent Hospital, Worcester, Massachusetts
- Metrowest-Framingham Union Hosp., Framingham, Massachusetts
- Metrowest Leonard Morse Hospital, Natick, Massachusetts
- Baptist Medical Center, San Antonio

- Northeast Baptist Hospital, San Antonio
- North Central Baptist Hospital, San Antonio
- Southeast Baptist Hospital, San Antonio
- St. Luke's Baptist Hospital, San Antonio

Holy Cross Hospital is not corporately associated with any other licensed health care facility.

The following pages contain an "adverse action" letter from Holy Cross Hospital, an "adverse action" letter provided to the IHFSRB during the current calendar year, and photocopies of the IDPH licenses and notifications of accreditation for each of the Illinois hospitals identified above.

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:

STATE OF TENNESSEE NOTARY PUBLIC DAVIDSON COUNTY, TN

HOLY CROSS
HOSPITAL

September 9, 2010

Mr. Dale Galassie, Chairman
Illinois Health Facilities and
Services Review Board
525 West Jefferson
Springfield, IL 62761

Dear Mr. Galassie,

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 that:

1. Holy Cross Hospital has not had any adverse actions taken against it during the three (3) year period prior to the filing of this application, and
2. Holy Cross Hospital authorizes the State Board and 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 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,

Wayne M. Lerner, D.P.H.
Chief Executive Officer

NOTARIZED: 9-10-10

Beverly Lodato

OFFICIAL SEAL
BEVERLY LODATO
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 1-28-2014

ATTACHMENT 1

← DISPLAY THIS PART IN A CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION

↓

State of Illinois 1954420

Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

HOLY CROSS HOSPITAL

EXPIRATION DATE	CATEGORY	I.D. NUMBER
12/31/10	BGBD	0000992

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 01/01/10

11/07/09

HOLY CROSS HOSPITAL
2701 WEST 68TH STREET

CHICAGO IL 60629

FEE RECEIPT NO.

ATTACHMENT 11

142 East Ontario Street • Chicago, Illinois 60611 • P: 312-202-8258 • www.hfap.org

HFAP
Healthcare Facilities Accreditation Program

November 3, 2008

Leona Gibbons
Holy Cross Hospital
2701 West 68th Street
Chicago, IL 60629

Dear Ms. Gibbons:

This letter is to verify that Holy Cross Hospital, located in Chicago, Illinois was surveyed on March 24-26, 2008. This facility is currently accredited by the Healthcare Facilities Accreditation Program (HFAP) of the American Osteopathic Association (AOA) and will remain accredited until further action by the Bureau of Healthcare Facilities Accreditation.

You may use a copy of this letter to verify your accreditation status with agencies outside of your facility. Questions about HFAP may be directed to me at 312-02-8060, or 800-621-1773, ext. 8060.

Sincerely,

George A. Reuther

George A. Reuther
Chief Operating Officer
Healthcare Facilities Accreditation Program

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

ATTACHMENT 11

DISPLAY THIS PART IN A CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION

VHS West Suburban Medical Center, Inc.
3 Erie Court
Oak Park, IL 60302

FEE RECEIPT NO.

ATTACHMENT 11

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

August 3, 2010

Patricia Shehorn, Administrator
VHS West Suburban Medical Center, Inc.
3 Erie Court
Oak Park, IL 60302

Dear Administrator Shehorn,

Enclosed is your Illinois Full General Hospital License ID No. 0005702. This license is effective 08/01/10 through 07/31/11 based on the change of ownership information submitted. You will receive a renewal license prior to expiration of the current license. Please replace your old license with the new one we have issued and send the old one back to the address and contact below:

Illinois Department of Public Health
Attn: Kevin Fargusson
525 W. Jefferson, 4th Floor
Springfield, IL 62761

If the staff of the Division of Health Care Facilities and Programs can be of any assistance to you in the operation of your Hospital, please address your concerns to the Central Office Operations Section, 525 West Jefferson Street, 4th Floor, Springfield, Illinois 62761-0001, or feel free to call us at (217) 782-7412. The Departments TTY number is 800/547-0466, for use by the hearing impaired.

Sincerely,

Karen Senger RN

Karen Senger, RN
Supervisor, Central Office Operations Section
Division of Health Care Facilities and Programs
Illinois Department of Public Health

KS/kef

Enclosure

AMERICAN OSTEOPATHIC ASSOCIATION

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

CERTIFIED #: 7004 2510 0000 1977 6351

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

ATTACHMENT 11

ATTACHMENT 11

State of Illinois 1756957
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.

DANON T. ARNOLD, M.D.
DIRECTOR

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

EXPIRATION DATE	CATEGORY	I.D. NUMBER
07/31/11	BGBD	0005702

FULL LICENSE
GENERAL HOSPITAL

EFFECTIVE: 08/01/10

BUSINESS ADDRESS
VHS Westlake Hospital, Inc.
1225 West Lake Street
Melrose Park, IL 60160

This 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 1756957
Department of Public Health
LICENSE, PERMIT, CERTIFICATION, REGISTRATION

VHS Westlake Hospital, Inc.

EXPIRATION DATE	CATEGORY	I.D. NUMBER
07/31/11	BGBD	0005702

FULL LICENSE
GENERAL HOSPITAL

EFFECTIVE: 08/01/10

VHS Westlake Hospital, Inc.
1225 West Lake Street
Melrose Park, IL 60160

FEE RECEIPT NO.

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

August 3, 2010

Patricia Shehorn, Administrator
VHS Westlake Hospital, Inc.
1225 West Lake Street
Melrose Park, IL 60160

Dear Administrator Shehorn,

Enclosed is your Illinois Full General Hospital License ID No. 0005702. This license is effective 08/01/10 through 07/31/11 based on the change of ownership information submitted. You will receive a renewal license prior to expiration of the current license. Please replace your old license with the new one we have issued and send the old one back to the address and contact below:

Illinois Department of Public Health
Attn: Kevin Fargusson
525 W. Jefferson, 4th Floor
Springfield, IL 62761

If the staff of the Division of Health Care Facilities and Programs can be of any assistance to you in the operation of your Hospital, please address your concerns to the Central Office Operations Section, 525 West Jefferson Street, 4th Floor, Springfield, Illinois 62761-0001, or feel free to call us at (217) 782-7412. The Departments TTY number is 800/547-0466, for use by the hearing impaired.

Sincerely,

Karen Senger RN

Karen Senger, RN
Supervisor, Central Office Operations Section
Division of Health Care Facilities and Programs
Illinois Department of Public Health

KS/kef

Enclosure

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

ATTACHMENT 10

AMERICAN OSTEOPATHIC ASSOCIATION

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

June 13, 2008

JUN 20 2008

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

Dear Mr. Sheborn:

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/pmh

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

ATTACHMENT 11

ATTACHMENT 11

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.

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.

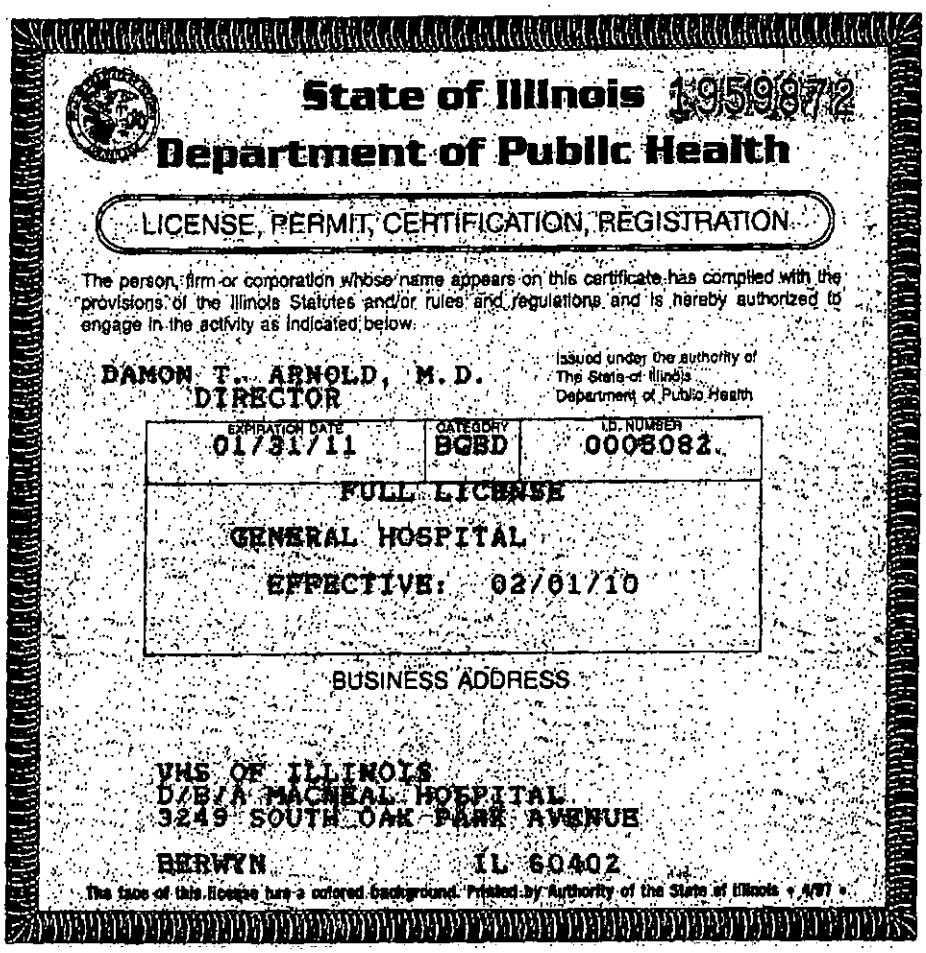
We encourage you to share this accreditation decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the Centers for Medicare and Medicaid Services (CMS), state or regional regulatory services, and the public you serve of your organization's accreditation 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 11



State of Illinois 1959872

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
01/31/11	BGBD	0006082

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 02/01/10

BUSINESS ADDRESS

UHS OF ILLINOIS
D/B/A MACNEAL HOSPITAL
3249 SOUTH OAK PARK AVENUE

BERWYN IL 60402

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

ATTACHMENT 11

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 11

PURPOSE

The purpose of the proposed project, which is limited to a change-of-ownership, is to ensure that inpatient and outpatient hospital services remain accessible to the residents of the southwestern Chicago neighborhoods traditionally served by Holy Cross Hospital.

As well documented, residents of the southwestern quadrant of Chicago (and, to a lesser extent, the Cook County suburban communities to the west), particularly when compared to virtually any other part of the metropolitan Chicago area, have minimal access to hospital services. These neighborhoods and communities, as identified in the ZIP Code-specific patient origin analysis presented on the next page, constitute Holy Cross Hospital's current and anticipated service area. The closest hospitals to Holy Cross and their drive times (all drive times per MapQuest, adjusted consistent with IHFSRB rule) are the following:

- Little Company of Mary Hospital, Evergreen Park (15 minutes)
- St. Bernard Hospital, Chicago (15 minutes)
- Advocate Christ Medical Center, Oak Lawn (16 minutes)
- MetroSouth Medical Center, Blue Island (30 minutes)
- MacNeal Hospital, Berwyn (34 minutes)

The table on the following page presents the 2009 patient origin for the hospital, and identifies each ZIP Code area that contributed at least 1.0% of the hospital's

admissions. No changes of any substance in patient origin have been experienced during 2010, and no changes of substance are anticipated following the proposed change of ownership.

Holy Cross Hospital
2009 Patient Origin

ZIP Code	Community	%	Cumulative %
60629	Chicago	23.7%	23.7%
60636	Chicago	18.3%	41.9%
60632	Chicago	8.3%	50.2%
60620	Chicago	7.5%	57.7%
60609	Chicago	6.5%	64.2%
60621	Chicago	4.0%	68.3%
60652	Chicago	2.5%	70.8%
60638	Chicago	1.9%	72.7%
60637	Chicago	2.0%	74.7%
60619	Chicago	1.6%	76.3%
60628	Chicago	1.6%	77.9%
60653	Chicago	1.3%	79.3%
60649	Chicago	1.2%	80.5%
60643	Chicago	1.2%	81.7%
60453	Oak Lawn	1.1%	82.8%
60608	Chicago	1.1%	83.9%
	other < 1.0%	16.5%	100.3%
		100.3%	

Holy Cross Hospital is located in ZIP Code area 60629, which accounts for nearly one-quarter of the hospital's admissions. As can be noted from the table above, three ZIP Code areas account for over one-half of the hospital's admissions (ZIP Code areas 60636 and 60632 are located immediately to the west and north of 60629, respectively), and 16 ZIP Code areas account for approximately 84% of the hospital's admissions. Each of the sixteen ZIP Code areas are located on the far southwest side of Chicago, with the only

exception being ZIP Code area 60453/Oak Lawn, which accounts for slightly more than 1% of the hospital's admissions.

The primary issues faced by the hospital that have led to this project are: 1) the desire of the hospital to remain a viable provider of services, 2) the desire that the hospital maintain its Catholic identity, and 3) the hospital's financial inability to continue to operate and make the needed capital improvements that will assure its future. The need for the Sisters of St. Casimir to divest was identified both through a hospital-directed strategic planning process as well as through independent outside analyses over the past two years.

The proposed change of ownership will 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 Vanguard-related co-applicants have certified that, consistent with IHFSRB requirements, they will neither eliminate programs nor reduce accessibility.

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, the goal will be to return to 2009 market shares for all services within twelve months of the change of ownership.

exception being ZIP Code area 60453/Oak Lawn, which accounts for slightly more than 1% of the hospital's admissions.

The primary issues faced by the hospital that have led to this project are: 1) the desire of the hospital to remain a viable provider of services, 2) the desire that the hospital maintain its Catholic identity, and 3) the hospital's financial inability to continue to operate and make the needed capital improvements that will assure its future. The need for the Sisters of St. Casimir to divest was identified both through a hospital-directed strategic planning process as well as through independent outside analyses over the past two years.

The proposed change of ownership will 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 Vanguard-related co-applicants have certified that, consistent with IHFSRB requirements, they will neither

ALTERNATIVES

Holy Cross Hospital's decision to be acquired by Vanguard Health Systems, Inc. was precipitated by the hospital's realization that in order to continue to serve its community, it would require access to capital that could not be generated from the hospital's operation. Two alternatives to the proposed change-of-ownership were considered over the past two years, and a summary of those alternatives and the reasons for rejecting the alternatives are presented below.

Alternative 1: Discontinuation of the Hospital, and Sell the Buildings for Non-Health Care Uses

The "discontinuation" or closing of the hospital was immediately dismissed for two reasons. First, and as discussed in other parts of this application, the southwest side of Chicago does not enjoy the number of hospitals located in other parts of the city, and the elimination of Holy Cross Hospital as a health care resource would be a significant hardship on the communities that have been served by the hospital for over eighty years. Second, Holy Cross Hospital typically has a patient census of 16-17 patients in ICU beds and another 50-55 patients in telemetry beds. The hospitals in the general area of Holy Cross Hospital do not have the monitored bed capacity to absorb an additional 65-70 patients a day. Third, Holy Cross Hospital accepts an average of over 60 EMS transports a day—more than any other hospital in Illinois—as a result of the physical distance between hospitals on the southwest side of Chicago. The closure of Holy Cross would

result in extended travel times for these EMS-transported patients, jeopardizing their well being.

Alternative 2: Develop a Partnership with Another Area Provider

The Sisters and senior management evaluated potential "partners" for Holy Cross Hospital, to identify area providers having the financial ability to subsidize the hospital's operations and address the hospital's capital requirements. Two potential "partners" were identified as "having the right fit"—one being a hospital and one being a multi-hospital system. Both were approached by the Sisters, and both indicated that they were not interested in a relationship with Holy Cross.

SUMMARY COMPARISON OF ALTERNATIVES TO PROPOSED PROJECT

	Cost	Financial Benefits	Quality	Accessibility
Alternative 1 Discontinue Hospital	maintenance costs or the property would continue until sold (short term)	proceeds from sale vs proceeds from change of ownership	not applicable	significantly reduced for area residents
Alternative 2 Develop a partnership with an area hospital	unknown	unknown	similar	identical*, assuming services were not eliminated

* identical to the proposed project

67

ATTACHMENT 13

IMPACT STATEMENT

The proposed change of ownership will have a significant positive community and health care delivery impact on the residents of the southwestern portion of Chicago and the surrounding communities historically served by Holy Cross Hospital. Consistent with IHFSRB rules, this impact statement covers the two-year period following the proposed change of ownership.

Holy Cross Hospital has identified the need to have significantly greater access to capital, and without the acquisition as being proposed, the scope of services to be provided at Holy Cross Hospital 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 (closed) 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 (274) or to the scope of services currently provided at Holy Cross Hospital.

The current and proposed bed complement, consistent with Holy Cross Hospital's 2009 IDPH Hospital Profile (draft) are:

- 204 medical/surgical beds
- 20 intensive care beds
- 16 obstetrics/gynecology beds
- 34 comprehensive rehabilitation beds.

Among the other clinical services currently offered and proposed to be provided are: 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 Hospital Development Company 2, Inc.

Reason for the Transaction

The proposed change of ownership is the result of the Hospital's need to have greater access to capital for a variety of operational and facility/equipment-related reasons.

Additions or Reductions in Staff

Vanguard fully intends to offer all hospital employees at the time of closing their current position at their current wage or salary and seniority level, and all accrued vacation time will be honored. 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 specific major capital investments have been identified as of the filing of this application. Upon the change of ownership, Vanguard will initiate a detailed capital requiriements assessment. Vanguard has, however, made a commitment to invest a minimum of $20M to address the hospital's facility, IT, and equipment-related needs.

2. Benefit

The community will benefit greatly from the change of ownership, and primarily from the continued availability of Holy Cross Hospital and its current programmatic complement. Last year, the hospital admitted approximately 10,100 patients, provided approximately 70,500 outpatient visits, and treated over 43,200 patients in its emergency department. As noted above, Vanguard is 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 Holy Cross Hospital is particularly important to the more disadvantaged communities and neighborhoods traditionally served by Holy Cross Hospital. In 2009, 29.4% of all patients admitted to the hospital were Medicaid recipients, and another 5.3% 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 currently-owned Chicago area hospitals. According to IDPH data, during 2009 21.3% and 25.3% of the patients admitted to Louis A. Weiss Memorial Hospital and MacNeal Memorial Hospital were Medicaid recipients, respectively. In addition, 2.9% and 2.1% 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.

In addition, on August 1, 2010 Vanguard assumed ownership of Westlake Hospital and West Suburban Medical Center. During 2009, Westlake's Medicaid and charity care admissions constituted 38.6% and 3.8% of the hospital's total admissions, and Medicaid and charity care admissions constituted 25.3% and 2.1% of the total admissions to West Suburban.

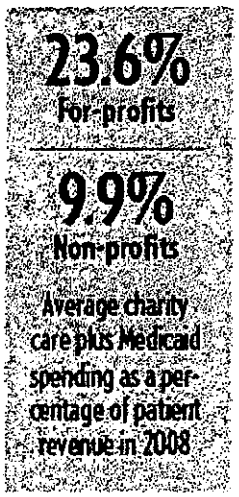
Finally, with 975 employees, Holy Cross Hospital is the third largest employer in the area, and, as noted above, Vanguard has committed to retain all of the hospital's current employees, at their current positions and wages or salaries.

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.

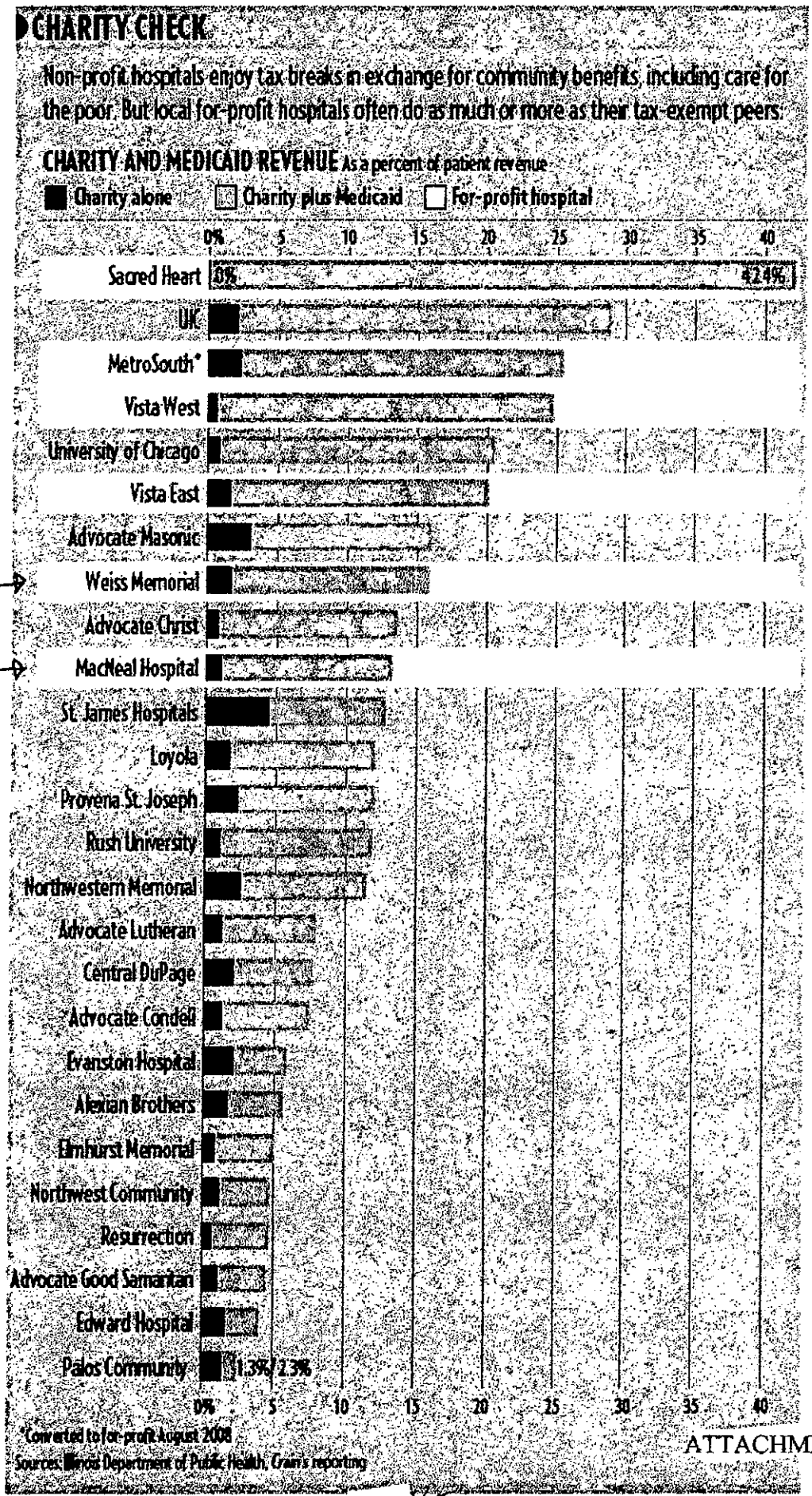
Illinois has been a flashpoint in a national debate over charity care ever since Champaign County officials stripped Provena Covenant Medical Center of its exemption in 2003,

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



ATTACHMENT 19A

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.

ATTACHMENT 19A

ACCESS

Holy Cross Hospital's charity care/financial assistance policies are attached. Financial assistance and charity care provisions are made to patients having a household income equal to or less than 150% 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 151% of the Federal Poverty Level.

Similarly, Vanguard Health Systems' Illinois hospitals operate under common admissions and charity care/financial assistance policies, and those policies (attached) will be adopted by Holy Cross Hospital 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.

ATTACHMENT 19B

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").

Holy Cross Hospital 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 Holy Cross Hospital 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 Holy Cross Hospital will not become more restrictive than those now in place.

VANGUARD
HEALTH SYSTEMS

September 6, 2010

Illinois Health Facilities
and Services Review Board
Springfield, Illinois

RE: Acquisition of Holy Cross Hospital
Melrose Park, Illinois

To Whom It May Concern:

Please be advised that upon the proposed acquisition of Holy Cross Hospital, there will be no policies adopted that will result in restrictions to admissions to the hospital.

It is the intent of Hospital Development Company Number 2, Inc., which will be the licensee following the change of ownership, to adopt the common admissions-related policies currently in effect at Vanguard Health Systems' Illinois hospitals. Those policies and procedures are included in ATTACHMENT 19B 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,

Kent H. Wallace
President

Holy Cross Hospital

Current Financial Aid Policies

ATTACHMENT 19B

HOLY CROSS HOSPITAL

Policy Title:	**Hospital Sponsored Financial Aid**	Policy #:	**B-1.2**
Originating Department:	**Business Office**	Page	**1** of **3**

Current Revision Date: 9/30/07	*Supersedes Date:*	*Original Effective Date:9/2001*

Purpose: Holy Cross's policy is to provide those who are Indigent, as defined by Regionally Adjusted Federal Poverty Guidelines, with Charity Care or Partial Charity Care to relieve the financial burden associated with medically necessary treatment. Holy Cross intends, with this policy, to establish a policy and appropriate procedures for use, in circumstances in which free care, compliant with all applicable federal, state, and local laws, shall be extended to Holy Cross's Indigent patients, who may be Uninsured/Underinsured or have suffered a catastrophic injury

Distribution/Scope: **Business Office**

Policy: The following definitions are applicable to all sections of this Policy:

1. **Charity Care (or "Free Care"):** A 100% waiver of patient financial obligation resulting from medical services provided by Holy Cross. Patients who are classified as Indigent, whether they are Uninsured or Underinsured, and who have annualized household incomes not in excess of 100% of the Regionally Adjusted Federal Poverty Guidelines will be eligible to receive Charity Care.

2. **Partial Charity Care:** A percentage discount, based on the Optimal Charity Care Sliding Scale, applied to patient financial obligation resulting from medical services provided by Holy Cross. Patients' who are Indigent, whether they are Uninsured or Underinsured, and who have annualized household incomes is in excess of 150%, of the Regionally Adjusted Federal Poverty Guidelines will be eligible to receive Partial Charity Care.

3. **Indigent Patient:** An individual who is unable to pay for medical services rendered when taking into consideration his / her household income and assets as well as their requirement for other necessities of life for themselves and their dependants. Assets would be defined, but not limited to:

   a. **Equity in a home**
   b. **Other significant personal property including real estate, automobiles, boats and other substantial personal property.**
   c. **Savings, retirement account(s), investments and other forms of assets that can be liquidated.**

4. **Uninsured Patient:** An individual who is uninsured, having no third-party coverage by a commercial third-party insurer; an ERISA plan; a Federal Health Care Program (including without limitation Medicare, Medicaid, SCHIP and CHAMPUS), Workers' Compensation, Medical Savings Accounts or other coverage for all or any part of his bill, including claims against third parties covered by insurance to which Holy Cross is subrogated, but only if payment is actually made by such insurance company.

5. **Underinsured Patient:** People with public or private insurance policies that do not cover all necessary health care services (adjusted for geographical region), resulting in out-of-pocket expenses that exceed their ability to pay

ATTACHMENT 19B

6. **Holy Cross** Charity Care Discounting Guidelines: The policies and procedures for determining the optimal Charity Care Discount bestowed upon Indigent patients, whether they are Uninsured or Underinsured.

CHARITY CARE POLICY

1. Holy Cross will provide access to necessary care for patients, regardless of ability to satisfy their financial obligation, in compliance with applicable federal and state laws. Charity Care shall be extended to patients in accordance with Holy Cross's mission and values, ensuring a demonstrative benefit to the community.

2. Both Uninsured and Underinsured patients will be considered eligible to receive Charity Care benefits, either Full or Partial, from Holy Cross. However, the applicant will be required to exhaust all other payment options as a condition of their approval. Payment sources include any and all forms of Federal, State, and Local medical assistance programs, grants, and other forms of financial aid. The patient's cooperation in accessing applicable & identifiable funding sources is required.

3. Holy Cross's patients who meet criteria based upon inability to pay for services will be screened and processed for assistance without respect to their residency, gender, ethnic origin or employment status. Annualized household income, both tangible and asset based, will be the primary factor in determining eligibility and the discounted amount for qualifying patients.

4. Annualized household income and family size must be verified through Holy Cross's Patient Financial Service Department obtaining and reviewing relevant patient documents. Such documents include, but are not limited to:

   a. Previous year's tax return plus last three month's pay stubs
   b. W-2 Withholding Statement
   c. Direct deposit payroll, pension or Social Security Income Statement
   d. Written or telephone verification, if obtaining hardcopy would be impossible
   e. Hospital access to data through applicable tools such as Trans Union

(Note: hospital may choose to obtain patient attestation and verify income through additional technology enablers.)

5. Holy Cross will document any and all Charity Care assistance, whether it is Full or Partial, in order to maintain information integrity and accessibility as well as to meet all internal and external compliance requirements.

Procedure:

1. Notice of Charity Care Policy

   a. Holy Cross will post, at inpatient and outpatient admission areas and on its website, notice of its Charity Care policy. This will include taking steps to ensure that Charity Care literature (e.g. brochures, etc.) and Applications are readily accessible to patients at said locations.
   b. At the earliest feasible time, Holy Cross personnel will obtain necessary patient financial records and documentation regarding eligibility for any and all types of alternative funding to expedite processing of patient Charity Care Application. This time shall not exceed 90 days from date application was submitted.

ATTACHMENT 19B

2. Calculation of Charity Care Benefits (if Patient is Ineligible for Alternative Funding)

   a. Holy Cross personnel will apply the appropriate Uninsured / Underinsured discount to outstanding patient financial obligation.

   b. Holy Cross personnel will determine appropriate Charity Care Discount Percentage by analyzing patient financial information within the framework of Optimal Charity Care Sliding Scale (below).

Percent of Poverty	Discount
100%	100%
101% to 150 %	75%
151% and greater	N/A

3. Calculation of Charity Care Benefits (if Patient is Eligible for Alternative Funding)
   a. Holy Cross personnel will forward full patient bill to appropriate funding source (Example: Private Funding) and adjust the patient balance based on reimbursement from said organization.

   b. Holy Cross personnel will then apply the appropriate Uninsured / Underinsured Discount to the remaining patient balance.

   c. Holy Cross personnel will determine appropriate Charity Care Discount Percentage by analyzing patient financial information within the framework of Optimal Charity Care Sliding Scale (as seen above). For example, if the patients annualized household income is at 150% of the Regionally Adjusted Federal Poverty Guidelines they will receive a 75% discount on their bill, but patient would still be responsible for Remaining Balance.

Approved: _____ Date: _____
Department

Approved: _____ Date: _____
Vice President

ATTACHMENT 19B

HOLY CROSS HOSPITAL

Policy Title: **Self Pay Debt Reduction Provisions** Policy #: **B-1.2.1**

Originating Department: **Business Office** Page **1** of **4**

Current Revision Date: 4/1/2009	*Supersedes Date: 4/1/2008*	*Original Effective Date:9/2001*

Purpose: Holy Cross Hospital's policy is to provide Uninsured, Underinsured, low-income, and medically indigent patients, with Debt Reduction Provisions in order to alleviate the burdensome financial obligations associated with receiving acute and unexpected medical care.

Distribution/Scope: **Business Office**

Policy: The following definitions are applicable to all sections of this Policy:

1. Hospital Uninsured patient Discount Act (Public Act 95-0965): Effective April 1, 2009 Illinois hospitals are required to provide discounts to charges equal to 135% of the hospital's cost. The maximum amount collected in a 12-month period from an eligible patient is 25% of the family's annual gross income.

2. **Medically Indigent:** A patient who's medical or hospital bills, after any third party payments, exceed a specified percentage of the person's annual household gross income, determined in accordance with Holy Cross Hospital's eligibility system, and who is financially unable to pay the remaining bill. Holy Cross Hospital will classify patient as medically indigent if payment of outstanding financial obligation would require the liquidation of assets deemed critical to living, or payment would cause undue financial hardship to the patient's family support system.

3. **Patient Assets:** Assets include both immediately available cash (highly liquid assets), such as checking and savings accounts, and other investments (moderately liquid assets), such as life stock and bonds, insurance policies, trust accounts, IRA and other retirement funds, etc. Other assets may be taken into consideration. Those assets listed will be reviewed in accordance to the limits established in the Code of Civil Procedure, 735 ILCS 5/12-1001.

4. **Patient Gross Household Income:** Includes gross wages (before taxes), salaries, Social Security Benefits, military allotments, private and government pensions, workers compensation, insurance and annuity payments, royalties, estates, trusts, income from rents, training stipends and veterans benefits. Gross wages will be reduced for payments made for child support.

5. Federal Poverty Income Guidelines: The United States Department of Health and Human Services provide updates periodically which are published in the Federal Register. These guidelines provide the annual income by family size that qualifies a family position of 100% - 250% of the federal poverty level.

6. **Uninsured Patient:** An individual who is uninsured, having no third-party coverage by a commercial third-party insurer; an ERISA plan; a Federal Health Care Program (including without limitation Medicare, Medicaid, SCHIP and CHAMPUS), Workers' Compensation, Medical Savings Accounts or other coverage for all or any part of his bill, including claims against third parties covered by insurance to which Holy Cross Hospital is subrogated, but only if payment is actually made by such insurance company.

7. **Underinsured Patient:** People with public or private insurance policies that do not cover all necessary health care services (adjusted for geographical region), resulting in out-of-pocket expenses that exceed their ability to pay.

ATTACHMENT 19B

8. **Catastrophic Care Policy:** Policy in which Holy Cross Hospital intends to cap low-income, medically indigent patient charges at 35% of their annual household gross income.

9. **Prompt-Pay Discounting Policy:** Policy in which Holy Cross Hospital intends to discount patient liability portion of medical bill by 10% if patient pays obligation IN FULL within a specified number of days after patient receives bill.

10. **Debt Amnesty Policy:** Policy in which Holy Cross Hospital issues a percentage reduction in patients' outstanding financial liability through offering a one-time discount via a publicly issued coupon. A debt amnesty program could be developed and utilized on a periodic basis. Should this need to be deployed, Holy Cross will facilitate a campaign.

11. **Holy Cross Hospital Debt Reduction Provisions:** Policies, and their procedural steps, engaged by Holy Cross Hospital to limit financial obligation for Uninsured, Underinsured, low-income and medically indigent patients in order to prevent unmanageable medical bills.

A. *Uninsured Patient Discounts*

i. Holy Cross Hospital provides a discount to hospital charges of 135% of cost for all Uninsured Patients in accordance with The Hospital Uninsured Patient Discount Act (Public Act 95-0965). The current discount in place is 64% of hospital charges.

ii. Holy Cross Hospital is a Safety Net provider which means the hospital provides a disproportionate amount of care to low-income, uninsured, and vulnerable populations. We are distinguished by their commitment to provide access to care for people with limited or no access to health care due to their financial circumstances, insurance status, or health condition.

iii. The Public Act allows for Illinois Hospitals to require patients to apply for the discount within a 60 day period from the day of service. This would require patients to submit required documentation for income verification and Illinois residency. Due to the vulnerable patient population served by Holy Cross Hospital the hospital provides the Uninsured discount to all patients at the time of billing.

iv. For patients to be eligible for the maximum amount collected in a 12-month period of 25% of the family's annual gross income Holy Cross Hospital will require patients to provide verification of income, information regarding assets and documentation of residency within 90 days of the date of service. The 12-month period is defined as starting from the date Holy Cross Hospital Financial Counseling staff determines the patient is eligible for the maximum. The hospital excludes patients from the maximum if the assets of the patient exceed 600% of the Federal Poverty Level.

v. In accordance with the Public Act Holy Cross Hospital will file a copy of the Worksheet C Part I from the Medicare Cost Report with the Illinois Attorney General 30 days after the Cost Report filing deadline.

B. *Catastrophic Care Policy*

i. Holy Cross Hospital will provide access to necessary care for patients, regardless of ability to satisfy their financial obligation, in compliance with applicable federal laws. Catastrophic Care Provisions shall be extended to patients in accordance with Holy Cross Hospital's mission and velues.

ii. Underinsured patients, who are classified as medically indigent, will be considered eligible for a Catastrophic Care Discount from Holy Cross Hospital. However, the applicant must exhaust all other payment options as a condition of their approval. Payment sources include any and all forms of Federal, State, and Local medical assistance programs, grants, and other forms of financial aid.

iii. Holy Cross Hospital's patients who meet criteria based upon inability to pay for services will be screened and processed for Catastrophic Care Discounts without respect to their residency, gender, ethnic origin or employment status. Annualized gross household income, both tangible and asset based, will be the primary factor in determining patient eligibility.

iv. Annualized household income and family size must be verified through Holy Cross Hospital's Financial Department obtaining and reviewing relevant patient documents. Such documents include, but are not limited to:

1. Previous year's tax return plus last three month's pay stubs

2. W-2 Withholding Statement
3. Direct deposit payroll, pension or Social Security Income Statement
4. Written or telephone verification, if obtaining hardcopy would be impossible
5. Income and dependent attestation with funding software
6. Asset based documents such as home, real estate, business partnerships

v. Holy Cross Hospital will document any and all Catastrophic Care Discounts in order to maintain integrity and accessibility of information as well as to meet all internal and external compliance requirements.

C. Prompt-Pay Discounting Policy

i. A 10% prompt-pay discount is available to all patients when upon receipt of a patient bill the balance is paid IN FULL within 45 days of receiving the bill. The 10% discount is applied to any outstanding patient financial liability and the remaining balance is the emount to be paid IN FULL.

Procedure:

A. Catastrophic Care Discount Calculation

(Based on ceiling of 35% of annual household gross income)

a. Holy Cross Hospital personnel will take necessary steps to identify accrued patient charges.
b. Holy Cross Hospital personnel will compare patient's gross annual household income, based on analysis of pertinent financial documents (listed in Policy section) to accrued patient charges.
c. If aggregate patient charges are greater than 35% of annual household gross income, hospital charges will be capped at 35% of patient's gross income.
d. Holy Cross Hospital personnel will take action absolve patient of remaining, "over-the-cap", charges by applying them to Charity Care.

Example 1 – Catastrophic Care discount calculation and Charity Care amounts:

Total Patient Gross Income	$50,000
Total Patient Charges, NET	$70,000
Patient Charges as a % of Gross Income (equals $70,000 divided by $50,000)	140%
Do Charges Exceed 35% of Patient Annual Household Gross Income?	YES
Charges Capped at 35% of Patient Income (equals $70,000 multiplied by 35%)	$17,500
Remaining Charges Applied to Charity Care (equals $70,000 minus $17,500)	$52,500

Note 1: Catestrophic Care Application processing should be run concurrent with the Charity Care Application processing due to the dependence on similar patient financial documents.

Note 2: Should the patient default on payment arrangements for the discounted balance, the catastrophic care discount shall be added back to the account with the adjusted balance going to collection/collection agency. This will be articulated to the patient at the onset of the process.

B. Prompt-Pay Discount Calculation

(Based on 10% discount if patient pays FULL bill within 45 days of receiving said bill)

a. If patient meets his / her financial obligation, IN FULL, within 45 days of receiving their bill, Holy Cross Hospital personnel will take the necessary steps to provide the patient with a flat-rate discount of 10% off the billed charges received.
b. Holy Cross Hospital personnel will follow procedure to ensure that any discounted amount, from application of prompt-pay provisions, is accounted for in a self-pay discounting section and is NOT applied to Charity Care

Example 2 Prompt-pay Discount Calculation:

Total Patient Financial Obligation (amount due by patient)	$10,000
Is Payment Being Made within 45 Days of Receiving Bill	YES
Is Patient Paying Obligation in FULL?	YES
Discount Amount (equals $10,000 multiplied by 10% discount)	$1,000

Approved: — VACANT — Date: ——
Department

Approved: [signature] Date: 4/6/09
Vice President

ATTACHMENT 19B

Holy Cross Hospital

Proposed Admitting Policies

ATTACHMENT 19B

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 return 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.

ATTACHMENT 19B

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

Medicare Questionnaire/Second

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

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

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

Medicare Mandated Forms .....

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.

1/2

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

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

Consents .....

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 returned 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.

ATTACHMENT 19B

Holy Cross Hospital

Proposed Charity Care Policies

ATTACHMENT 19B

POLICIES &
PROCEDURES

DEPARTMENT: Business Office	**POLICY DESCRIPTION:** Charity Care, Financial Assistance and Billing & Collection Policies for Uninsured Patients
PAGE: 1 of 10	**REVISED January 23, 2009**
APPROVED:	**RETIRED:**
EFFECTIVE DATE: January 23, 2009	**REFERENCE NUMBER:** 11-0801

SCOPE:
All Company-affiliated hospitals.

PURPOSE:
This Policy and Procedure is established to provide the operational guidelines for the Company's hospitals (each a "Hospital" and, collectively, the "Hospitals") to identify uninsured patients who are Financially Indigent or Medically Indigent that may qualify for charity care (free care) or financial assistance, to process patient applications for charity care or financial assistance and to bill and collect from uninsured patients, including those who qualify as Financially Indigent or Medically Indigent under this Policy.

POLICY:
1. 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"). See attached Financial Assistance Eligibility Guidelines.

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, including those uninsured patients who qualify for classification as Financially Indigent or Medically Indigent under this Policy.

ATTACHMENT 19B

POLICIES &
PROCEDURES

DEPARTMENT: Business Office	**POLICY DESCRIPTION:** Charity Care, Financial Assistance and Billing & Collection Policies for Uninsured Patients
PAGE: 2 of 10	**REVISED January 23, 2009**
APPROVED:	**RETIRED:**
EFFECTIVE DATE: January 23, 2009	**REFERENCE NUMBER:** 11-0801

PROCEDURE:

A. CHARITY CARE AND FINANCIAL ASSISTANCE PROCESS

1. **Application.** Each Company Hospital will request that each patient applying for charity care financial assistance complete a Financial Assistance Application Form (Assistance Application). An example Financial Assistance Application Form is attached hereto. The Assistance Application allows for the collection of needed information to determine eligibility for financial assistance.

A. Calculation of Immediate Family Members. Each Hospital will request that patients requesting charity care verify the number of people in the patient's household.

1. *Adults*. In calculating the number of people in an adult patient's household, Hospital will include the patient, the patient's spouse and any dependents of the patient or the patient's spouse.

2. *Minors*. For persons under the age of 18. In calculating the number of people in a minor patient's household, Hospital will include the patient, the patient's mother, dependents of the patient's mother, the patient's father, and dependents of the patient's father.

B. Calculation of Income.

1. *Adults*. For adults, determine the sum of the total yearly gross income of the patient and the patient's spouse (the "Income"). Hospital may consider other financial assets of the patient and the patient's family (members of family are as defined in section "Calculation of Immediate Family Members") and the patient's or the patient's family's ability to pay.

2. *Minors*. If the patient is a minor, determine the Income from the patient, the patient's mother and the patient's father. Hospital may consider other financial assets of the patient and the patient's family (members of family are as defined in section "Calculation of Immediate Family Members") and the patient's or the patient's family's ability to pay.

POLICIES &
PROCEDURES

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2. **Income Verification.** Hospital shall request that the patient verify the Income and provide the documentation requested as set forth in the Assistance Application. NOTE: Tax Returns and W-2's should be collected for year prior to date of admission.

A. Documentation Verifying Income. Income may be verified through any of the following mechanisms:

- Tax Returns (Hospital preferred income verification document)
- IRS Form W-2
- Wage and Earnings Statement
- Pay Check Remittance
- Social Security
- Worker's Compensation or Unemployment Compensation Determination Letters
- Qualification within the preceding 6 months for governmental assistance program (including food stamps, CDIC, Medicaid and AFDC)
- Telephone verification by the patient's employer of the patient's Income
- Bank statements, which indicate payroll deposits.

B. Documentation Unavailable. In cases where the patient is unable to provide documentation verifying Income, the Hospital may at it's sole discretion verify the patient's Income in either of the following two ways:

1. By having the patient sign the Assistance Application attesting to the veracity of the Income information provided or

2. Through the written attestation of the Hospital personnel completing the Assistance Application that the patient verbally verified Hospital's calculation of Income.

Note: ***In all instances where the patient is unable to provide the requested documentation to verify Income, Hospital will require that a satisfactory explanation of the reason the patient is unable to provide the requested documentation be noted on the Financial Assistance Assessment Form.***

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C. Expired Patients. Expired patients may be deemed to have no Income for purposes of the Hospital's calculation of Income. Documentation of Income is not required for expired patients. Income verification is still required for any other family members (members of family are as defined in section "Calculation of Immediate Family Members").

D. Homeless Patients. Homeless patients may be deemed to have no Income for purposes of the Hospital's calculation of Income. Documentation of Income is not required for homeless patients. Income verification is still required for any other family members (members of family are as defined in section "Calculation of Immediate Family Members") only if other family information is available.

E. Incarcerated Patients. Incarcerated patients (incarceration verification should be attempted by Hospital personnel) may be deemed to have no Income for purposes of the Hospital's calculation of Income, *but only if their medical expenses are not covered by the governmental entity incarcerating them (ie the Federal Government, the State or a County is responsible for the care) since in such event they are not uninsured patients.* Income verification is still required for any other family members (members of family are as defined in section "Calculation of Immediate Family Members").

F. International Patients. International patients who are uninsured and whose visit to the Hospital was unscheduled will be deemed to have no Income for purposes of the Hospital's calculation of Income. Income verification is, moreover, still required for any other family members (members of family are as defined in section "Calculation of Immediate Family Members") only if other family are United States citizens.

G. Eligibility Cannot be Determined. If and when Hospital personnel cannot clearly determine eligibility, the Hospital personnel will use best judgment and submit a memorandum (such memorandum should be the first sheet in the documentation packet) listing reasons for judgment along with Financial Assistance documentation to appropriate supervisor. The Hospital Supervisor will then review the memorandum and documentation. If the Supervisor agrees to approve the eligibility, they will sign Eligibility Determination form and continue with normal Approval process. If the Supervisor does not approve eligibility of the patient under this Policy, the Supervisor should sign the submitted memorandum and return all documentation to Hospital personnel who will note account and

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send documentation to the Hospital's Business Office for filing. If Supervisor disagrees with hospital personnel's judgment, Supervisor should state reasons for new judgment and will return documentation to hospital personnel who will follow either denial process or approval process as determined by Supervisor.

H. Classification Pending Income Verification. During the Income Verification process, while Hospital is collecting the information necessary to determine a patient's Income, the patient may be treated as a self-pay patient in accordance with Hospital policies.

3. **Information Falsification.** Falsification of information may result in denial of the Assistance Application. If, after a patient is granted financial assistance as either Financially Indigent or Medically Indigent, and Hospital finds material provision(s) of the Assistance Application to be untrue, the financial assistance may be withdrawn.

4. **Request for Additional Information.** If adequate documents are not provided, Hospital will contact the patient and request additional information. If the patient does not comply with the request within 14 calendar days from the date of the request, such non-compliance will be considered an automatic denial for financial assistance. A note will be input into Hospital computer system and any and all paperwork that was completed will be filed according to the date of the denial note. No further actions will be taken by Hospital personnel. If requested documentation is later obtained, all filed documentation will be pulled and patient will be reconsidered for Financial Assistance.

5. **Automatic Classification as Financially Indigent.** The following is a listing of types of accounts where Financial Assistance is considered to be automatic and documentation of Income or a Financial Assistance application is not needed:

- Medicaid accounts-Exhausted Days/Benefits
- Medicaid spend down accounts
- Medicaid or Medicare Dental denials
- Medicare Replacement accounts with Medicaid as secondary-where Medicare Replacement plan left patient with responsibility

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6. **Classification as Financially Indigent.** Financially Indigent means an uninsured person who is accepted for care with no obligation (charity care) or with a discounted obligation to pay for the services rendered, based on the Hospital Eligibility Criteria.

A. Classification. The Hospital may classify as Financially Indigent all uninsured patients whose income, as determined in accordance with the Assistance Application, is less than or equal to 200% of the poverty guidelines updated annually in the Federal Register by the U.S. Department of Health and Human Services (Federal Poverty Guidelines).

B. Acceptance. If Hospital accepts the patient as Financially Indigent, the patient may be granted charity care or financial assistance discounts in accordance with the attached Financial Assistance Eligibility Guidelines.

7. **Classification as Medically Indigent.** Medically Indigent means *an uninsured patient* who does not qualify as Financially Indigent under this policy because the patient's Income exceeds 500% of Federal Poverty Guidelines, but whose medical or hospital bills exceed a specified percentage of the person's Income, and who is unable to pay the remaining bill.

A. Initial Assessment. To be considered for classification as a Medically Indigent patient, the amount owed by the patient on all outstanding accounts after all payments by the patient must exceed 10% of the patient's Income and the patient must be unable to pay the remaining bill. If the patient does not meet the Initial Assessment criteria, the patient may not be classified as Medically Indigent.

B. Acceptance. The Hospital may also accept a patient as Medically Indigent when they meet the acceptance criteria set forth below.

(1) The patient's bill is greater than 50% of the patient's Income, calculated in accordance with the Hospital's income verification procedures, and the patient's Income is greater than 500% of the Federal Poverty Guidelines. The Hospital will determine the amount of financial assistance granted to these patient's in accordance with the attached Financial Assistance Eligibility Guidelines.

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(2) NOTE: TO QUALIFY AS MEDICALLY INDIGENT, THE PATIENT MUST BE UNINSURED.

8. **Approval Procedures.** Hospital will complete a Financial Assistance Eligibility Determination Form for each patient granted status as Financially Indigent or Medically Indigent. The approval signature process is as following:

$1 - $2,000	Director
$2,001 - $10,000	Director and CFO
$10,001 and above	Director, CFO and CEO

A. The accounts will be filed according to the date the Financial Assistance adjustment was entered onto the account.

B. The Eligibility Determination Form allows for the documentation of the administrative review and approval process utilized by the Hospital to grant financial assistance. Any change in the Eligibility Determination Form must be approved by the Director of Patient Financial Services. **NOTE: If application is approved, approval is automatic for all admissions for calendar year on balances that can be considered for Financial Assistance.**

9. **Denial for Financial Assistance.** If the Hospital determines that the patient is not Financially Indigent or Medically Independent under this policy, it shall notify the patient of this denial in writing. A suggested denial of coverage letter is attached to this policy.

10. **Document Retention Procedures.** Hospital will maintain documentation sufficient to identify for each patient qualified as Financially Indigent or Medically Indigent, the patient's Income, the method used to verify the patient's Income, the amount owed by the patient, and the person who approved granting the patient status as Financially Indigent or Medically Indigent. All documentation will be forwarded and filed within the Hospital's Business Office for audit purposes. Financial Assistance applications and all documentation will be retained within the Hospital's Business Office for 1 calendar year. After which, the documents will be boxed and marked as: Charity Docs, JANUARY YYYY-DECEMBER YYYY and forwarded to the Hospital Warehouse,

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where it will then be retained for an additional 6 years before shredding.

11. **Reservation of Rights.** It is the policy of the Company and its Hospitals to reserve the right to limit or deny financial assistance at the sole discretion of each of its Hospitals.

12. **Non-covered Services.** Elective and non-emergency services are not covered by this policy.

B. <u>BILLING AND COLLECTION PRACTICES FOR ALL UNINSURED PATIENTS, INCLUDING THOSE WHO QUALIFY AS FINANICALLY INDIGENT OR MEDICALLY INDIGENT UNDER THIS POLICY</u>

1. **Fair and Respectful Treatment.** Uninsured patients will be treated fairly and with respect during and after treatment, regardless of their ability to pay.

2. **Trained Financial Counselors.** All uninsured patients at the Company's hospitals will be provided with financial counseling, including assistance applying for state and federal health care programs such as Medicare and Medicaid. If not eligible for governmental assistance, uninsured patients will be informed of and assisted in applying for charity care and financial assistance under the hospital's charity care and financial assistance policy. Financial counselors will attempt to meet with all uninsured patients prior to discharge from the Company's hospital. Hospitals should ensure that appropriate staff members are knowledgeable about the existence of the hospital's financial assistance policies. Training should be provided to staff members (i.e., billing office, financial department, etc.) who directly interact with patients regarding their hospital bills.

3. **Additional Invoice Statements or Enclosures.** When sending a bill to uninsured patients, the Hospital should include (a) 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 from the Hospital under its charity care or financial assistance policy; and (b) a statement on the bill or in an enclosure to the bill that provides the patient a telephone number of a hospital employee or office from whom or which the patient may obtain information about such financial assistance policy for patients and how to apply for such assistance. The following statement on the bill or in an enclosure to the bill complies with the above requirements of this Section B.3.:

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"Please note, based on your household income, you may be eligible for Medicaid *[Note: please refer to MediCal for California patients and Arizona's AHCCCS program for Arizona patients]* or financial assistance from the Hospital. For further information, please contact our customer service department at (XXX) XXX-XXXX."

4. **Notices.** Each of the Company's hospitals should post notices regarding the availability of financial assistance 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)."

5. **Liens on Primary Residences.** The Company's hospitals shall not, in dealing with patients who quality as Financially Indigent or Medically Indigent under this Policy, place or foreclose liens on primary residences as a means of collecting unpaid hospital bills. However, as to those patients who qualify as Medically Indigent but have income in excess of 500% of the Federal Poverty Guidelines, the Company may place liens on primary residences as a means of collecting discounted hospital bills, but the Company's hospitals may not pursue foreclosure actions in respect of such liens.

6. **Garnishments.** The Company's hospitals shall only use garnishments on Medically Indigent Patients where clearly legal under state law and only where it has evidence that the Medically Indigent Patient has sufficient income or assets to pay his discounted bill.

7. **Collection Actions Against Uninsured Patients.** Each of the Company's hospitals should have written policies outlining when and under whose authority an unpaid balance of any uninsured patient is advanced to collection, and hospitals should use their best efforts to ensure that patient accounts for all uninsured patients are processed fairly and consistently.

8. **Interest Free, Extended Payment Plans**. All uninsured patients shall be offered extended payment plans by the Company's hospitals to assist the patients in settling

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past due outstanding hospital bills. The Company's hospitals will not charge uninsured patients any interest under such extended payment plans.

9. **Body Attachments.** The Company's hospitals shall not use body attachment to require that its uninsured patients or responsible party appear in court.

10. **Collection Agencies Follow Hospital Collection Policies.** The Company's hospitals should define the standards and scope of practices to be used by their outside (non-hospital) collection agencies, and should obtain written agreements from such agencies that they will adhere to such standards and scope of practices. These standards and practices should not be inconsistent with the Company's collection practices for its hospitals set forth in this Policy.

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

HHS, Office of Inspector General, Guidance dated February 2, 2004, entitled " Hospital Discounts Offered to Patients Who Cannot Afford To Pay Their Hospital Bills".

Letter dated February 19, 2004, from Tommy G. Thompson, HHS Secretary, to Richard J. Davidson, President, American Hospital Association, including Questions and Answers attached thereto entitled "Questions On Charges For The Uninsured".

Federal Poverty Guidelines published by US Department of Health and Human Services from time to time. (Most recent publication at effective date of this Policy is *Federal Register*, (74 FR 4199-4201) January 23, 2009.

FINANCIAL ASSISTANCE ELIGIBILITY GUIDELINES

Based on Federal Poverty Guidelines Effective January 23, 2009

Schedule A (shaded)
Financially Indigent

Schedule B (unshaded)
Medically Indigent

Number In Household	100%	200%	300%	400%	500%
1	10,830	21,660	32,490	43,320	54,150
2	14,570	29,140	43,710	58,280	72,850
3	18,310	36,620	54,930	73,240	91,550
4	22,050	44,100	66,150	88,200	110,250
5	25,790	51,580	77,370	103,160	128,950
6	29,530	59,060	88,590	118,120	147,650
7	33,270	66,540	99,810	133,080	166,350
8	37,010	74,020	111,030	148,040	185,050
Discount	100%		80%	60%	40%
Financially Indigent Classification					

Schedule C
Catastrophic Eligibility as Medically Indigent

Only applicable if patients income exceeds 500% of Federal Poverty Guidelines

Balance Due	Discount
Balance Due is equal to or greater than 90% patients annual income	80%
Balance Due is equal to or greater than 70% and less than 90% patients annual income	60%
Balance Due is equal to or greater than 50% and less than 70% patients annual income	40%

ATTACHMENT 19B

[HOSPITAL LETTERHEAD]

«GUARANTOR»
«ADDRESS»
«CITY», «State» «zip»

[DATE]

Re: «PATIENT»
Admission: «ACCOUNT»
Balance Due: $«TOTAL_CHARGES»

Dear «GUARANTOR»,

Thank you for choosing _____ Hospital the [system] [Hospital] of choice in _____. We appreciate you taking the time to complete and return the Application for Assistance. _____ Hospital uses this information to determine your eligibility for a reduce fee under the _____ Hospital Financial Assistance program.

In reviewing your Application for Assistance, we are happy to inform you that you have been approved for a «DISCOUNT»% discount your new balance has been reduced to $«REMAINING_BAL». Our determination was based upon your income, household size and Federal Poverty Guidelines.

If you have any questions about our decision, please call the Hospital's [Customer Service] at (___)-_____.

Sincerely,

[Customer Service Representative]

ATTACHMENT 19B

FINANCIAL ASSISTANCE ELIGIBILITY DETERMINATION
OFFICE USE ONLY

Patient Name: _____

Account Number(s): _____ Total Yearly Income: $_____ Total Charges:$_____

Balance Due: $_____ Income Verification Code: _____ Number in Household: _____ Financial Class: _____

1. **Is Total Yearly Income equal to or less than 200% of the Federal Poverty Guidelines?** (See Financial Assistance Eligibility Guidelines - Schedule A) **Circle One**

   YES Approved for 100% financial assistance as Financially Indigent.

   NO Does not qualify for assistance as Financially Indigent. Continue to Step 2.

2. **Is this balance due greater than 10% of Total Yearly Income? Circle One**

   YES Continue to Step 3.

   NO Patient does not qualify for Financial Assistance.

3. **Is Total Yearly Income equal to or less than 500% of the Federal Poverty Guidelines?** See Financial Assistance Eligibility Guidelines - Schedule B. **Circle One**

   YES Total Yearly Income is greater than _____% and less than _____ % of the Federal Poverty Guidelines. Patient qualifies for _____% discount as Medically Indigent pursuant to Financial Assistance Eligibility Guidelines - Schedule B .

   NO: Continue to Step 4.

4. **Is this balance due greater than 50% of Total Yearly Income? Circle One**

   YES Balance due is _____% of the total yearly income. Eligible for_____% discount as Medically Indigent pursuant to Financial Assistance Eligibility Guidelines - Schedule C. Continue to Step 5.

   NO: Patient does not qualify for Financial Assistance.

5. $_____ *Balance Due Before Discount* Multiply by _____% = $_____ *Discount Amount* $_____ *Remaining Balance Due After Discount*

Employee Name (Print)_____

Employee Signature_____ Approved By _____

Date_____ Approved By _____

$1 - $2,000	Director
$2,001 - $10,000	Director and CFO
$10,001 & above	Director, CFO and CEO

Approved By_____

Income Verification Codes

1	IRS Form W-2, Wage and Earnings Statement	7	Written attestation of patient
2	Pay Check Remittance	8	Verbal attestation of patient
3	Tax Returns	9	Patient deceased, no estate
4	Social Security, Work Comp or Unempl Comp letter	10	Government Program
5	Telephone verification by employer	11	Other
6	Bank Statements		

ATTACHMENT 19B

FINANCIAL ASSISTANCE APPLICATION INSTRUCTIONS

Instructions:
As part of its commitment to serve the community, _____ Hospital elects to provide financial assistance to individuals who are financially indigent or medically indigent and satisfy certain requirements.

To determine if a person qualifies for financial assistance, we need to obtain certain financial information. Your cooperation will allow us to give all due consideration to your request for financial assistance.

Please provide the information requested and mail to the following address:

_____ Hospital
_____
_____
_____

Income Verification:

IN ORDER TO CONSIDER YOUR REQUEST FOR FINANCIAL ASSISTANCE, VERIFICATION OF INCOME IS REQUIRED. PLEASE PROVIDE A COPY OF THE FOLLOWING DOCUMENTS:

- Governmental Assistance, Social Security, Workers Compensation, or Unemployment Compensation Determination Letter
- Income Tax Return for previous year

PLEASE ALSO INCLUDE ONE OR MORE OF THE FOLLOWING:

- IRS Form W-2, Wage and Earnings Statement for all household earnings
- Last 2 pay check stubs for all household earnings
- Bank Statement that contains income information

In the event income verification is unavailable, please contact our office for further instructions. Applications without verification are considered incomplete and **WILL NOT BE PROCESSED**. Please return the application and verification of income within 7 days to the above address.

Notification of Determination:
We will notify you of your eligibility following receipt and review of all necessary information. The notification will be mailed to the mailing address you have provided on the Financial Assistance Application.

Physician Services:
The physicians providing services at this Hospital are not employees of _____ Hospital. You will receive separate bills from your private physician and from other physicians whose services you required (pathologist, radiologist, surgeon, etc.). The Financial Assistance Application does not apply to any amounts due by you for physician services. For questions regarding their bills, or to make payment arrangements for physician services, please contact the individual physician's office.

For assistance in completing this application, please contact _____ Hospital [Customer Service] at (___) _____ or Toll Free: 1-_____, Monday through Friday between the hours of 8:00 a.m. and 5:00 p.m.

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GRNTOR #: _____

HOSP CODE: _____

PATIENT INFORMATION/INFORMACION DEL PACIENTE

Patient Name/Nombre del Paciente	Account Balance/Balancia de Cuenta	Patient Number/Numero del Paciente	Date of Birth/Fetch del Nacimiento
Admission Date/Fecha De Entrada	Discharge Date/Fecha De Despedida	Social Security No/Num de Seguro Social	Marital Status/Estado Civil
Home Address/Direccion De Residencia			
City/Ciudad		State/Estado	Zip
Name of Medical Provider/Nombre Del Proveedor De Sercisios Medicos		Beginning Coverage Date/Fecha del Comienzo	
Name of Doctor/Nombre Del Medico			
Employer Name/Nombre		Occupation/Ocupacion	Telephone/Telefono

GUARANTOR INFORMATION/PERSONA RESPONSABLE

Name/Nombre		Social Security No/Num de Seguro Social	Age/Edad
Realationship to Applicant Relacion con el Paciente	Address/Direccion		Telephone/Telefono
City/Ciudad		State/Estado	Zip
Employer/Empleador		Employer Phone/Number De Empleador	Occupation/Ocupacion
Address/Direccion			
City/Ciudad		State/Estado	ZIP:

ATTACHMENT 19B

FINANCIAL INFORMATION/INFORMACION FINANCIAL

Total Monthly Income/Ingresos Mensuales	No. of Dependents Cuantos Dependientes	Residence(Own/Rent) Casa Propia o Renta	Car (Model/Year)/Carro (Modelo/Ano)

RESOURCES/RECURSOS

Name of Bank/Nombre del Banco	Checking Account/Cueta de Cheques	Savings Account/Cuentas de Ahorros
	$	$

MONTHLY EXPENSES/GASTOS MENSUALES

Rent/Mortgage/ Payment Payment/Renta o Pago Hipotecario	Water Bill/Pago de Agua	Gas Bill/Pago de Gas	Phone Bill/Cuenta De Telefono
$	$	$	$
Electric Bill/Pago de Electricidad	Car Payment/Pago de Carro	Insurance Premium/Pago de Prima	Other Bills/Otro Gastos
$	$	$	$

HOUSEHOLD COMPOSITION/INFORMACION DE LA CASA

Name/Nombre	Relationship/Relacion con el Paciente	Date of Birth/Fecha de Nacimiento	Social Security No. Num de Seguro Social

If unable to provide requested documents, please explain below/

Por favor de dar una explicacion si no es posible proveer los documentos.

COMMENTS/COMETARIOS:

ATTACHMENT 19B

AFFIDAVIT/DECLARACION JURADA

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 perjurla 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 elegibllidad 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.

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Signature/Firma _____ Date/Fecha _____

For Hospital Use Only/Uso Solamente Para el Hospital

Facility/Facilidad: _____ **Accepted/Aceptar:** _____ **Denied/Negacion:** _____

COMMENTS/COMETARIOS:

ATTACHMENT 19B

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

ATTACHMENT 19B

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.

ATTACHMENT 19B

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.

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, Holy Cross Hospital 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 Holy Cross Hospital. 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 made "more restrictive", patients will not be "deflected" from Holy Cross Hospital 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 four other general acute care hospitals in the Chicago area: Louis A. Weiss Memorial Hospital ("Weiss"), located at 4646 North Marine Drive in Chicago, MacNeal Memorial

Hospital ("MacNeal"), located at 3249 South Oak Park Avenue in Berwyn, West Suburban Medical Center ("West Suburban"), located at 3 Erie Court in Oak Park, and Westlake Hospital ("Westlake"), located at 1225 Lake Street in Melrose Park. Weiss is located 18.3 miles (38 minutes), MacNeal is located 9.6 miles (27 minutes), West Suburban Medical Center is located 12.7 miles (34 minutes), and Westlake is located 16.2 miles (39 minutes) from Holy Cross Hospital.

MacNeal is designated as a disproportionate share hospital, and all four of the hospitals currently in the health care system provide a high percentage of their care to Medicaid recipients. During 2009, 25.3% of the patients admitted to MacNeal, 22.6% of the patients admitted to Weiss, 29.1% of the patient admitted to West Suburban, and 37.0% of the patients admitted to Westlake were Medicaid recipients.

The table on the following page presents the 2009 utilization, bed complements and services provided by each of the four above-identified health care system hospitals.

2009 Utilization of Hospitals in Health System

	Weiss Memorial		MacNeal Memorial		Westlake Hospital		West Sub. Med. Ctr.	
	Number	Utilization	Number	Utilization	Number	Utilization	Number	Utilization
Beds								
Med/Surg	184	46.6%	272	60.8%	111	55.2%	135	52.8%
Pediatrics	0		10	29.2%	5	10.7%	5	12.3%
ICU	16	83.7%	26	53.8%	12	54.5%	24	60.3%
OB/Gyn	0		25	50.9%	24	34.6%	20	71.1%
Acute Mentall Illness	10	84.6%	64	63.1%	33	80.0%	0	
Gen'l Long Term Care							50	66.1%
Rehabilitation	26	44.7%	0		40	18.3%	0	
	236	50.6%	397	59.1%	225	46.3%	234	57.1%
Other Services								
Surgery (ORs/hrs)	10	9,372	12	13,714	6	3,447	8	8,614
Cardiac Cath (rms/proc)	1	855	3	1,659		780		540
Emergency Dept (vistits)		23,423		60,191		21,960		49,325
Outpatients (visits)		83,333		195,780		67,632		213,093
Imaging (rms/proc)								
General R & F	11	35,405	7	61,332	11	21,316	6	38,720
Nuclear Medicine	3	4,158	3	7,460	2	1,355	3	3,152
Mammography	2	3,533	3	21,698	2	4,960	1	0
Ultrasound	2	4,230	7	17,880	5	10,870	8	16,850
Diag. Angiography	0		0		0		0	0.0
Interventional Angiog.	0		0		0		0	0.0
CT	2	11,933	3	25,518	1	6,786	3	15,702
MRI	1	2,417	3	7,787	1	1,427	1	2,622
Lithotripsy (proc)			1	38	1	0		
Linear Accelerator (proc)	1	309						

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ATTACHMENT 19C

Referral Agreements

Copies of Holy Cross Hospital's current referral agreements are attached. It is the intent of the prospective licensee, Hospital Development Company, Number 2, Inc., to retain all of Holy Cross Hospital'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 Hospital Development Company, Number 2, 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 Holy Cross Hospital currently maintains transfer agreements, along with the facility's distance from Holy Cross Hospital:

Rush University Medical Center, Chicago (25 min./8.1 miles)

Advocate Illinois Masonic Medical Center, Chicago (35 min./14.6 miles)

International Nursing & Rehabilitation, Chicago (9 min./2.9 miles)

Referrals from Holy Cross Hospital 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, Vanguard fully intends to retain Holy Cross Hospital's clinical programmatic complement for a minimum of two years. An initial evaluation of the clinical services provided by Holy Cross Hospital would suggest that the hospital provides few, if any, clinical services not typically provided by general acute care hospitals.

Availability of Community Services

Holy Cross Hospital is a primary provider of both hospital- and community-based health care programs in its community, and it is vanguard's intent 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 Vanguard-related 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 Holy Cross Hospital, and as of the writing of this document, it is not the intent of the acquiring co-applicants to eliminate any of these programs.

- Parish Nurse Program
- Inoculations
- Senior Outreach
- Flu and H1N1 shots
- Healthy Chicago Lawn
- Southwest Organizing Project
- Greater Southwest Development Corporation
- Latino Organization of the Southwest
- New Communities Project
- National Latino Education Institute
- IDPH H1N1 Advisory Board
- Southside Health Cooperative
- Medical Home Network
- HIV Early detection program
- Haz-Mat training
- CPR education
- Nutritional training
- Kidney disease check-ups
- Smoking cessation
- Rush Research Collaboration Women's Walking Program
- FQHC support (4 sited)
- WIC
- Family Case Management
- Season's Hospice
- Metropolitan Family Services
- Southwest PADS
- 5-4-3-2-1 (healthy foods and exercise)
- NLEI medical assistant training
- Alivio Medical center classes host
- Community Leadership Training (SWOP)
- IMAN leadership training

INTER- HOSPITAL TRANSFER AGREEMENT

This Inter-Hospital Transfer Agreement is made as of March 1, 2004, by and between Holy Cross Hospital (HCH), and Advocate Illinois Masonic Medical Center (AIMMC).

WHEREAS, HCH wishes to provide emergency coronary angioplasty for patients who have presented to the Emergency Department and

WHEREAS, from time to time, such patients may require open heart surgery or other specialized cardiac intervention unavailable at HCH on an emergency basis ("Emergency Procedures"); and

WHEREAS, AIMMC provides such specialty care and desires to accept patients transferred by HCH for the emergency provision of such services.

NOW, THEREFORE, in consideration of the premises, the parties agree as follows:

1. AIMMC will accept all cardiac patients transferred by HCH to it for the performance of timely Emergency Procedures upon receipt of phone notification of such transfer by HCH.

2. HCH will be responsible for arranging any and all transportation incurred in connection with this transfer.

3. AIMMC will look solely to patients for payment for any services provided to the transferred patient and HCH is not responsible for any payment obligations related to the transferred patient.

4. There will be a timely interchange of medical and other information necessary and useful in the care of the patient. Copies of relevant medical records will be sent with the patient.

5. Neither party shall be liable for the negligent acts or omissions of the other in treatment of the patient.

HOLY CROSS HOSPITAL

By: Brian Lemon

ILLINOIS MASONIC MEDICAL CENTER

By:

ATTACHMENT 19C

PATIENT TRANSFER AGREEMENT

This Patient Transfer Agreement ("Agreement") is made and effective as of the 1 day of July, 2009 ("Effective Date") between Rush University Medical Center, an Illinois not-for-profit corporation ("Rush"), and Holy Cross Hospital, an Illinois not-for-profit corporation ("Transferring Hospital"). Transferring Hospital and Rush may from time to time be referred to herein individually as a "Party" and collectively as the "Parties".

PREAMBLE

A. Transferring Hospital operates a general acute care hospital and ancillary facilities.

B. Transferring Hospital receives, from time to time, patients who are in need of specialized critical care services that are not available at the Transferring Hospital.

C. Rush is able to provide specialized critical care to this patient population.

D. The Parties wish to provide for the transfer of patients requiring specialized critical care from the Transferring Hospital to Rush under the following terms and conditions.

The Parties agree as follows:

TERMS

Section 1: Transfer of Patients

1.1. **Acceptance of Patients.** The need for transfer of a patient to Rush shall be determined by the patient's attending physician at Transferring Hospital. When the attending physician determines that transfer is medically appropriate, the Transferring Hospital shall contact Rush regarding the need for transfer. Rush shall notify the Transferring Hospital if it can accept the patient after Rush has determined (i) it has the appropriate space, equipment and personnel to provide care to the patient; (ii) a member of Rush's medical staff has agreed to accept responsibility for the care of the patient; (iii) customary admission requirements are met and State and Federal laws and regulations are met; and (iv) the Transferring Hospital has provided sufficient information to permit Rush to determine it can provide the necessary patient care. Notwithstanding the foregoing, Rush's decision to accept a patient in need of emergency care shall not be based upon the patient's ability or inability to pay for the services to be rendered by Rush. Notice of the transfer shall be given by the Transferring Hospital as far in advance as possible.

1.2. **Appropriate Transfer.** It shall be Transferring Hospital's responsibility to arrange for appropriate and safe transportation and care of the patient during a transfer. The Transferring Hospital shall ensure that the transfer is an "appropriate transfer" under the Emergency Medical Treatment and Active Labor Act ("EMTALA"), as may be amended, and is carried out in accordance with all applicable laws and regulations. When deemed appropriate by Rush, it shall provide assistance in the transfer process and logistics through its Transfer Center.

1.3. **Transfer Log.** The Transferring Hospital shall keep an accurate and current log of all patients transferred to Rush and the disposition of such patient transfers.

1.4 **Standard of Performance.** Each Party shall 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.

1.5. **Billing and Collections.** All charges incurred with respect to any services performed by either Party for patients transferred pursuant to this Agreement shall be billed and collected by the Party providing such services directly from the patient, a thirty party payor, Medicare or Medicaid or any other sources normally billed by such Party. Neither Party shall assume any responsibility for the collection of any accounts receivable, other than those incurred as a result of rendering services directly to the patient; and neither institution shall be liable for any debts, obligations, or claims of a financial or legal nature incurred by the other institution.

1.6. **Personal Effects.** Personal effects of any transferred patient shall be delivered to the Rush transfer team or admissions department. Personal effects include money, jewelry, personal papers and articles for personal hygiene.

1.7 **Return Transfer.** In the event the Rush attending physician determines the patient no longer requires the specialized care services offered by Rush, in accord with any relevant laws, regulations and Rush policies and upon consent of the patient, the patient shall be returned to the Transferring Hospital when deemed medically stable for transfer. Transferring Hospital agrees that upon request of Rush, it will accept the patient back for continued care within its functional capability in accordance with its own admission policies and procedures. The provisions of this Section 1.7 are intended to provide for continuity of care for the patient. Both Rush and Transferring Hospital acknowledge that the patient has the right to choose to be transferred from Rush to a hospital other than Transferring Hospital, subject to the willingness of such other Hospital to accept such transfer.

1.8 **Outcome of Care**. In accordance with the Health Insurance Portability and Accountability Act (HIPAA), Rush agrees to share quality data on all patients transferred to Rush by the Transferring Hospital and those transferred back to the Transferring Hospital pursuant to Section 1.7 of this Agreement so long as the sharing of such data involves the carrying out of treatment or pertains to a designated HIPAA exception.

Section 2: Medical Records

Transferring Hospital shall provide 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 Rush can provide adequate care of such patient. Such information shall be provided by the Transferring Hospital in advance, where possible, and in any event, at the time of the transfer. The Transferring Hospital shall send a copy of all patient medical records that are available at the time of transfer to Rush. Other records shall be sent as soon as practicable after the transfer. The patient's medical record shall include a physician's order transferring the patient and evidence that the patient was transferred promptly, safely and in accordance with all applicable laws and regulations.

Section 3: Term and Termination

3.1. **Term.** The term of this Agreement shall be five (5) years from the Effective Date, unless sooner terminated as provided herein.

3.2. **Termination.** This Agreement may be terminated by either Party upon thirty (30) days prior written notice. This Agreement may be terminated if either Party is in default of any material term of this Agreement and has failed to cure such default within ten (10) days of receipt of written notice from the other Party specifying such default. Either Party may terminate this Agreement effective immediately upon the happening of any of the following:

(i) Continuation of this Agreement would endanger patient care.

(ii) A general assignment by the other Party for the benefit of creditors.

(iii) The filing of a bankruptcy petition by or against the other Party or the appointment of a receiver for any of its property;

(iv) Exclusion of either Party from participation in the Medicare or Medicaid programs.

(v) Either Party's loss or suspension of any certification, license, accreditation (including JCAHO or HFAP accreditation, as applicable), or other approval necessary to render patient care services.

Section 4: Certification and Insurance

4.1. **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 each Party to provide the services set forth in this Agreement.

4.2. **Insurance.** Each Party shall maintain during the term of this Agreement, at its sole cost and expense, general and professional liability insurance in such amounts as are reasonable and customary in the industry to guard against those risks which are customarily insured against in connection with the operation of activities of comparable scope and size. Minimum coverage levels shall be $1,000,000 per occurrence and $3,000,000 annual aggregate. Evidence of such insurance shall be provided upon request. Each Party shall notify the other Party within thirty (30) days of any material change or cancellation in any policy of insurance required to be secured or maintained by such Party.

Section 5: Liability

It is understood and agreed that neither of the Parties to this Agreement shall be liable for any negligent or wrongful act chargeable to the other unless such liability is imposed by a court of competent jurisdiction. This Agreement shall not be construed as seeking to either enlarge or diminish any obligation or duty owed by one Party against the other or against third parties. In the event of a claim for any wrongful or negligent act, each Party shall bear the cost of its own defense.

Section 6: Miscellaneous

6.1. **Non-Referral of Patients.** Neither Party is obligated to refer or transfer patients to the other and neither Party will receive any payment for any patient referred or transferred to the other Party.

6.2. **Relationship of the Parties.** The Parties enter into this Agreement as independent parties. Neither Party shall have, nor represent itself to have, any authority to bind the other Party or to act on its behalf. This Agreement does not confer any right to use any name, trade name, trademark, or other designation of either Party to this Agreement (including contraction, abbreviation or simulation of any of the foregoing) in any way without the prior written consent of the other Party.

6.3. **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:

Notices to the Transferring Hospital:
Wayne Lerner
Chief Executive Officer
Holy Cross Hospital
Executive Office
2701 W. 68th Street
Chicago, IL 60629

with a copy to:
Andrew P. Tecson, Esq.
Chuhak & Tecson, P.C.
30 South Wacker Drive, Suite 2600
Chicago, Illinois 60606

Notices to the Rush:
Norma A. Melgoza
Assistant Vice President, Hospital Operations
Rush University Medical Center
1725 W. Harrison Street, Suite 129
Chicago, IL 60612

with a copy to:
Rush University Medical Center
Office of Legal Affairs
1700 West Van Buren Street, Suite 301
Chicago, Illinois 60612-3244
Attn: General Counsel

6.4. **Assignment.** Neither Party may assign its rights or delegate its obligations under this Agreement without the prior written consent of the other.

6.5. **Entire Agreement.** This Agreement contains the entire agreement of the Parties with respect to the subject matter and may not be amended or modified except in a writing signed by both Parties.

6.6. **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.

6.7. **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.

6.8. **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.

6.9. **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.

6.10. **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.

6.11. **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.

6.12 **Non-Exclusivity:** This Agreement is non-exclusive.

6.13 **Compliance with Laws:** At all times, both Parties shall comply with all federal, state and local laws, rules and regulations including, but not limited to the Health Insurance Portability and Accountability Act of 1996.

6.14 **Exclusion:** Both Parties shall immediately notify the other Party in the event such Party becomes excluded from a government health care program.

Rush and the Transferring Hospital have executed this Agreement on the day and year first written above.

HOLY CROSS HOSPITAL

By: _____
Wayne Lerner, Chief Executive Officer

Date: 7/6/09

RUSH UNIVERSITY MEDICAL CENTER

By: _____
J. Robert Clapp, Jr.
Senior Vice President of Hospital Affairs

Date: 7/15/09

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ATTACHMENT 19C

HOLY CROSS HOSPITAL
CHICAGO, ILLINOIS

PATIENT TRANSFER AGREEMENT

This agreement is made and effective as of **December 1, 2008** between Holy Cross Hospital, a Non-profit corporation and **International Nursing & Rehabilitation**, a nursing home at **4815 S. Western Blvd., Chicago, IL**, both of which are organized and exist under the laws of the State of Illinois.

In the interests of good patient care and in securing the optimum use of the hospital and International Nursing & Rehabilitation, the parties agree as follows:

AUTONOMY

I. Each party shall have exclusive control of its management, assets and affairs. 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 to this agreement.

TRANSFER OF PATIENTS

II. When a patients need for transfer from one of the above institutions to another has been determined by the patient's physician, the institution to which the transfer is to be made agrees to admit the patient as promptly as possible. Neither Holy Cross Hospital, nor any employee will be responsible for the patient after the patient is released from the hospital.

PRIORITY OR METHOD OF SELECTION OF PATIENTS

III. All patients admitted to the hospital must be under the medical care of a member of the hospital's medical staff.

The hospital agrees to admit the patient from International Nursing & Rehabilitation as promptly as possible, depending on urgency of need.

1. Patients declared as emergencies by their physician will be admitted without delay unless physical facilities absolutely do not permit it.
2. Patients categorized as urgent will be admitted as soon as possible.
3. Elective cases will be booked and admitted according to the routine procedure of the hospital.

International Nursing and Rehabilitation agrees:

1. To admit the patient from the hospital as promptly as possible provided general admissions requirements of the institution are met.
2. To give priority to readmission of patients transferred from **International Nursing and Rehabilitation** to the hospital.

TRANSFER INFORMATION

IV. Both parties agree to send with each patient, at the time of transfer, or in case of emergency, as promptly as possible thereafter, a summary of pertinent medical and other information utilizing the **PATIENT TRANSFER FORM** and/or other medical forms.

Each party agrees to notify the other party, as far in advance as possible, of an impending transfer.

TRANSFER OF PERSONAL EFFECTS

V. A patient personal effects and valuable will ordinarily be transferred with the patient from one institution to other, under the responsibility of the patient and/or family. Each institution assumes responsibility for items placed by patients into safekeeping, and these items are released only to the patients or close relatives and only upon signing a receipt.

FINANCIAL RELATIONASHIPS

VI. Neither party shall assume any responsibility for the collection of any accounts receivable, other than those incurred as a result of rendering services directly to the patient; and neither institution shall be liable for any debts, obligations, or claims of a financial or legal nature incurred by the other institution; and each institution assumes full responsibility for its own maintenance and operation.

TERMINATION OF AGREEMENT

VII. This agreement shall be terminated by either facility upon a ninety (90) day written notice. The agreement shall be automatically terminated should either facility fail to maintain its licensure of certification as a **nursing facility** to hospital under the laws of the State of Illinois.

ADVERTISING-PUBLICITY

VIII. Neither party shall use the name of the party in any promotional or advertising material unless review and approval of the intended use shall first be obtained from the party whose name is to be used.

NON-EXCLUSIVE CLAUSE

IX. Nothing in this agreement shall be constructed as limiting the right of either party to affiliate or contract with any other hospital, or nursing facility, on either a limited or general basis, while the agreement is in effect.

MODIFICATION OF AGREEMENT

X. This agreement shall be modified or amended from time by mutual agreement of the parties, and any such modification or amendment shall be attached to and become part of this agreement.

HOLY CROSS HOSPITAL

By: _____

Date: 12/9/08

INTERNATIONAL NURSING

By: _____

Date: 12/8/08

VANGUARD
HEALTH SYSTEMS

September 8, 2010

Illinois Health Facilities
and Services Review Board

RE: Acquisition of Holy Cross Hospital
Chicago, Illinois

To Whom It May Concern:

Please be advised that, consistent with the Audited Financial Statements provided in the Applications for Permit, the acquiring applicants have sufficient funds in the form of cash and short-tern investments to address all costs associated with the acquisition of Holy Cross Hospital in Chicago, Illinois.

Sincerely,

Harold Pilgrim
SVP and Chief Operating Officer

Vanguard Health Systems 20 Burton Hills Boulevard, Suite 100 • Nashville, TN 37215 • 615.665.6000 • Fax 615.665.6099

OPERATING CAPITAL COSTS
per ADJUSTED PATIENT DAY

Holy Cross Hospital
2012

ADJUSTED PATIENT DAYS:

$$\frac{\$21,231,000}{4,760} = 4,460$$

OPERATING COSTS

salaries & benefits	$58,611,000
supplies	$26,018,685
TOTAL	$84,629,685

Operating cost/adjusted pt day:	$18,974.01

CAPITAL COSTS

interest	$418,003
depreciation & amortization	$5,850,997
	$6,269,000

Capital cost/adjusted pt day:	$1,405.51

ATTACHMENT 42D and E

After paginating the entire, completed application, indicate in the chart below, the page numbers for the attachments included as part of the project's application for permit:

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PROJECT OVERVIEW

This Project Overview, which is being provided as a supplement to the Narrative Description provided in Section I.3 of the Certificate of Need application, provides a summary of certain key features and background issues related to the proposed change of ownership of Holy Cross Hospital ("Holy Cross").

The proposed transaction will cause the sale of Holy Cross, a 272-bed general hospital located on the southwest side of Chicago, to Vanguard Health Systems, Inc. ("Vanguard"). As a result of discussions with the Archdiocese of Chicago, Holy Cross will, following the transaction's close, continue to operate as a Catholic hospital under Vanguard's ownership.

Holy Cross Hospital is the only licensed health care facility sponsored by the Sisters of St. Casimir ("the Sisters"). Holy Cross Hospital operates independently from the Sisters. Holy Cross is governed by a separate Board of Directors. Following the change of ownership, the Hospital will remain Catholic, with the Sisters providing oversight of the Hospital's Catholicity. The Archdiocese of Chicago has approved the continued Catholicity of Holy Cross, and the Sisters involvement to assure this Catholicity.

Vanguard Health Systems, Inc.

Vanguard currently owns four hospitals in the Chicago area: MacNeal Hospital ("MacNeal"), which it acquired in 2000; Louis A. Weiss Memorial Hospital ("Weiss"), which it acquired in 2002, and Westlake Hospital ("Westlake") and West Suburban Medical Center ("West Suburban"), which Vanguard acquired July 31, 2010. All four of these hospitals are known for their service and outreach to the urban communities that they are privileged to serve.

Under Vanguard's ownership, Weiss and MacNeal have demonstrated their ability to provide high-quality and accessible clinical services while enhancing health care delivery efficiencies. Under Vanguard's ownership, these hospitals pride themselves in their strong connections to the communities they serve and continue to expand their programmatic bases through innovative outreach programs. With respect to Westlake and West Suburban, intensive and detailed program evaluations at those hospitals have been underway since those transactions closed on July 31, 2010, as Vanguard similarly detailed in the Certificate of Need applications filed in connection with the sale of these to hospitals. Vanguard expects that both Westlake and West Suburban will continue to provide a high quality level of service and much-needed programs to the communities under its ownership.

Both Weiss and MacNeal have strong track records of providing Medicaid and Medicare services in volumes that are comparable with or exceed the amount of Medicaid and Medicare care provided by not-for-profit hospitals in their respective

market areas. Approximately 54% of the patients admitted to Weiss are Medicare recipients, and 23% are Medicaid recipients. Approximately 44% of the patients admitted to MacNeal are Medicare recipients, and 25% are Medicaid recipients.

Vanguard's Chicago-area hospitals have committed to a charity care policy that compares favorably to other area hospitals, whether for-profit or not-for-profit. Vanguard determines a patient's ability to qualify for charity care using a sliding scale that qualifies patients with a household income of up to 500% of the Federal Poverty Level for some level of charity care, with full write-offs provided at 200% of the Federal Poverty Level. Vanguard has committed to extending this same charity care policy to Holy Cross patients. In addition, it is Vanguard's intention to build on Holy Cross' relationships with its community as it positions the hospital for the future. Community-based services that will be reviewed include school-based health care centers; prenatal care clinics, domestic violence shelters and multi-cultural and social services.

Vanguard is currently in the process of evaluating the community-oriented services offered at Westlake and West Suburban so as to better understand the needs of its patients and how it can better partner with the community to provide value necessary services and programs to local residents. Vanguard successfully employed this same approach at MacNeal and Weiss when it acquired those hospitals in 2000 and 2002, respectively. At Weiss, for example, Vanguard came to understand the importance of providing accessible services for the older population that is served by the hospital. Similarly, at MacNeal, Vanguard sought to strengthen the hospital's ability to better service its Hispanic patients. To that end, the hospital developed a partnership with Alivio Medical Center since many of residents of MacNeal's primary service area consider Alivio their medical home. The MacNeal-Alivio collaboration has served to integrate Spanish-speaking immigrants, who are often uninsured or underinsured, into MacNeal's system of care. Vanguard plans to continue this successful strategy of evaluating community needs to implement programs at both Westlake and West Suburban as well as Holy Cross. In particular, Vanguard intends to focus on the health care needs of the burgeoning Latino population to the west of Holy Cross and the African American population to the east.

Although Vanguard is an investor-owned health system, it has chosen to operate its hospitals with a core set of values and vision that are consistent with a not-for-profit hospital model, particularly in the areas of quality of care, provision of charity care services, and the broad spectrum of services offered by Vanguard hospitals across the country.

Importantly, Vanguard has successfully acquired and operates faith-based hospitals in Illinois, Texas and Massachusetts. As a result of these collaborations, Vanguard has experience in partnering with faith-based organizations and has learned how these partnerships can enhance, rather than impede, the functioning of an efficient hospital.

Holy Cross Hospital

Holy Cross Hospital was founded by the Sisters in 1927. The Sisters act as the sponsor of the hospital, but the Sisters do not own the hospital, nor does the congregation maintain "control" over the hospital as defined by the IHFSRB's rules.

The hospital has a primary service area ("PSA") consisting of six ZIP code areas with a population of 451,000, and a secondary service area ("SSA") consisting of five additional ZIP code areas with a population of 271,000. The entire PSA/SSA is located in the City of Chicago. In 2009, 68% of the patients admitted to the hospital were African American and 11% were Latino. Only 13.7% of the patients admitted to Holy Cross were covered by private health insurance, with 76% being covered through public sector (primarily Medicaid and Medicare) programs in 2009. As compared to other hospitals, the hospital has a disproportionately low percentage (6%) of surgical patients and a disproportionately high percentage of medical patients, primarily general medicine, cardiology and pulmonary medicine.

Nearly 70% of the hospital's admissions are initiated in the hospital's Emergency Department, and the hospital accepts more EMS transports than any other hospital in Illinois—three times as many as John H. Stroger Hospital of Cook County.

In 2008, faced with imminent closure because of routinely late and inadequate Medicaid payments, Holy Cross reached out to the Illinois Department of Public Health ("IDPH") to discuss possible alternatives to closure. Following its discussion with IDPH, the hospital was permitted to suspend its obstetrical service. At the time of its OB service suspension, only 1.5 obstetricians were practicing at the hospital and a high percentage of the women who presented in labor at Holy Cross had not received any pre-natal care. At the time that Holy Cross initiated discussions with IDPH, the hospital had only five days of cash on hand and the OB service was operating at half of its break-even level. In order to stabilize this situation, Holy Cross successfully entered into relationships with area Federally Qualified Health Care Centers ("FQHCs") to strengthen the continuum of care for pregnant women served by Holy Cross Hospital. The hospital transformed its obstetrics program from one relying primarily on physicians in private practice to one that relies on the hospital's relationships with area FQHCs. Using this model, the hospital's obstetrics service was reopened in February 2010 and, since that time, a few private practice obstetricians have joined the staff of Holy Cross. The partnerships that were developed with the area FQHCs—including the relocating of one of those centers to the Holy Cross campus—convinced Holy Cross that a "partnership" approach to health care would best serve the needs of its community.

With this realization, Holy Cross looked to expand on this same partnership model to better serve its community and stabilize the hospital. That exploration inextricably led to the conclusion that the hospital would benefit from a new owner with financial resources, expertise in providing quality and accessible care with an urban setting, and a willingness to continue the hospital's Catholic mission.

Financial Considerations

Holy Cross experienced operating losses ranging from $1.9 million to $9.2 million per year from 2003 through 2005, although the hospital has operated in the black since 2006. The hospital's financial turn-around is primarily the result of four factors. First, operating expenses were reduced to what the hospital's management views as a "bare bones" minimum. Second, virtually all capital expenditures have been suspended, with capital improvements being limited to between $1 million and $3 million per year. Third, Medicaid reimbursements were increased through the intervention of elected legislative leaders who were concerned about the probable closure of the facility, although there was no long-term commitment to maintaining these increased payments. Fourth, the Sisters decided to forgive millions of dollars in loans to the hospital in recent years so that the hospital could remain open.

Holy Cross has concluded that it does not have the financial resources to address the hospital's programmatic and facility inadequacies going forward, and that the Sisters and the State of Illinois cannot be expected to provide financial lifelines to the hospital indefinitely. As a consequence, Holy Cross has determined that it must be sold so that it can continue to provide quality and accessible care to its community.

Decision to Sell

The decision to initiate the sale of Holy Cross to Vanguard was a very difficult one, made after a lengthy evaluation and discernment process by senior hospital management and the Sisters. The motivating factors for the divestiture decision were the desire to maintain a viable Catholic hospital in the community, the need to have access to capital for improvements to the facility, and the ongoing financial challenges that affect the day-to-day operations of the hospital. As part of a formal discernment process that is required by the Archdiocese of Chicago, all reasonable alternatives were evaluated with respect to the hospital's key constituencies—its community, patients, employees, and clinical leadership—as well as the hospital's overall mission. At the conclusion of the evaluation and discernment process, a determination was made that the best alternative for the community would be to sell the hospital to a health care system with sufficient financial resources to insure quality and accessible care, and one that would agree to the continued sponsorship of the Sisters.

Search for Potential Purchasers

Once it determined that the best option available was to sell the hospital, Holy Cross reached out to several not-for-profit organizations, both Catholic and non-Catholic, but was unsuccessful in attracting a potential not-for-profit buyer. Among those solicited were other community hospitals and health care systems that are located in same proximate geographic area as Holy Cross. In addition, Holy Cross also considered a potential acquisition of the hospital by the lay members of the hospital's Board of Directors.

After evaluating all available options, Vanguard emerged as a viable purchaser of the hospital, by virtue not only of its operational capabilities and financial capacity to address the hospital's capital needs, but also because of its track record in the Chicago market, its experience in the acquisition of faith-based hospitals, its willingness to commit to continuing to provide services to the hospital's urban community, its willingness to invest significant amounts of capital to improve the infrastructure of Holy Cross Hospital, and its pledge to operate Holy Cross prospectively as a Catholic hospital.

Structure of the Transaction and Key Covenants

Consistent with the asset sale agreement, Vanguard, through one or more subsidiary entities, will acquire substantially all of the assets of the Holy Cross, with the exception of any outstanding charitable bequests, grants or donations held by or for the benefit of Holy Cross. The hospital's assets, including the site, buildings and a wholly owned physician hospital organization ("PHO") are currently owned by Holy Cross.

Holy Cross employees will keep their accrued vacation and seniority levels. In addition, Vanguard has committed to maintain the hospital as an acute care hospital for five years if the hospital continues to receive Government Support Payments equal to the amount received last year, to operate the hospital as a Catholic hospital, to continue to provide Medicaid and Medicare services, and to provide no less than the same level of charity care currently provided by the hospital. In addition, Vanguard has pledged to provide $20M for improvements to the hospital's physical plant and IT systems, and to improve and replace diagnostic and treatment equipment.

Pursuant to Roman Catholic canon law, Holy Cross must also receive approval of the sale from the leaders of the Catholic Church representatives in Rome and a "no objection" determination from the Archbishop of Chicago, Cardinal George. The required approval and "no objection" determination have been received.

Holy Cross and the Sisters' paramount objective is to continue operations as a Catholic hospital. They have worked closely with Vanguard and the Archdiocese of Chicago to effectuate that goal. The Sisters will remain active at the hospital following the change of ownership, and they will be responsible for the Catholic aspects of the hospital's operation. Vanguard has had a successful experience with this type of Catholic integration as a result of its acquisition of St. Vincent's Hospital in Worcester, Massachusetts.