16-091

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, D.C. 20549

FORM 10-K

(Mark One)

☑ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the fiscal year ended June 30, 2010

OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from _____ to _____

Commission File Number: 333-71934

VANGUARD HEALTH SYSTEMS, INC.

(Exact name of registrant as specified in its charter)

Delaware	62-1698183
(State or other jurisdiction of incorporation or organization)	*(I.R.S. Employer Identification No.)*

20 Burton Hills Boulevard, Suite 100
Nashville, TN 37215
(Address and zip code of principal executive offices)

(615) 665-6000
(Registrant's telephone number, including area code)

Securities Registered Pursuant to Section 12(b) of the Act: None

Securities Registered Pursuant to Section 12(g) of the Act: None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act.
☐ Yes ☑ No

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act.
☑ Yes * ☐ No

Indicate by check mark whether the registrant (1) has filed all reports required to be filed under Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports) and (2) has been subject to such filing requirements for the past 90 days. ☐ Yes ☑ No *

* (Note: The registrant was required to file all reports under Section 13 or 15(d) of the Securities and Exchange Act of 1934

from April 1, 2010 through June 30, 2010, but as of July 1, 2010, the registrant is a voluntary filer not subject to these filing requirements. However, the registrant filed all required reports under Section 13 or 15(d) of the Securities and Exchange Act of 1934 during the preceding 12 months, which would be required to be filed if the registrant were required to file such reports.)

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of the Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files) ☐ Yes ☐ No

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of the registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendments to this Form 10-K ☑

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer or a smaller reporting company. See the definitions of "large accelerated filer", "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer ☐	Accelerated filer ☐	Non-accelerated filer ☑ (Do not check if a smaller reporting company)	Smaller reporting company ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). ☐ Yes ☑ No

There were 749,104 shares of registrant's common stock outstanding as of as of August 15, 2010 (all of which are privately owned and not traded on a public market).

Documents incorporated by reference: None

VANGUARD HEALTH SYSTEMS, INC.
ANNUAL REPORT ON FORM 10-K
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VANGUARD HEALTH SYSTEMS, INC.

CAUTIONARY STATEMENT REGARDING FORWARD-LOOKING STATEMENTS

This annual report on Form 10-K contains "forward-looking statements" within the meaning of the federal securities laws that are intended to be covered by safe harbors created thereby. Forward-looking statements are those statements that are based upon management's plans, objectives, goals, strategies, future events, future revenue or performance, capital expenditures, financing needs, plans or intentions relating to acquisitions, business trends and other information that is not historical information. These statements are based upon estimates and assumptions made by the Company's management that, although believed to be reasonable, are subject to numerous factors, risks and uncertainties that could cause actual outcomes and results to be materially different from those projected. When used in this annual report on Form 10-K, the words "estimates," "expects," "anticipates," "projects," "plans," "intends," "believes," "forecasts," "continues," or future or conditional verbs, such as "will," "should," "could" or "may," and variations of such words or similar expressions are intended to identify forward-looking statements.

These factors, risks and uncertainties include, among other things, statements relating to:

- Our high degree of leverage and interest rate risk
- Our ability to incur substantially more debt
- Operating and financial restrictions in our debt agreements
- Our ability to generate cash necessary to service our debt
- Weakened economic conditions and volatile capital markets
- Potential liability related to disclosures of relationships between physicians and our hospitals
- Post-payment claims reviews by governmental agencies could result in additional costs to us
- Our ability to successfully implement our business strategies
- Our ability to grow our business and successfully integrate our recent acquisition in Chicago, our pending acquisition of the Detroit Medical Center and other future acquisitions
- Potential acquisitions could be costly, unsuccessful or subject us to unexpected liabilities
- Conflicts of interest that may arise as a result of our control by a small number of stockholders
- The highly competitive nature of the healthcare industry
- Governmental regulation of the industry, including Medicare and Medicaid reimbursement level
- Pressures to contain costs by managed care organizations and other insurers and our ability to negotiate acceptable terms with these third party payers
- Our ability to attract and retain qualified management and healthcare professionals, including physicians and nurses
- The currently unknown effect on us of the major federal healthcare reforms enacted by Congress in March 2010 or other potential additional federal or state healthcare reforms
- Future governmental investigations
- Our failure to adequately enhance our facilities with technologically advanced equipment could adversely affect our revenues and market position
- Potential lawsuits or other claims asserted against us
- The availability of capital to fund our corporate growth strategy
- Our ability to maintain or increase patient membership and control costs of our managed healthcare plans
- Our exposure to the increased amounts of and collection risks associated with uninsured accounts and the co-pay and

deductible portions of insured accounts

- Dependence on our senior management team and local management personnel
- Volatility of professional and general liability insurance for us and the physicians who practice at our hospitals and increases in the quantity and severity of professional liability claims
- Our ability to maintain and increase patient volumes and control the costs of providing services, including salaries and benefits, supplies and bad debts
- Increased costs from further government regulation of healthcare and our failure to comply, or allegations of our failure to comply, with applicable laws and regulations

- The geographic concentration of our operations
- Technological and pharmaceutical improvements that increase the cost of providing, or reduce the demand for, healthcare services and shift demand for inpatient services to outpatient settings
- A failure of our information systems would adversely impact our ability to manage our operations
- Material non-cash charges to earnings from impairment of goodwill associated with declines in the fair market values of our reporting units
- Volatility of materials and labor costs for, or state efforts to regulate, potential construction projects that may be necessary for future growth

See "Item 1A — Risk Factors" for further discussion. We assume no obligation to update any forward-looking statements.

PART I

Item 1. Business.

Company Overview

We own and operate acute care hospitals, complementary outpatient facilities and related health plans principally located in urban and suburban markets. As of June 30, 2010 we owned 15 acute care hospitals with a total of 4,135 beds in the following four locations:

- San Antonio, Texas
- Metropolitan Phoenix, Arizona
- Metropolitan Chicago, Illinois
- Massachusetts

Historically, we have concentrated our operations in markets with high population growth, median income in excess of the national average or markets where we could grow our business by acquiring a strong, well-positioned healthcare system. Our objective is to help communities achieve health for life by delivering an ideal patient-centered experience in a highly reliable environment of care. We must continue to strengthen our financial operations to fund further investment in these communities. During the year ended June 30, 2010, we generated revenues of $3,376.9 million. During this period 75.1% of our total revenues were derived from acute care hospitals and complementary outpatient facilities.

Our general acute care hospitals offer a variety of medical and surgical services including emergency services, general surgery, internal medicine, cardiology, obstetrics, orthopedics and neurology. In addition, certain of our facilities provide on-campus and off-campus services including outpatient surgery, physical therapy, radiation therapy, diagnostic imaging and laboratory services. We also own three strategically important managed care health plans: a Medicaid managed health plan, Phoenix Health Plan ("PHP"), that served approximately 201,400 members as of June 30, 2010 in Arizona; Abrazo Advantage Health Plan ("AAHP"), a managed Medicare and dual-eligible health plan that served approximately 2,700 members as of June 30, 2010 in Arizona; and MacNeal Health Providers ("MHP") a preferred provider network that served approximately 37,100 members in metropolitan Chicago as of June 30, 2010 under capitated contracts covering only outpatient and physician services.

We are a Delaware corporation formed in July 1997. Our principal executive offices are located at 20 Burton Hills Boulevard, Suite 100, Nashville, Tennessee, 37215 and our telephone number at that address is (615) 665-6000. Our corporate website address is www.vanguardhealth.com. Information contained on our website does not constitute part of this Annual Report on Form 10-K. The terms "*we*", "our", "the Company", "us", "registrant" and "Vanguard" as used in this report refer to Vanguard Health Systems, Inc. and its subsidiaries as a consolidated entity, except where it is clear from the context that such terms mean only Vanguard Health Systems, Inc. "Subsidiaries" means direct and indirect corporate subsidiaries of Vanguard Health Systems, Inc. and partnerships, joint ventures and limited liability companies in which such subsidiaries are partners or members.

Industry Overview

Healthcare expenditures are a large and growing component of the U.S. economy, representing $2.3 trillion in 2008, or 16.2% of gross domestic product ("GDP") in 2008, according to the Center for Medicare and Medicaid Services, and are

expected to grow at 6.2% per year to $4.4 trillion, or 20.3%, of GDP, in 2018. Payments to providers of acute hospital services represented 31% of the $2.3 trillion total in 2008.

The number of individuals age 65 and older has grown 1.2% compounded annually over the past 20 years and is expected to grow 2.9% compounded annually over the next 20 years, approximately three times faster than the overall population, according to the U.S. Census Bureau. We believe that an increasing number of individuals age 65 and older will drive demand for our specialized medical services.

Hospitals receive payment for patient services from:

- the federal government, primarily under the Medicare program
- state Medicaid programs;
- health maintenance organizations, preferred provider organizations, managed Medicare providers, managed Medicaid providers and other private insurers; and
- individual patients.

Many of these payers have implemented reimbursement models influenced by hospital quality indicators and reporting. We have developed an infrastructure centered on quality initiatives that we believe will enable our facilities to meet or exceed the quality guidelines established by these payers.

The recently enacted Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, the "Health Reform Law"), will change how healthcare services are covered, delivered and reimbursed. It will do so through expanded coverage of uninsured individuals, significant reductions in the growth of Medicare program payments, material decreases in Medicare and Medicaid disproportionate share hospital ("DSH") payments, and the establishment of programs where reimbursement is tied in part to quality and integration. The Health Reform Law is expected to expand health insurance coverage to approximately 32 to 34 million additional individuals through a combination of public program expansion and private sector health insurance reforms. We believe the expansion of private sector and Medicaid coverage will, over time, increase our reimbursement related to providing services to individuals who were previously uninsured. On the other hand, the reductions in the growth in Medicare payments and the decreases in DSH payments will adversely affect our government reimbursement. Because of the many variables involved, we are unable to predict the net impact of the Health Reform Law on us; however, we believe our experienced management team, emphasis on quality care and our diverse service offerings will enable us to capitalize on the opportunities presented by the Health Reform Law, as well as adapt in a timely manner to its challenges. See "Item IA. Risk Factors — Risks Related to Our Business and Structure — We are unable to predict the impact of the Health Reform Law, which represents significant change to the healthcare industry" included elsewhere in this report.

Recent Acquisition Activity

On June 10, 2010, we entered into a definitive agreement to purchase the Detroit Medical Center ("DMC"), which owns and operates eight hospitals in and around Detroit, Michigan with 1,734 licensed beds, including Children's Hospital of Michigan, Detroit Receiving Hospital, Harper University Hospital, Huron Valley-Sinai Hospital, Hutzel Women's Hospital, Rehabilitation Institute of Michigan, Sinai-Grace Hospital and DMC Surgery Hospital. The DMC acquisition provides us an opportunity to acquire a leading hospital system in a major metropolitan area in terms of both market position and clinical quality.

Under the purchase agreement, we will acquire all of DMC's assets (other than donor restricted assets and certain other assets) and assume all of its liabilities (other than its outstanding bonds and notes and certain other liabilities) for $417.0 million in cash, which will be used to repay all of such non-assumed debt. The $417.0 million cash payment represents our full cash funding obligations to DMC in order to close the transaction, except for our assumption or payment of DMC's usual and customary transaction expenses. The assumed liabilities include a pension liability under a "frozen" defined benefit pension plan of DMC estimated at $184 million as of December 31, 2009 that we anticipate we will fund over seven years based upon actuarial assumptions and estimates, as adjusted periodically by actuaries. We will also commit to spend $500.0 million in capital expenditures in the DMC facilities during the five years subsequent to closing of the transaction, which amount relates to a specific project list agreed to between the DMC board of representatives and us. In addition, we will commit to spend $350.0 million during this five-year period relating to the routine capital needs of the DMC facilities. The acquisition is pending review and approval by the Michigan Attorney General. If such approval is obtained, we expect to close the transaction during our second quarter of fiscal year 2011.

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Under the purchase agreement, we will acquire all of DMC's assets (other than donor restricted assets and certain other assets) and assume all of its liabilities (other than its outstanding bonds and notes and certain other liabilities) for $417.0 million in cash, which will be used to repay all of such non-assumed debt. The $417.0 million cash payment represents our full cash funding obligations to DMC in order to close the transaction, except for our assumption or payment of DMC's usual and customary transaction expenses. The assumed liabilities include a pension liability under a "frozen" defined benefit pension plan of DMC estimated at $184 million as of December 31, 2009 that we anticipate we will fund over seven years based upon actuarial assumptions and estimates, as adjusted periodically by actuaries. We will also commit to spend $500.0 million in capital expenditures in the DMC facilities during the five years subsequent to closing of the transaction, which amount relates to a specific project list agreed to between the DMC board of representatives and us. In addition, we will commit to spend $350.0 million during this five-year period relating to the routine capital needs of the DMC facilities. The acquisition is pending review and approval by the Michigan Attorney General. If such approval is obtained, we expect to close the transaction during our second quarter of fiscal year 2011.

During August 2010, we entered into definitive agreements to purchase certain assets and assume certain liabilities of the Arizona Heart Hospital and of the Arizona Heart Institute both located in Phoenix, Arizona. We expect these acquisitions to provide us a base upon which to expand our cardiology service offerings in the metropolitan Phoenix market. We expect both of these acquisitions to close during the second quarter of fiscal 2011. However, the Arizona Health Institute acquisition could be delayed since that entity recently made a voluntary filing with the U.S. Bankruptcy Court for the District of Arizona under Chapter 11 of the Bankruptcy Code for a reorganization of its business and the sale of its assets is now subject to the prior approval of such court.

On August 1, 2010, we completed the purchase of Westlake Hospital and West Suburban Medical Center in the western suburbs of Chicago, Illinois from Resurrection Health Care. Westlake Hospital is a 225-bed acute care facility located in Melrose Park, Illinois, and West Suburban Medical Center is a 234-bed acute care facility located in Oak Park, Illinois. Both of these facilities are located less than 10 miles from our MacNeal Hospital and will enable us to achieve a market presence in the western suburban area of Chicago. As part of the purchase, we acquired substantially all of the assets (other than cash on hand) and assumed certain liabilities of these hospitals for a total cash purchase price of approximately $45.0 million.

The Merger

On July 23, 2004, Vanguard executed an agreement and plan of merger with VHS Holdings LLC ("Holdings") and Health Systems Acquisition Corp., a newly formed Delaware corporation ("Acquisition Corp."), pursuant to which on September 23, 2004 Acquisition Corp. merged with and into Vanguard, with Vanguard being the surviving corporation (the "Merger"). In the Merger, holders of the outstanding Vanguard capital stock, options to acquire Vanguard common stock and other securities convertible into Vanguard common stock received aggregate consideration of approximately $1,248.6 million.

The Blackstone Group, together with its affiliates (collectively, "Blackstone"), funded the Merger in part by subscribing for and purchasing approximately $494.9 million aggregate amount of (1) Class A membership units in Holdings and (2) common stock of Acquisition Corp. (merged with and into Vanguard), in an amount equal to $125.0 million of such common stock. In addition, Morgan Stanley Capital Partners, together with its affiliates (collectively, "MSCP"), subscribed for and purchased Class A membership units in Holdings by contributing to Holdings a number of shares of Vanguard common stock equal to (1) $130.0 million divided by (2) the per share consideration payable for each share of Vanguard common stock in connection with the Merger. Certain senior members of management and certain other stockholders of Vanguard (the "Rollover Management Investors") subscribed for and purchased Class A membership units in Holdings, having an aggregate purchase price of approximately $119.1 million, by (a) paying cash using the proceeds of consideration received in connection with the Merger and/or (b) contributing shares of Vanguard common stock in the same manner as MSCP. Baptist Health Services ("Baptist"), the former owner of our division, Baptist Health System of San Antonio, also purchased $5.0 million of Class A membership units in Holdings. Immediately after completion of the Merger in September 2004, Blackstone, MSCP (together with Baptist) and the Rollover Management Investors held approximately 66.1%, 18.0% and 15.9%, respectively, of the common equity of Vanguard (most of which is indirectly held through the ownership of the Class A membership units in Holdings). Certain members of senior management also purchased $5.7 million of the equity incentive units in Holdings.

Our Mission and Business Strategies

Our mission is to help communities achieve health for life. We expect to change the way healthcare is delivered in our communities through our corporate and regional business strategies. We have established a corporate values framework that includes safety, excellence, respect, integrity and accountability to support both our mission and the corporate and regional business strategies that will define our future success. Some of the more key elements of our business strategy are outlined below.

- Delivery of an ideal patient-centered experience — we expect each of our facilities to create a highly reliable environment of care, and we have focused particularly on our company-wide patient safety model, our comprehensive patient satisfaction program, opening lines of communication between our nurses and physicians and implementing clinical quality best practices across our hospitals to provide the most timely, coordinated and compassionate care to our patients.

- Nurse leadership initiatives — we realize that our nursing workforce is our most valuable tool in improving the health of our patients and have developed and partially implemented our nursing professional practice model, which incorporates leadership, clinical practice, professional development and interdisciplinary collaboration to foster nursing practice that is evidence-based, innovative and patient-focused.

- Physician collaboration and alignment — we have implemented an employed hospitalist program, physician leadership councils, information technology upgrades and medical officer leadership initiatives to foster our clinical integration roadmap that seeks to align the goals of the physicians who practice in our hospitals to the goals set forth in our nursing professional practice model while respecting physician care decisions and methods of practice.

- Promoting care efficiencies — we continue to identify better ways to deliver services that are in demand in the communities we serve and have launched multiple initiatives including electronic intensive care units and company-wide standardization projects for our emergency and operating room departments in order to ensure that the appropriate levels of care are available for our patients and are provided in the most efficient manner.

- Strengthening our financial operations to fund continuing community investment — we expect to combine a population health strategy with a complex clinical program strategy to transform our care delivery processes and adapt to upcoming changes in reimbursement from a fee for service basis to a fee for episode basis in order to produce financial returns that will enable us to continue to upgrade services and facilities that are vital to the communities we serve.

The Markets We Serve

San Antonio, Texas

In the San Antonio market, as of June 30, 2010, we owned and operated 5 hospitals with a total of 1,741 licensed beds and related outpatient service locations complementary to the hospitals. We acquired these hospitals in January 2003 from the non-profit Baptist Health Services (formerly known as Baptist Health System) and continue to operate the hospitals as the Baptist Health System. The acquisition followed our strategy of acquiring a significant market share in a growing market, San Antonio, Texas. Our facilities primarily serve the residents of Bexar County which encompasses most of the metropolitan San Antonio area.

During fiscal 2010, we entered into a $56.4 million agreement for the construction of a replacement facility for our Southeast Baptist Hospital in San Antonio. We expect to spend a total of $86.2 million, including costs to equip, to complete the project and expect the new facility to open in the summer of 2011. We expect that this state of the art replacement facility will enable us to recruit more quality physicians and provide a greater variety of services than our previous facility in this community.

We continue to recognize opportunities to improve efficiencies in these hospitals including emergency room throughput, operating room upgrades and further electronic intensive care monitoring development. We also intend to expand our cardiology, vascular and trauma services in certain of these hospitals during fiscal 2011 either through additional investment in capital and physician resources or strategic partnerships.

During the years ended June 30, 2008, 2009 and 2010, we generated approximately 32.1%, 29.6% and 26.8% of our total revenues, respectively, in this market. We have invested approximately $542.0 million of capital in this market since we purchased these hospitals.

Metropolitan Phoenix, Arizona

In the Phoenix market, as of June 30, 2010, we owned and operated 5 hospitals with a total of 988 licensed beds and related outpatient service locations complementary to the hospitals, a prepaid Medicaid managed health plan, Phoenix Health Plan ("PHP"), and a managed Medicare and dual-eligible health plan, Abrazo Advantage Health Plan ("AAHP"). Phoenix is the fifth largest city in the U.S. and has been one of the fastest growing major metropolitan areas during the past ten years. Our facilities primarily serve the residents of Maricopa County, which encompasses most of the metropolitan Phoenix area.

During the years ended June 30, 2008, 2009 and 2010, exclusive of PHP and AAHP, we generated approximately 18.8%, 17.9% and 17.5% of our total revenues, respectively, in this market. Three of our hospitals in this market were formerly not-for-profit hospitals. We believe that payers will choose to contract with us in order to give their enrollees a comprehensive choice of providers in the western and northern Phoenix areas. Recently, we have negotiated improvements in our payer rates at our Phoenix hospitals generally, and Arizona's state Medicaid program remains a comprehensive provider of healthcare coverage to low income individuals and families. We believe our network strategy will enable us to continue to effectively negotiate with managed care payers and to build upon our network's comprehensive range of integrated services.

We expect to introduce a more efficient mix of service offerings between the various Arizona hospitals including general surgery and cardiology services. We also plan to expand select services at certain of these facilities including neurology, oncology, endovascular and trauma services. Further expansion of primary care locations or emergency care facilities in the communities surrounding our hospitals should improve volumes, while continued development of our hospitalist programs in these hospitals should improve quality of care.

Metropolitan Chicago, Illinois

In the Chicago metropolitan area, as of June 30, 2010, we owned and operated 2 hospitals with 766 licensed beds, and related outpatient service locations complementary to the hospitals. Weiss Hospital is operated by us in a consolidated joint venture corporation in which we own 80.1% and the University of Chicago Hospitals owns 19.9% of the equity interests. During the years ended June 30, 2008, 2009 and 2010, we generated approximately 14.9%, 14.6% and 14.1%, respectively, of our total revenues in this market.

We chose MacNeal Hospital and Weiss Hospital, both former not-for-profit facilities, as our first two entries into the largely not-for-profit metropolitan Chicago area. Both MacNeal and Weiss Hospitals are large, well-equipped, university-affiliated hospitals with strong reputations and medical staffs. MacNeal offers tertiary services such as open heart surgery that patients would otherwise have to travel outside the local community to receive. Both hospitals partner with various medical schools, the most significant being the University of Chicago Medical School and the University of Illinois Medical School, to provide medical training through residency programs in multiple specialties. In addition, MacNeal Hospital runs a successful free-standing program in family practice, one of the oldest such programs in the state of Illinois, and Weiss Hospital also runs a successful free-standing residency program in internal medicine. Our medical education programs help us to attract quality physicians to both the hospitals and our network of primary care and occupational medicine centers. We intend to further develop and strengthen our cardiovascular, orthopedics and oncology services at these hospitals. We expect to realize efficiencies by combining MacNeal Hospital into a health network with our newly acquired Westlake Hospital and West Suburban Medical Center. This network strategy will enable us to coordinate service levels among the hospitals to meet the needs of this community and to provide those services in a more efficient setting.

Massachusetts

In Massachusetts, as of June 30, 2010, we owned and operated 3 hospitals with a total of 640 licensed beds and related healthcare services complementary to the hospitals. These hospitals include Saint Vincent Hospital located in Worcester and MetroWest Medical Center, a two-campus hospital system comprised of Framingham Union Hospital in Framingham and Leonard Morse Hospital in Natick. These hospitals were acquired by us on December 31, 2004. We believe that opportunities for growth through increased market share exist in the Massachusetts area through the possible addition of new services, partnerships and the implementation of a strong primary care physician strategy. During the years ended June 30, 2008, 2009 and 2010, the Massachusetts facilities represented 19.7%, 18.3% and 18.2% of our total revenues, respectively.

Saint Vincent Hospital, located in Worcester, is a 321-bed teaching hospital with an extensive residency program. Worcester is located in central Massachusetts and is the second largest city in Massachusetts. The service area is characterized by a patient base that is older, more affluent and well-insured. Saint Vincent Hospital is focused on strengthening its payer relationships, developing its primary care physician base and expanding its offerings primarily in cancer care and geriatrics.

MetroWest Medical Center's two campus system has a combined total of 319 licensed beds with locations in Framingham and Natick, in the suburbs west of Boston. These facilities serve communities that are generally well-insured. We are seeking to develop strong ambulatory care capabilities in these service areas, as well as to expand our orthopedics and radiation oncology services and advance the research capabilities of these hospitals.

Our Facilities

We owned and operated 15 acute care hospitals as of June 30, 2010. The following table contains information concerning our hospitals:

Hospital	City	Licensed Beds	Date Acquired
Texas			
Baptist Medical Center	San Antonio	636	January 1, 2003
Northeast Baptist Hospital	San Antonio	367	January 1, 2003
North Central Baptist Hospital	San Antonio	268	January 1, 2003
Southeast Baptist Hospital	San Antonio	175	January 1, 2003
St. Luke's Baptist Hospital	San Antonio	295	January 1, 2003
Arizona			
Maryvale Hospital	Phoenix	232	June 1, 1998
Arrowhead Hospital	Glendale	220	June 1, 2000
Phoenix Baptist Hospital	Phoenix	236	June 1, 2000
Paradise Valley Hospital	Phoenix	136	November 1, 2001
West Valley Hospital (1)	Goodyear	164	September 4, 2003
Illinois			
MacNeal Hospital	Berwyn	427	February 1, 2000
Louis A. Weiss Memorial Hospital (2)	Chicago	339	June 1, 2002
Massachusetts			
MetroWest Medical Center — Leonard Morse Hospital	Natick	141	December 31, 2004
MetroWest Medical Center — Framingham Union Hospital	Framingham	178	December 31, 2004
Saint Vincent Hopsital at Worcester Medical Center	Worcester	321	December 31, 2004
Total Licensed Beds		4,135	

(1) This hospital was constructed, not acquired.

(2) This hospital is operated by us in a consolidated joint venture corporation in which we own 80.1% of the equity interests and the University of Chicago Hospitals owns 19.9% of the equity interests.

In addition to the hospitals listed in the table above, as of June 30, 2010, we owned certain outpatient service locations complementary to the hospitals, as well as two surgery centers in Orange County, California. We also own and operate a limited number of medical office buildings in conjunction with our hospitals which are primarily occupied by physicians practicing at our hospitals.

Our Hospital Operations

Acute Care Services

Our hospitals typically provide the full range of services commonly available in acute care hospitals, such as internal medicine, general surgery, cardiology, oncology, neurosurgery, orthopedics, obstetrics, diagnostic and emergency services, as well as select tertiary services such as open-heart surgery and level II and III neonatal intensive care at certain facilities. Our hospitals also generally provide outpatient and ancillary healthcare services such as outpatient surgery, laboratory, radiology, respiratory therapy and physical therapy. We also provide outpatient services at our imaging centers and ambulatory surgery centers. Certain of our hospitals have a limited number of psychiatric, skilled nursing and rehabilitation beds.

Management and Oversight

Our senior management team has extensive experience in operating multi-facility hospital networks and plays a vital role in the strategic planning for our facilities. A hospital's local management team is generally comprised of a chief executive officer, chief operating officer, chief financial officer and chief nursing officer. Local management teams, in consultation with our corporate staff, develop annual operating plans setting forth quality and patient satisfaction improvement initiatives, revenue growth strategies through the expansion of offered services and the recruitment of physicians in each community and plans to improve operating efficiencies and reduce costs. We believe that the ability of each local management team to identify and meet the needs of our patients, medical staffs and the community as a whole is critical to the success of our hospitals. We base the compensation for each local management team in part on its ability to achieve the goals set forth in the annual operating plan, including quality of care, patient satisfaction and financial measures.

Boards of trustees at each hospital, consisting of local community leaders, members of the medical staff and the hospital chief executive officer, advise the local management teams. Members of each board of trustees are identified and recommended by our local management teams and serve three-year staggered terms. The boards of trustees establish policies concerning medical, professional and ethical practices, monitor these practices and ensure that they conform to our high standards. We have formed Physician Advisory Councils at each of our hospitals that focus on quality of care, clinical integration and other issues important to physicians and make recommendations to the boards of trustees as necessary. We maintain company-wide compliance and quality assurance programs and use patient care evaluations and other assessment methods to support and monitor quality of care standards and to meet accreditation and regulatory requirements.

We also provide support to the local management teams through our corporate resources in areas such as revenue cycle, business office, legal, managed care, clinical efficiency, physician services and other administrative functions. These resources also allow for sharing best practices and standardization of policies and processes among all of our hospitals.

Attracting Patients

We believe that there are three key elements to attracting patients and retaining their loyalty. The first is the hospital's reputation in the market, driven by a combination of factors including awareness of services, perception of quality, past delivery of care and profile in mass media. The second is direct patient experience and the willingness of past patients and their families to promote the hospital and to return to the hospital as new needs arise. The third element in attracting patients is through market intermediaries who control or recommend use of hospitals, outpatient facilities, ancillary service and specialist physicians. These intermediaries include employers, social service agencies, insurance companies, managed care providers, attorneys and referring physicians.

Our marketing efforts are geared to managing each of those three elements positively. Media relations, marketing communications, web-based platforms and targeted market research are designed to enhance the reputation of our hospitals, improve awareness of the scope of services and build preference for use of our facilities and services. Our recruitment and retention efforts are designed to build a staff who delivers safety, quality, customer satisfaction and efficiency. The quality of the physician and nursing staff are key drivers of positive perception. Our capital investment strategies are also designed to improve our attractiveness to patients. Clean, modern, well equipped and conveniently located facilities are similarly key perceptual drivers.

Our focus on improving customer satisfaction is designed to help us create committed users who will promote our reputation. Our goal in providing care is to offer the best possible outcome with the greatest patient satisfaction. We employ tools of customer relationship management to better inform our patients of services they or their families may need and to provide timely reminders and aids in promoting and protecting their health. We also strive to understand and deliver care from the patient's perspective by including patients and their families in the design of our services and facilities.

In each of our markets we are developing closer relationships with major employers and learning more about their needs and how we might best help them improve productivity and reduce health care costs, absenteeism and workers compensation claims. Our hospitals work closely with social agencies and especially federally qualified health centers to provide appropriate care and follow-up for medically indigent patients. Our managed care teams work closely with insurers to develop high quality, cost efficient programs to improve outcomes. We maintain active relationships with more than 200 physicians in each market to better understand how to serve them and their patients, how to provide well-coordinated care and how to best engage them in collaborative care models built around electronic medical records and collectively developed care protocols. Through these efforts we hope to position ourselves as a trusted partner to these market intermediaries.

Outpatient Services

The healthcare industry has experienced a general shift during recent years from inpatient services to outpatient services as Medicare, Medicaid and managed care payers have sought to reduce costs by shifting lower-acuity cases to an outpatient setting.

Advances in medical equipment technology and pharmacology have supported the shift to outpatient utilization, which has resulted in an increase in the acuity of inpatient admissions. However, we expect inpatient admissions to recover over the long-term as the baby boomer population reaches ages where inpatient admissions become more prevalent. We have responded to the shift to outpatient services through expanding service offerings and increasing the throughput and convenience of our emergency departments, outpatient surgery facilities and other ancillary units in our hospitals. We also own two ambulatory surgery centers in Orange County, California, various primary care centers in each of our markets and interests in diagnostic imaging centers in San Antonio, Texas. We continually look to add improved resources to our facilities including new relationships with quality primary care and specialty physicians, maintaining a first class nursing staff and utilizing technologically advanced equipment, all of which we believe are critical to be the provider of choice for baby boomers. We have focused on core services including cardiology, neurology, oncology, orthopedics and women's services. We also operate sub-acute units such as rehabilitation, skilled nursing facilities and psychiatric services, where appropriate, to meet the needs of our patients while increasing volumes and increasing care management efficiencies.

Operating Statistics

The following table sets forth certain operating statistics from continuing operations for the periods indicated. Acute care hospital operations are subject to fluctuations due to seasonal cycles of illness and weather, including increased patient utilization during the cold weather months and decreases during holiday periods.

	Year ended June 30,				
	2006	2007	2008	2009	2010
Number of hospitals at end of period (a)	15	15	15	15	15
Number of licensed beds at end of period (a)	3,937	4,143	4,181	4,135	4,135
Discharges (a)	162,446	166,873	169,668	167,880	168,370
Adjusted discharges (a)	274,451	277,231	283,250	288,807	295,702
Net revenue per adjusted discharge (a)(b)	$ 7,230	$ 7,674	$ 8,047	$ 8,503	$ 8,408
Average length of stay (days) (a)	4.32	4.33	4.33	4.23	4.17
Total surgeries (a)	113,043	113,833	110,877	114,348	113,289
Emergency room visits (a)	554,250	572,946	588,246	605,729	626,237
Member lives (a)	146,200	145,600	149,600	218,700	241,200

(a) The definitions for these operating statistics are set forth in "Item 6 — Selected Financial Data" included elsewhere in this Report.

(b) Net revenue per adjusted discharge for the year ended June 30, 2010 would have been $8,764 absent the policy changes for uninsured discounts and Medicaid pending in our Illinois hospitals on April 1, 2009 and our Phoenix and San Antonio hospitals on July 1, 2009. Net revenue per adjusted discharge was substantially the same for the year ended June 30, 2009 absent the policy changes for uninsured discounts.

Our Health Plan Operations

Phoenix Health Plan

In addition to our hospital operations, we own three health plans. PHP is a prepaid Medicaid managed health plan that currently serves nine counties throughout the state of Arizona. We acquired PHP in May 2001. We are able to enroll eligible patients in our hospitals into PHP or other approved Medicaid managed health plans who otherwise would not be able to pay for their hospital expenses. We believe the volume of patients generated through our health plans will help attract quality physicians to the communities our hospitals serve.

For the year ended June 30, 2010, we derived approximately $745.2 million of our total revenues from PHP. PHP had approximately 201,400 members as of June 30, 2010, and derives substantially all of its revenues through a contract with the Arizona Health Care Cost Containment System ("AHCCCS"), which is Arizona's state Medicaid program. The contract requires PHP to arrange for healthcare services for enrolled Medicaid patients in exchange for monthly capitation payments and supplemental payments from AHCCCS. PHP subcontracts with physicians, hospitals and other healthcare providers to provide services to its members. These services are provided regardless of the actual costs incurred to provide these services. We receive reinsurance and other supplemental payments from AHCCCS to cover certain costs of healthcare services that exceed certain thresholds.

As part of its contract with AHCCCS, PHP is required to maintain a performance guarantee in the amount of $50.0 million. Vanguard maintains this performance guarantee on behalf of PHP in the form of surety bonds totaling $50.0 million with independent third party insurers that expire on October 1, 2010. We were also required to arrange for $5.0 million in letters of credit to collateralize our $50.0 million in surety bonds with the third party insurers. The amount of the performance guaranty that AHCCCS requires is based upon the membership in the health plan and the related capitation amounts paid to us.

Our current contract with AHCCCS commenced on October 1, 2008 and covers members in nine Arizona counties: Apache, Conconino, Gila, Maricopa, Mohave, Navajo, Pima, Pinal and Yavapai. This contract covers the three-year period beginning October 1, 2008 and ending September 30, 2011. Our previous contract with AHCCCS covered only Gila, Maricopa and Pinal counties. AHCCCS has the option to renew the new contract, in whole or in part, for two additional one-year periods commencing on October 1, 2011 and on October 1, 2012.

Abrazo Advantage Health Plan

Effective January 1, 2006, AAHP became a Medicare Advantage Prescription Drug Special Needs Plan provider under a contract with CMS that renews annually. This allows AAHP to offer Medicare and Part D drug benefit coverage for Medicare members and dual-eligible members (those that are eligible for Medicare and Medicaid). PHP had historically served dual-eligible members through its AHCCCS contract. As of June 30, 2010, approximately 2,700 members were enrolled in AAHP, most of whom were previously enrolled in PHP. For the year ended June 30, 2010, we derived approximately $34.6 million of our total revenues from AAHP. AAHP's current contract with CMS expires on December 31, 2010.

MacNeal Health Providers

The operations of MHP are somewhat integrated with our MacNeal Hospital in Berwyn, Illinois. For the year ended June 30, 2010, we derived approximately $59.9 million of our total revenues from MHP. MHP generates revenues from its contracts with health maintenance organizations from whom it took assignment of capitated member lives as well as third party administration services for other providers. As of June 30, 2010, MHP had contracts in effect covering approximately 37,100 capitated member lives. Such capitation is limited to physician services and outpatient ancillary services and does not cover inpatient hospital services. We try to utilize MacNeal Hospital and its medical staff as much as possible for the physician and outpatient ancillary services that are required by such capitation arrangements. Revenues of MHP are dependent upon health maintenance organizations in the metropolitan Chicago area continuing to assign capitated-member lives to health plans like MHP as opposed to entering into direct fee-for-service arrangements with healthcare providers.

Competition

The hospital industry is highly competitive. We currently face competition from established, not-for-profit healthcare systems, investor-owned hospital companies, large tertiary care hospitals, specialty hospitals and outpatient service providers. In the future, we expect to encounter increased competition from companies, like ours, that consolidate hospitals and healthcare companies in specific geographic markets. Continued consolidation in the healthcare industry will be a leading factor contributing to increased competition in our current markets and markets we may enter in the future. Due to the shift to outpatient care and more stringent payer-imposed pre-authorization requirements during the past few years, most hospitals have significant unused capacity resulting in increased competition for patients. Many of our competitors are larger than us and have more financial resources available than we do. Other not-for-profit competitors have endowment and charitable contribution resources available to them and can purchase equipment and other assets on a tax-free basis.

One of the most important factors in the competitive position of a hospital is its location, including its geographic coverage and access to patients. A location convenient to a large population of potential patients or a wide geographic coverage area through hospital networks can make a hospital significantly more competitive. Another important factor is the scope and quality of services a hospital offers, whether at a single facility or a network of facilities, compared to the services offered by its competitors. A hospital or network of hospitals that offers a broad range of services and has a strong local market presence is more likely to obtain favorable managed care contracts. We intend to evaluate changing circumstances in the geographic areas in which we operate on an ongoing basis to ensure that we offer the services and have the access to patients necessary to compete in these managed care markets and, as appropriate, to form our own, or join with others to form, local hospital networks.

A hospital's competitive position also depends in large measure on the quality and specialties of physicians associated with the hospital. Physicians refer patients to a hospital primarily on the basis of the quality and breadth of services provided by the hospital, the quality of the nursing staff and other professionals affiliated with the hospital, the hospital's location and the availability of modern equipment and facilities. Although physicians may terminate their affiliation with our hospitals, we seek to retain physicians of varied specialties on our medical staffs and to recruit other qualified physicians by maintaining or expanding our level of services and providing quality facilities, equipment and nursing care for our patients.

Another major factor in the competitive position of a hospital is the ability of its management to obtain contracts with managed care plans and other group payers. The importance of obtaining managed care contracts has increased in recent years due primarily to consolidations of health plans. Our markets have experienced significant managed care penetration. The revenues and operating results of our hospitals are significantly affected by our hospitals' ability to negotiate favorable contracts with managed care plans. Health maintenance organizations and preferred provider organizations use managed care contracts to encourage patients to use certain hospitals in exchange for discounts from the hospitals' established charges. Traditional health insurers and large employers also are interested in containing costs through similar contracts with hospitals.

The hospital industry and our hospitals continue to have significant unused capacity. Inpatient utilization, average lengths of stay and average occupancy rates have historically been negatively affected by payer-required pre-admission authorization, utilization review and payer pressure to maximize outpatient and alternative healthcare delivery services for less acutely ill patients. Admissions constraints, payer pressures and increased competition are expected to continue. We expect to meet these challenges first and foremost by our continued focus on our previously discussed quality of care initiatives, which should increase patient, nursing and physician satisfaction. We also may expand our outpatient facilities, strengthen our managed care relationships, upgrade facilities and equipment and offer new or expanded programs and services.

Employees and Medical Staff

As of June 30, 2010, we had approximately 20,100 employees, including approximately 2,100 part-time employees. Approximately 1,600 of our full-time employees at our three Massachusetts hospitals are unionized. Overall, we consider our employee relations to be good. While some of our non-unionized hospitals experience union organizing activity from time to time, we do not currently expect these efforts to materially affect our future operations. Our hospitals, like most hospitals, have experienced labor costs rising faster than the general inflation rate.

While the national nursing shortage has abated somewhat as a result of the weakended U.S. economy, certain pockets of the markets we serve continue to have limited available nursing resources. Nursing shortages often result in our using more contract labor resources to meet increased demand especially during the peak winter months. We expect our nurse leadership and recruiting initiatives to mitigate the impact of the nursing shortage. These initiatives include more involvement with nursing schools, participation in more job fairs, recruiting nurses from abroad, implementing preceptor programs, providing flexible work hours, improving performance leadership training, creating awareness of our quality of care and patient safety initiatives and providing competitive pay and benefits. We anticipate that demand for nurses will continue to exceed supply especially as the baby boomer population reaches the ages where inpatient stays become more frequent. We continue to implement best practices to reduce turnover and to stabilize our nursing workforce over time.

During fiscal year 2010, we achieved the 72nd percentile for employee engagement within the Gallup Organization Healthcare Employee Engagement Database. This result reflects continued improvement since we began monitoring employee engagement during fiscal year 2008, our baseline year. We believe our efforts to improve employee engagement will have a positive impact on nursing turnover thereby reducing operating costs and ultimately leading to higher patient satisfaction with the services we provide.

One of our primary nurse recruiting strategies for our San Antonio hospitals is our continued investment in the Baptist Health System School of Health Professions ("SHP"), our nursing school in San Antonio. SHP offers seven different healthcare educational programs with its greatest enrollment in the professional nursing program. SHP expects to enroll approximately 550 students for its Fall 2010 semester. The majority of SHP graduates have historically chosen permanent employment with our hospitals. We have changed SHP's nursing program from a diploma program to a degree program and may improve other SHP programs in future periods. We completed the necessary steps during fiscal 2009 to make SHP students eligible for participation in the Pell Grant and other federal grant and loan programs. Approximately 54% of SHP students receive some form of federal financial aid. These enhancements are factors in the increased SHP enrollment and has made SHP more attractive to potential students.

Our hospitals grant staff privileges to licensed physicians who may serve on the medical staffs of multiple hospitals, including hospitals not owned by us. A physician who is not an employee can terminate his or her affiliation with our hospital at any time. Although we employ a growing number of physicians, a physician does not have to be our employee to be a member of the medical staff of one of our hospitals. Any licensed physician may apply to be admitted to the medical staff of any of our hospitals, but admission to the staff must be approved by each hospital's medical staff and board of trustees in accordance with established credentialing criteria. Under state laws and other licensing standards, hospital medical staffs are generally self-governing organizations subject to ultimate oversight by the hospital's local governing board. Although we were generally successful in our physician recruiting efforts during fiscal 2010, we face continued challenges in some of our markets to recruit certain types of physician specialists who are in high demand. We expect that our previously described physician recruiting and alignment initiatives will make our hospitals more desirable environments in which more physicians will choose to practice.

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Compliance Program

We voluntarily maintain a company-wide compliance program designed to ensure that we maintain high standards of ethics and conduct in the operation of our business and implement policies and procedures so that all our employees act in compliance with all applicable laws, regulations and company policies. The organizational structure of our compliance program includes oversight by our board of directors and a high-level corporate management compliance committee. The board of directors and compliance committee are responsible for ensuring that the compliance program meets its stated goals and remains up-to-date to address the current regulatory environment and other issues affecting the healthcare industry. Our Senior Vice President of Compliance and Ethics reports jointly to our Chairman and Chief Executive Officer and to our board of directors, serves as our Chief Compliance Officer and is charged with direct responsibility for the day-to-day management of our compliance program. Other features of our compliance program include Regional Compliance Officers who report to our Chief Compliance Officer in all four of our operating regions, initial and periodic ethics and compliance training and effectiveness reviews, a toll-free hotline for employees to report, without fear of retaliation, any suspected legal or ethical violations, annual "fraud and abuse" audits to examine all of our payments to physicians and other referral sources and annual "coding audits" to make sure our hospitals bill the proper service codes for reimbursement from the Medicare program.

Our compliance program also oversees the implementation and monitoring of the standards set forth by the Health Insurance Portability and Accountability Act ("HIPAA") for privacy and security. To facilitate reporting of potential HIPAA compliance concerns by patients, family or employees, we established a second toll-free hotline dedicated to HIPAA and other privacy matters. Corporate HIPAA compliance staff monitors all reports to the privacy hotline and each phone call is responded to appropriately. Ongoing HIPAA compliance also includes self-monitoring of HIPAA policy and procedure implementation by each of our healthcare facilities and corporate compliance oversight.

Our Information Systems

We believe that our information systems must cost-effectively meet the needs of our hospital management, medical staff and nurses in the following areas of our business operations:

- patient accounting, including billing and collection of revenues;
- accounting, financial reporting and payroll;
- coding and compliance;
- laboratory, radiology and pharmacy systems;
- medical records and document storage;
- remote physician access to patient data;
- quality indicators;
- materials and asset management; and
- negotiating, pricing and administering our managed care contracts.

During fiscal 2010, we invested significantly in clinical information technology. We believe that the importance of and reliance upon clinical information technology will continue to increase in the future. Accordingly, we expect to make additional significant investments in clinical information technology during fiscal years 2011 and 2012 as part of our business strategy to increase the efficiency and quality of patient care.

Although we map the financial information systems from each of our hospitals to one centralized database, we do not automatically standardize our financial information systems among all of our hospitals. We carefully review the existing systems at the hospitals we acquire. If a particular information system is unable to cost-effectively meet the operational needs of the hospital, we will convert or upgrade the information system at that hospital to one of several standardized information systems that can cost-effectively meet these needs.

Professional and General Liability Insurance

As is typical in the healthcare industry, we are subject to claims and legal actions by patients and others in the ordinary course of business. We created a captive insurance subsidiary on June 1, 2002 to assume a substantial portion of the professional and general liability risks of our facilities. Since then we have self-insured our professional and general liability risks, either through premiums paid to our captive insurance subsidiary or by retaining risk through another of our subsidiaries, in respect of claims incurred up to $10.0 million annually. Beginning on July 1, 2010, we increased this self-insured retention to $15.0 million for our Illinois hospitals. We have also purchased umbrella excess policies for professional and general liability insurance for an additional $65.0 million of annual coverage in the aggregate.

The malpractice insurance environment remains volatile. Some states in which we operate, including Texas and Illinois, have passed in recent years tort reform legislation to place limits on non-economic damages. However, in November 2007 a judge in the Illinois Cook County Circuit Court declared that these Illinois malpractice limits were unconstitutional under state law and an appeal to the Illinois Supreme Court was unsuccessful. Additionally, in Texas an action has been brought to declare its tort reform legislation unconstitutional under federal law. Thus, while we have taken multiple steps at our facilities to reduce our professional liability exposures, absent significant legislation (not later declared unconstitutional) to curb the size of malpractice judgments in the states in which we operate, our insurance costs may increase in the future.

Sources of Revenues

Hospital revenues depend upon inpatient occupancy levels, the medical and ancillary services ordered by physicians and provided to patients, the volume of outpatient procedures and the charges or payment rates for such services. Charges and reimbursement rates for inpatient services vary significantly depending on the type of payer, the type of service (e.g., acute care, intensive care or subacute) and the geographic location of the hospital. Inpatient occupancy levels fluctuate for various reasons, many of which are beyond our control.

We receive payment for patient services from:

- the federal government, primarily under the Medicare program;
- state Medicaid programs;
- health maintenance organizations, preferred provider organizations, managed Medicare providers, managed Medicaid providers and other private insurers; and
- individual patients.

The table below presents the approximate percentage of net patient revenues we received from the following sources for the periods indicated:

	Year ended June 30,		
	2008	2009	2010
Medicare	26.2%	25.3%	25.5%
Medicaid	7.6%	7.9%	7.4%
Managed Medicare	14.0%	14.1%	14.8%
Managed Medicaid	7.5%	8.8%	9.5%
Managed care	35.0%	34.7%	34.9%
Self pay	8.6%	8.3%	6.8%
Other	1.1%	0.9%	1.1%
Total	100.0%	100.0%	100.0%

The Medicare program, the nation's largest health insurance program, is administered by CMS. Medicare provides certain hospital and medical insurance benefits to persons age 65 and over, some disabled persons and persons with end-stage renal disease without regard to beneficiary income or assets. Medicaid is a federal-state program, administered by the states, which provides hospital and medical benefits to qualifying individuals who are unable to afford healthcare. All of our general, acute care hospitals located in the United States are certified as healthcare services providers for persons covered under the Medicare and the various state Medicaid programs. Amounts received under these programs are generally significantly less than established hospital gross charges for the services provided.

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Our hospitals offer discounts from established charges to certain group purchasers of healthcare services, including private insurance companies, employers, health maintenance organizations, preferred provider organizations and other managed care plans. These discount programs limit our ability to increase net revenues in response to increasing costs. Patients generally are not responsible for any difference between established hospital charges and amounts reimbursed for such services under Medicare, Medicaid and managed care programs, but are generally responsible for exclusions, deductibles and coinsurance features of their coverages. Due to rising healthcare costs, many payers have increased the number of excluded services and the levels of deductibles and coinsurance resulting in a higher portion of the contracted rate due from the individual patients. Collecting amounts due from individual patients is typically more difficult than collecting from governmental or private managed care plans.

Traditional Medicare

One of the ways Medicare beneficiaries can elect to receive their medical benefits is through the traditional Medicare program, which provides reimbursement under a prospective payment fee-for-service system. A general description of the types of payments we receive for services provided to patients enrolled in the traditional Medicare program is provided below. The impact of recent changes to reimbursement for these types of services is included in the sections entitled "Annual Medicare Regulatory Update" and "Impact of Health Reform Law on Reimbursement."

Medicare Inpatient Acute Care Reimbursement

Medicare Severity-Adjusted Diagnosis-Related Group Payments. Sections 1886(d) and 1886(g) of the Social Security Act set forth a system of payments for the operating and capital costs of inpatient acute care hospital admissions based on a prospective payment system. Under the inpatient prospective payment system, Medicare payments for hospital inpatient operating services are made at predetermined rates for each hospital discharge. Discharges are classified according to a system of Medicare severity-adjusted diagnosis-related groups ("MS-DRGs"), which categorize patients with similar clinical characteristics that are expected to require similar amounts of hospital resources to treat. CMS assigns to each MS-DRG a relative weight that represents the average resources required to treat cases in that particular MS-DRG, relative to the average resources used to treat cases in all MS-DRGs.

The base payment amount for the operating component of the MS-DRG payment is comprised of an average standardized amount that is divided into a labor-related share and a nonlabor-related share. Both the labor-related share of operating base payments and the base payment amount for capital costs are adjusted for geographic variations in labor and capital costs, respectively. These base payments are multiplied by the relative weight of the MS-DRG assigned to each case. The MS-DRG operating and capital base rates, relative weights and geographic adjustment factors are updated annually, with consideration given to: the increased cost of goods and services purchased by hospitals; the relative costs associated with each MS-DRG; and changes in labor data by geographic area. Although these payments are adjusted for area labor and capital cost differentials, the adjustments do not consider an individual hospital's operating and capital costs. Historically, the average operating and capital costs for our hospitals have exceeded the Medicare rate increases. These annual adjustments are effective for the Medicare fiscal year beginning October 1 of each year and are indicated by the "market basket index" for that year.

Full annual market basket rate increases are only available for those providers who submit their patient care quality indicators data to the Secretary of HHS. CMS has expanded through a series of rules the number of quality measures that must be reported to receive the full market basket update. CMS requires hospitals to submit 44 quality measures in order to qualify for the full market basket update for federal fiscal year 2010, and the number of measures will increase to 46 for federal fiscal year 2011. Failure to submit the required quality indicators will result in a two percentage point reduction to the market basket update.

Outlier Payments. Outlier payments are additional payments made to hospitals for treating Medicare patients that are costlier to treat than the average patient in the same MS-DRG. To qualify as a cost outlier, a hospital's billed charges, adjusted to cost, must exceed the payment rate for the MS-DRG by a fixed threshold established annually by CMS. The Medicare fiscal intermediary calculates the cost of a claim by multiplying the billed charges by a cost-to-charge ratio that is typically based upon the hospital's most recently filed cost report. Generally, if the computed cost exceeds the sum of the MS-DRG payment plus the fixed threshold, the hospital receives 80% of the difference as an outlier payment.

Under the Social Security Act, CMS must project aggregate annual outlier payments to all prospective payment system hospitals to be not less than 5% or more than 6% of total MS-DRG payments. CMS adjusts the fixed threshold on an annual basis to bring the outlier percentage within the 5% to 6% parameters. CMS recently estimated that the total outlier payments in federal fiscal year 2010 will be 4.7% of total MS-DRG payments. Thus, CMS lowered the outlier threshold in federal fiscal year 2011 to $23,075 (from $23,140 in federal fiscal year 2010) to maintain projected outlier payments at 5.1% for the year. Changes to the outlier fixed threshold amount can impact a hospital's number of cases that qualify for the additional payment and the amount of reimbursement the hospital receives for those cases that qualify. The most recently filed cost reports for our hospitals as of June 30, 2008, 2009 and 2010 reflected outlier payments of $4.3 million, $4.2 million and $4.9 million, respectively.

Disproportionate Share Hospital Payments. Hospitals that treat a disproportionately large number of low-income patients currently receive additional payments from Medicare in the form of disproportionate share hospital ("DSH") payments. DSH payments are determined annually based upon certain statistical information defined by CMS and are calculated as a percentage add-on to the MS-DRG payments. This percentage varies, depending on several factors that include the percentage of low-income patients served. Under the Health Reform Law, beginning in federal fiscal year 2014, Medicare DSH payments will be reduced to 25% of the amount they otherwise would have been absent the new law. The remaining 75% of the amount that would otherwise be paid under Medicare DSH will be effectively pooled, and this pool will be reduced further each year by a formula that reflects reductions in the national level of uninsured who are under 65 years of age. Each DSH hospital will then be paid, out of the reduced DSH payment pool, an amount allocated based upon its level of uncompensated care. It is difficult to predict the full impact of the Medicare DSH reductions. The CBO estimates $22 billion in reductions to Medicare DSH payments between 2010 and 2019, while for the same time period, CMS estimates reimbursement reductions totaling $50 billion. During the years ended June 30, 2009 and 2010, we recognized $53.4 million and $58.8 million of Medicare DSH revenues, respectively.

Direct Graduate and Indirect Medical Education. The Medicare program provides additional reimbursement to approved teaching hospitals for additional expenses incurred by such institutions. This additional reimbursement, which is subject to certain limits, including intern and resident full-time equivalent limits established in 1996, is made in the form of Direct Graduate Medical Education ("GME") and Indirect Medical Education ("IME") payments. Pending health reform legislation includes provisions that would increase flexibility in GME funding rules to incentivize outpatient training. During our fiscal year 2010, five of our hospitals were affiliated with academic institutions and received GME or IME payments.

Hospital acquired conditions and serious medical errors. CMS has set forth a goal to transform Medicare from a passive payer to a value-based payer. As a result, for discharges occurring after October 1, 2008, Medicare no longer assigns an inpatient hospital discharge to a higher paying MS-DRG if a selected hospital acquired condition ("HAC") was not present on admission. There are currently 10 categories of conditions on the list of HACs. CMS has also established three National Coverage Determinations that prohibit Medicare reimbursement for erroneous surgical procedures performed on an inpatient or outpatient basis. Effective October 1, 2008, Medicare will no longer pay hospitals for the additional costs of care resulting from eight medical events such as patient falls, objects left inside patients during surgery, pressure ulcers, and certain types of infections. Certain states have established policies or proposed legislation to prohibit hospitals from charging or receiving payments from their Medicaid programs for highly preventable adverse medical events (often called "never events"), which were developed by the National Quality Forum. Never events include wrong-site surgery, serious medication errors, discharging a baby to the wrong mother, etc.

Medicare Outpatient Services Reimbursement

CMS reimburses hospital outpatient services and certain Medicare Part B services furnished to hospital inpatients who have no Part A coverage on a prospective payment system basis. CMS utilizes existing fee schedules to pay for physical, occupational and speech therapies, durable medical equipment, clinical diagnostic laboratory services and nonimplantable orthotics and prosthetics. Freestanding surgery centers and independent diagnostic testing facilities also receive reimbursement from Medicare on a fee schedule basis.

Those hospital outpatient services subject to prospective payment reimbursement are classified into groups called ambulatory payment classifications ("APCs"). Services in each APC are similar clinically and in terms of the resources they require. A payment rate is established for each APC. Depending upon the services provided, a hospital may be paid for more than one APC for a patient visit. CMS periodically updates the APCs and annually adjusts the rates paid for each APC. As part of a final rule published in November 2007, CMS continues to require hospitals to submit quality data relating to outpatient care in order to receive the full market basket index increase. This rule required submission of 11 quality measures in calendar 2009 and 2010 or else the market basket index increase for the subsequent calendar would be reduced by two percentage points.

Rehabilitation Units

CMS reimburses inpatient rehabilitation designated units pursuant to a prospective payment system. Under this prospective payment system, patients are classified into case mix groups based upon impairment, age, comorbidities and functional capability. Inpatient rehabilitation units are paid a predetermined amount per discharge that reflects the patient's case mix group and is adjusted for area wage levels, low-income patients, rural areas and high-cost outliers. As of June 30, 2010, we operated three inpatient rehabilitation units within our acute care hospitals.

Psychiatric Units

Medicare utilizes a prospective payment system to pay inpatient psychiatric hospitals and units. This system is a per diem prospective payment system with adjustments to account for certain patient and facility characteristics. Additionally, this system includes a stop-loss provision, an "outlier" policy authorizing additional payments for extraordinarily costly cases and an adjustment to the base payment if the facility maintains a full-service emergency department which all of our units qualified for. As of June 30, 2010, we operated five psychiatric units within our acute care hospitals subject to this reimbursement methodology.

Federal Fiscal Year 2010 and 2011 Payment Updates

The annual Medicare regulatory updates published by CMS on August 27, 2009 and November 20, 2009 in the Federal Register provided for the following adjustments in Medicare reimbursement for the Medicare fiscal year 2010 (October 1, 2009 through September 30, 2010):

- A market basket index increase of 2.1% for MS-DRG operating payments for hospitals who reported the 43 patient quality care indicators from 2009 and 0.1% for those who did not (this compares to 3.6% for 2009 and 3.3% for 2008, both of which are subject to a 2.0% reduction for those hospitals who did not report the patient quality care indicators applicable to those years).
- No across-the-board reduction to the to the MS-DRG base payment rate to offset the effect of documentation and/or coding changes or the classification of discharges not related to case mix changes (2009 and 2008 included reductions of 0.9% and 0.6%, respectively). However, CMS will consider phasing in future adjustments over an extended period beginning in fiscal 2011.
- Continuation of the capital indirect medical adjustment to payment rates for teaching hospitals.
- Continuation of a provision of the Deficit Reduction Act of 2005 that precludes hospitals from receiving additional payments to treat costs associated with 10 specifically identified patient hospital-acquired conditions including infections (the same 10 identified conditions as for 2009, but compares to 8 identified conditions for 2008).
- An increase in the inpatient cost outlier threshold to $23,140 from $20,045 in 2009 and $22,185 in 2008.
- An increase in the capital federal MS-DRG rate of 1.4% (compares to a 1.9% increase for federal fiscal year 2009).
- A market basket increase of 2.5% for hospital rehabilitation unit payment rates (this compares to 0% for both 2009 and 2008).
- An increase in the outpatient APC payment rate for calendar year 2010 by the full market basket of 2.1%.

On July 30, 2010, CMS issued a final rule related to the federal fiscal year 2011 hospital inpatient PPS. In this rule, CMS increased the MS-DRG rate for federal fiscal year 2011 by 2.35% which reflects the full market basket of 2.6% adjusted by the 0.25% reduction required by the Health Reform Law. However, CMS has also applied a documentation and coding adjustment of negative 2.9% in federal fiscal year 2011. This reduction represents half of the documentation and coding adjustment required to recover the increase in aggregate payments made in 2008 and 2009 during implementation of the MS-DRG system. CMS plans to recover the remaining 2.9% and interest in federal fiscal year 2012. The market basket update, the documentation and coding adjustment and the decrease mandated by the Health Reform Law together show the aggregate market basket adjustment

for federal fiscal year 2011 to be negative 0.55%. CMS has also announced that an additional prospective negative adjustment of 3.9% will be needed to avoid increased Medicare spending unrelated to patient severity of illness. CMS is not proposing this additional 3.9% reduction at this time but has stated that it will be required in the future.

We have submitted the required patient care quality indicators for our hospitals to receive the full market basket index increases for the both the inpatient and outpatient prospective payment systems for federal fiscal year 2009. We intend to submit the necessary information to realize the full federal fiscal year 2010 inpatient and outpatient increases as well. However, as additional patient quality indicator reporting requirements are added, system limitations or other difficulties could result in CMS deeming our submissions not timely or not complete to qualify for the full market basket index increases. Additionally, the U.S. Congress has given CMS the ability to continue to evaluate whether the 2008 and 2009 inpatient reductions for documentation and coding adjustments were sufficient to account for payment changes not related to case mix changes. This continuing evaluation could negatively impact MS-DRG payment rates for federal fiscal years 2011 and 2012.

Further realignments in the MS-DRG system could also reduce the payments we receive for certain specialties, including cardiology and orthopedics. The more widespread development of specialty hospitals in recent years has caused CMS to focus on payment levels for these specialty services. Changes in the payments for specialty services could adversely impact our revenues.

Impact of Health Reform Law on Medicare Reimbursement

Inpatient Reimbursement. The Health Reform Law provides for annual decreases to the market basket, including a 0.25% reduction in 2010 for discharges occurring on or after April 1, 2010. The Health Reform Law also provides for the following reductions to the market basket update for each of the following federal fiscal years. 0.25% in 2011, 0.1% in 2012 and 2013, 0.3% in 2014, 0.2% in 2015 and 2016 and 0.75% in 2017, 2018 and 2019. For federal fiscal year 2012 and each subsequent federal fiscal year, the Health Reform Law provides for the annual market basket update to be further reduced by a productivity adjustment. The amount of that reduction will be the projected, nationwide productivity gains over the preceding 10 years. To determine the projection, HHS will use the Bureau of Labor Statistics ("BLS") 10-year moving average of changes in specified economy-wide productivity (the BLS data is typically a few years old). The Health Reform Law does not contain guidelines for use by HHS in projecting the productivity figure. Based upon the latest available data, federal fiscal year 2012 market basket reductions resulting from this productivity adjustment are likely to range from 1.0% to 1.4%. CMS estimates that the combined market basket and productivity adjustments will reduce Medicare payments under the inpatient PPS by $112.6 billion from 2010 to 2019. A decrease in payments rates or an increase in rates that is below the increase in our costs may adversely affect our results of operations.

The Health Reform Law also provides for reduced payments to hospitals based on readmission rates. Beginning in federal fiscal year 2013, inpatient payments will be reduced if a hospital experiences "excessive" readmissions within a 30-day period of discharge for heart attack, heart failure, pneumonia or other conditions designated by HHS. Hospitals with what HHS defines as excessive readmissions for these conditions will receive reduced payments for all inpatient discharges, not just discharges relating to the conditions subject to the excessive readmission standard. Each hospital's performance will be publicly reported by HHS. HHS has the discretion to determine what "excessive" readmissions means, the amount of the payment reduction and other terms and conditions of this program.

Additionally, the Health Reform Law establishes a value-based purchasing program to further link payments to quality and efficiency. In federal fiscal year 2013, HHS is directed to implement a value-based purchasing program for inpatient hospital services. Beginning in federal fiscal year 2013, CMS will reduce the inpatient PPS payment amount for all discharges by the following: 1% for 2013; 1.25% for 2014; 1.5% for 2015; 1.75% for 2016, and 2% for 2017 and subsequent years. For each federal fiscal year, the total amount collected from these reductions will be pooled and used to fund payments to reward hospitals that meet certain quality performance standards established by HHS. HHS will have the authority to determine the quality performance measures, the standards hospitals must achieve in order to meet the quality performance measures and the methodology for calculating payments to hospitals that meet the required quality threshold. HHS will also determine the amount each hospital that meets or exceeds the quality performance standards will receive from the pool of dollars created by the reductions related to the value-based purchasing program.

Outpatient Reimbursement. In the Calendar Year 2010 Outpatient Prospective Payment System Final Rule, published in the November 20, 2009 Federal Register, CMS announced that the market basket update for 2010 outpatient hospital payments would be the full market basket of 2.1%. However, the Health Reform Law includes a 0.25% reduction to the market basket for 2010. The Health Reform Law also provides for the following reductions to the market basket update for each of the following calendar years: 0.25% in 2011, 0.1% in 2012 and 2013, 0.3% in 2014, 0.2% in 2015 and 2016 and 0.75% in 2017, 2018 and 2019. For calendar year 2012 and each subsequent calendar year, the Health Reform Law provides for an annual market basket update to be further reduced by a productivity adjustment. The amount of that reduction will be the projected, nationwide productivity gains over the preceding 10 years. To determine the projection, HHS will use the BLS 10-year moving average of changes in specified economy-wide productivity (the BLS data is typically a few years old). The Health Reform Law does not contain guidelines for use by HHS in projecting the productivity figure. However, CMS estimates that the combined market basket and productivity adjustments will reduce Medicare payments under the outpatient PPS by $26.3 billion from 2010 to 2019.

Rehabilitation Unit Reimbursement. The market basket increase for hospital rehabilitation units for 2010 is 2.5% (this compares to 0% for both 2009 and 2008). However, the Health Reform Law requires a 0.25% reduction to the market basket for 2010 for discharges occurring on or after April 1, 2010. CMS implemented this reduction through program guidance issued on April 1, 2010. Effective April 1, 2010, the market basket update for rehabilitation hospitals and units was reduced to 2.25%, resulting in a standard payment conversion factor of $13,627. The Health Reform Law also provides for the following reductions to the market basket update for each of the following federal fiscal years: 0.25% in 2011, 0.1% in 2012 and 2013, 0.3% in 2014, 0.2% in 2015 and 2016 and 0.75% in 2017, 2018 and 2019. For federal fiscal year 2012 and each subsequent federal fiscal year, the Health Reform Law provides for the annual market basket update to be further reduced by a productivity adjustment. The amount of that reduction will be the projected, nationwide productivity gains over the preceding 10 years. To determine the projection, HHS will use the BLS 10-year moving average of changes in specified economy-wide productivity (the BLS data is typically a few years old). The Health Reform Law does not contain guidelines for use by HHS in projecting the productivity figure. However, CMS estimates that the combined market basket and productivity adjustments will reduce Medicare payments under the inpatient rehabilitation units prospective payment system by $5.7 billion from 2010 to 2019. Beginning in federal fiscal year 2014, inpatient rehabilitation units will be required to report quality measures to HHS or will receive a two percentage point reduction to the market basket update. Effective January 1, 2010, rehabilitation units must comply with new rules regarding preadmission screening, post-admission treatment planning and on-going coordination of care.

Psychiatric Unit Reimbursement. The annual market basket update for inpatient psychiatric units for rate year 2010 was 2.1%, and the annual market basket update for rate year 2011 is 2.4%. However, the Health Reform Law includes a 0.25% reduction to the market basket for rate year 2010 and again in 2011. The Health Reform Law also provides for the following reductions to the market basket update for each of the following rate years: 0.1% in 2012 and 2013, 0.3% in 2014, 0.2% in 2015 and 2016 and 0.75% in 2017, 2018 and 2019. In addition, the Health Reform Law requires that CMS develop a quality reporting program for psychiatric hospitals and units for implementation in July 2013. For rate year 2012 and each subsequent rate year, the Health Reform Law provides for the annual market basket update to be further reduced by a productivity adjustment. The amount of that reduction will be the projected, nationwide productivity gains over the preceding 10 years. To determine the projection, HHS will use the BLS 10-year moving average of changes in specified economy-wide productivity (the BLS data is typically a few years old). The Health Reform Law does not contain guidelines for use by HHS in projecting the productivity figure. However, CMS estimates that the combined market basket and productivity adjustments will reduce Medicare payments under the prospective payment system for inpatient psychiatric hospitals and units by $4.3 billion from 2010 to 2019.

Contractor Reform

CMS has a significant initiative underway that could affect the administration of the Medicare program and impact how hospitals bill and receive payment for covered Medicare services. In accordance with the Medicare Modernization Act ("MMA"), CMS has begun implementation of contractor reform whereby CMS will competitively bid the Medicare fiscal intermediary and Medicare carrier functions to 15 Medicare Administrative Contractors ("MACs"). Hospital management companies like Vanguard will have the option to work with the selected MAC in the jurisdiction where a given hospital is located or to use the MAC in the jurisdiction where our home office is located. For hospital management companies, either all hospitals in the system must choose to stay with the MAC chosen for their locality or all hospitals must opt to use the home office MAC. We have filed a request for our single home office MAC to serve all of our hospitals. CMS has now completed the process of awarding contracts for all 15 MAC jurisdictions. Individual MAC jurisdictions are in varying phases of transition. All of these changes could impact claims processing functions and the resulting cash flows, however, we are unable to predict the impact that these changes could have, if any, to our cash flows.

Recovery Audit Contractors

The MMA established the Recovery Audit Contractor ("RAC") three-year demonstration program to detect Medicare overpayments not identified through existing claims review mechanisms. The RAC program relies on private auditing firms to examine Medicare claims filed by healthcare providers. Fees to the RACs are paid on a contingency basis. The RAC program began as a demonstration project in 2005 in three states (New York, California and Florida) which was expanded into the three additional states of Arizona, Massachusetts and South Carolina in July 2007. No RAC audits, however, were initiated at our Arizona or Massachusetts hospitals during the demonstration project. The program was made permanent by the Tax Relief and Health Care Act of 2006 enacted in December 2006. CMS ended the demonstration project in March 2008 and commenced the permanent RAC program in all states beginning in 2009 with plans to have RACs in full operation in all 50 states by 2010.

In a report issued in July 2008, CMS reported that the RACs in the demonstration project corrected over $1 billion of Medicare improper payments from 2005 through March 2008. Roughly 96% of the improper payments ($992.7 million) were overpayments collected from providers, while the remaining 4% ($37.8 million) were underpayments repaid to providers. Of the overpayments, 85% were collected from inpatient hospital providers, while the other principal collections were 6% from inpatient rehabilitation facilities and 4% from outpatient hospital providers.

RACs utilize a post-payment targeted review process employing data analysis techniques in order to identify those Medicare claims most likely to contain overpayments, such as incorrectly coded services, incorrect payment amounts, non-covered services and duplicate payments. The RAC review is either "automated," for which a decision can be made without reviewing a medical record, or "complex," for which the RAC must contact the provider in order to procure and review the medical record to make a decision about the payment. CMS has given RACs the authority to look back at claims up to three years old, provided that the claim was paid on or after October 1, 2007. Claims identified as overpayments will be subject to the Medicare appeals process.

As to "automated" reviews where a review of the medical record is not required, RACs make claim determinations using proprietary software designed to detect certain kinds of errors where both of the following conditions must apply. First, there must be certainty that the service is not covered or is coded incorrectly. Second, there must be a written Medicare policy, Medicare article or Medicare-sanctioned coding guideline supporting the determination. For example, an automated review could identify when a provider is billing for more units than allowed on one day. However, the RAC may also use automated review even if such written policies don't exist on certain CMS-approved "clinically unbelievable issues" and when making certain other types of administrative determinations (e.g., duplicate claims, pricing mistakes) when there is certainty that an error exists.

As to "complex" reviews where a review of the medical record is required, RACs make claim determinations when there is a high probability (but not certainty) that a service is not covered, or where no Medicare policy, guidance or Medicare-sanctioned coding guideline exists. It is expected that many complex reviews will be medical necessity audits that assess whether care provided was medically necessary and provided in the appropriate setting. It is currently expected that, while RACs made complex reviews in calendar year 2009 related to DRG validation and coding, the RACs will not conduct complex reviews for medical necessity cases until calendar year 2010.

RACs are paid a contingency fee based on the overpayments they identify and collect. Therefore, we expect that the RACs will look very closely at claims submitted by our facilities in an attempt to identify possible overpayments. We believe the claims for reimbursement submitted to the Medicare program by our facilities have been accurate. However, we cannot predict, once our facilities are subject to RAC reviews in all subject matters in the future, the results of such reviews. It is reasonably possible that the aggregate payments that our facilities will be required to return to the Medicare program pursuant to these RAC reviews may have a material adverse effect on our financial position, results of operations or cash flows.

Accountable Care Organizations and Pilot Projects

The Health Reform Law requires HHS to establish a Medicare Shared Savings Program that promotes accountability and coordination of care through the creation of Accountable Care Organizations ("ACOs"), beginning no later than January 1, 2012. The program will allow providers (including hospitals), physicians and other designated professionals and suppliers to form ACOs and voluntarily work together to invest in infrastructure and redesign delivery processes to achieve high quality and efficient delivery of services. The program is intended to produce savings as a result of improved quality and operational efficiency. ACOs that achieve quality performance standards established by HHS will be eligible to share in a portion of the amounts saved by the Medicare program. HHS has significant discretion to determine key elements of the program, including what steps providers must take to be considered an ACO, how to decide if Medicare program savings have occurred, and what portion of such savings will be paid to ACOs. In addition, HHS will determine to what degree hospitals, physicians and other eligible participants will be able to form and operate an ACO without violating certain existing laws, including the Civil Monetary Penalty Law, the Anti-kickback Statute and the Stark Law. The Health Reform Law does not authorize HHS to waive other laws that may impact the ability of hospitals and other eligible participants to participate in ACOs, such as antitrust laws.

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The Health Reform Law requires HHS to establish a five-year, voluntary national bundled payment pilot program for Medicare services beginning no later than January 1, 2013. Under the program, providers would agree to receive one payment for services provided to Medicare patients for certain medical conditions or episodes of care. HHS will have the discretion to determine how the program will function. For example, HHS will determine what medical conditions will be included in the program and the amount of the payment for each condition. In addition, the Health Reform Law provides for a five-year bundled payment pilot program for Medicaid services to begin January 1, 2012. HHS will select up to eight states to participate based on the potential to lower costs under the Medicaid program while improving care. State programs may target particular categories of beneficiaries, selected diagnoses or geographic regions of the state. The selected state programs will provide one payment for both hospital and physician services provided to Medicaid patients for certain episodes of inpatient care. For both pilot programs, HHS will determine the relationship between the programs and restrictions in certain existing laws, including the Civil Monetary Penalty Law, the Anti-kickback Statute, the Stark Law and HIPAA privacy, security and transaction standard requirements. However, the Health Reform Law does not authorize HHS to waive other laws that may impact the ability of hospitals and other eligible participants to participate in the pilot programs, such as antitrust laws.

Managed Medicare

Managed Medicare plans represent arrangements where a private company contracts with CMS to provide members with Medicare Part A, Part B and Part D benefits. Managed Medicare plans can be structured as health maintenance organizations, preferred provider organizations or private fee-for-service plans. The Medicare program allows beneficiaries to choose enrollment in certain managed Medicare care plans. The Medicare Improvement for Patients and Providers Act of 2008 reduced payments to managed Medicare plans. Additionally, the Health Reform Law reduces premium payments to managed Medicare plans over a three-year period such that CMS' managed care per capita premium payments are, on average, equal to traditional Medicare. The CBO has estimated that, as a result of these changes, payments to plans will be reduced by $138 billion between 2010 and 2019, while CMS has estimated the reduction to be $145 billion. The Health Reform Law also expands RAC programs to include managed Medicare plans. This recent legislation combined with continued weakened economic conditions may result in decreased enrollment in such plans and may limit our ability to negotiate adequate rate increases with these providers for our hospital services.

Medicaid

Medicaid programs are funded jointly by the federal government and the states and are administered by states under approved plans. Most state Medicaid program payments are made under a prospective payment system or are based on negotiated payment levels with individual hospitals. Medicaid reimbursement is less than Medicare reimbursement for the same services and is often less than a hospital's cost of services. Many states have recently reduced or are currently considering legislation to reduce the level of Medicaid funding (including upper payment limits) or program eligibility that could adversely affect future levels of Medicaid reimbursement received by our hospitals. As permitted by law, certain states in which we operate have adopted broad-based provider taxes to fund their Medicaid programs. Since states must operate with balanced budgets and since the Medicaid program is often the state's largest program, states may consider further reductions in their Medicaid expenditures.

Disproportionate Share Payments

Certain states in which we operate provide DSH payments to hospitals that treat a disproportionately large number of low-income patients as part of their state Medicaid programs, similar to DSH payments received from Medicare. During the years ended June 30, 2009 and 2010, we recognized revenues of approximately $26.0 million and $29.1 million, respectively, related to Medicaid DSH reimbursement payments. These amounts do not include our revenues recognized from payments related to various Upper Payment Limit, Provider Tax Assessment and Community Benefit programs, which totaled $25.9 million and $35.6 million, respectively, during fiscal 2009 and 2010, since these programs are separate from DSH. These states continually assess the level of expenditures for disproportionate share reimbursement and may reduce these payments or restructure this portion of their Medicaid programs.

Impact of Health Reform Law on Medicaid Reimbursement

The Health Reform Law requires states to expand Medicaid coverage to all individuals under age 65 with incomes up to 133% of the federal poverty level by 2014, but such limit effectively increases to 138% with the "5% income disregard" provision. Effective March 23, 2010, the Health Reform Law requires states to at least maintain Medicaid eligibility standards established prior to the enactment of the law for adults until January 1, 2014 and for children until October 1, 2019. However, states with budget deficits may seek exemptions from this requirement to address eligibility standards that apply to adults making more than 133% of the federal poverty level.

The Health Reform Law increases federal funding for Medicaid Integrity Contractors ("MICS"), private contractors who perform post-payment audits of Medicaid claims to identify overpayments, for federal fiscal years 2011 and beyond. Through the Deficit Reduction Act of 2005, Congress expanded the federal government's involvement in fighting fraud, waste and abuse in the Medicaid program. MICs are assigned to 5 geographic regions and have commenced audits in several of the states assigned to those regions. Throughout 2010, MIC audits will continue and expand to other states. The Health Reform Law also expands the scope of RAC programs to include Medicaid by requiring all states to enter contracts with RACs by December 31, 2010.

The Health Reform Law will also reduce funding for the Medicaid DSH hospital program in federal fiscal years 2014 through 2020 by the following amounts: 2014 — $500 million; 2015 — $600 million; 2016 — $600 million; 2017 — $1.8 billion, 2018 — $5 billion; 2019 — $5.6 billion; and 2020 - $4 billion. How such cuts are allocated among the states and how the states allocate these cuts among providers have yet to be determined.

Managed Medicaid

Managed Medicaid programs represent arrangements where states contract with one or more entities for patient enrollment, care management and claims adjudication for enrollees in their state Medicaid programs. The states usually do not give up program responsibilities for financing, eligibility criteria and core benefit plan design. We generally contract directly with one of the designated entities, usually a managed care organization. The provisions of these programs are state-specific.

Annual Cost Reports

All hospitals participating in the Medicare and Medicaid programs are required to meet specific financial reporting requirements. Federal and, where applicable, state regulations require submission of annual cost reports identifying medical costs and expenses associated with the services provided by each hospital to Medicare beneficiaries and Medicaid recipients. Moreover, annual cost reports required under the Medicare and Medicaid programs are subject to routine audits, which may result in adjustments to the amounts ultimately determined to be due to us under these reimbursement programs. The audit process takes several years to reach the final determination of allowable amounts under the programs. Providers also have the right of appeal, and it is common to contest issues raised in audits of prior years' reports.

Many prior year cost reports of our facilities are still open. If any of our facilities are found to have been in violation of federal or state laws relating to preparing and filing of Medicare or Medicaid cost reports, whether prior to or after our ownership of these facilities, we and our facilities could be subject to substantial monetary fines, civil and criminal penalties and exclusion from participation in the Medicare and Medicaid programs. If an allegation is lodged against one of our facilities for a violation occurring during the time period before we acquired the facility, we may have indemnification rights against the seller of the facility to us. In each of our acquisitions, we have negotiated customary indemnification and hold harmless provisions for any damages we may incur in these areas.

Managed Care and Other Private Insurers

Managed care providers, including health maintenance organizations, preferred provider organizations, other private insurance companies and employers, are organizations that provide insurance coverage and a network of healthcare providers to members for a fixed monthly premium. To attract additional volume, most of our hospitals offer discounts from established charges or prospective payment systems to these large group purchasers of healthcare services. These discount programs often limit our ability to increase charges in response to increasing costs. However, as part of our business strategy, we have been able to renegotiate payment rates on many of our managed care contracts to improve our operating margin. While we generally received annual average payment rate increases of 4% to 8% from non-governmental managed care payers during fiscal year 2010, there can be no assurance that we will continue to receive increases in the future and that patient volumes from these payers will not be adversely affected by rate negotiations. These contracts often contain exclusions, carve-outs, performance criteria and other provisions and guidelines that require our constant focus and attention. Patients who are members of managed care plans are not required to pay us for their healthcare services except for coinsurance and deductible portions of their plan coverage calculated after managed care discounts have been applied. While the majority of our admissions and revenues are generated from patients covered by managed care plans, the percentage may decrease in the future due to increased Medicare utilization associated with the aging U.S. population. We experienced a 13,412 day decrease in managed care patient days during the year ended June 30, 2010 compared to the year ended June 30, 2009 or a decrease from 24.2% of total inpatient days for fiscal year 2009 to 22.6% for fiscal year 2010.

Self-Pay Patients

Self-pay patients are patients who do not qualify for government programs payments, such as Medicare and Medicaid, who do not qualify for charity care under our guidelines and who do not have some form of private insurance. These patients are responsible for their own medical bills. We also include in our self-pay accounts those unpaid coinsurance and deductible amounts for which payment has been received from the primary payer.

Effective for service dates on or after April 1, 2009, as a result of a state mandate, we implemented a new uninsured discount policy for those patients receiving services in our Illinois hospitals who had no insurance coverage and who did not otherwise qualify for charity care under our guidelines. Under this policy, we apply an uninsured discount (calculated as a standard percentage of gross charges) at the time of patient billing and include this discount as a reduction to patient service revenues. We implemented this policy in our Phoenix and San Antonio facilities effective July 1, 2009. These discounts were approximately $11.7 million and $215.7 million for the years ended June 30, 2009 and 2010, respectively.

A significant portion of our self-pay patients are admitted through our hospitals' emergency departments and often require high-acuity treatment. The Emergency Medical Treatment and Active Labor Act ("EMTALA") requires any hospital that participates in the Medicare program to conduct an appropriate medical screening examination of every person who presents to the hospital's emergency room for treatment and, if the individual is suffering from an emergency medical condition, to either stabilize that condition or make an appropriate transfer of the individual to a facility that can handle the condition. The obligation to screen and stabilize emergency medical conditions exists regardless of an individual's ability to pay for treatment. High-acuity treatment is more costly to provide and, therefore, results in higher billings, which are the least collectible of all accounts. We believe self-pay patient volumes and revenues have been impacted during the last two years due to a combination of broad economic factors, including reductions in state Medicaid budgets, increasing numbers of individuals and employers who choose not to purchase insurance and an increased burden of coinsurance and deductibles to be made by patients instead of insurers.

Self-pay accounts pose significant collectability problems. At June 30, 2010, approximately 20.6% of our accounts receivable, prior to the allowance for doubtful accounts, contractual allowances and the charity care allowance, was comprised of self-pay accounts. The majority of our provision for doubtful accounts relates to self-pay patients. As of June 30, 2010, our combined allowances for doubtful accounts, uninsured discounts and charity care covered approximately 84% of our self-pay receivables. Until the Health Reform Law is implemented, we remain vulnerable to further increased self-pay utilization. We are taking multiple actions in an effort to mitigate the effect on us of the high number of uninsured patients and the related economic impact. These initiatives include conducting detailed reviews of intake procedures in hospitals facing the greatest pressures and applying these intake best practices to all of our hospitals. We developed hospital-specific reports detailing collection rates by type of patient to help the hospital management teams better identify areas of vulnerability and opportunities for improvement. Also, we completely redesigned our self-pay collection workflows, enhanced technology and improved staff training in an effort to increase collections.

The Health Reform Law requires health plans to reimburse hospitals for emergency services provided to enrollees without prior authorization and without regard to whether a participating provider contract is in place. Further, the Health Reform Law contains provisions that seek to decrease the number of uninsured individuals, including requirements, which do not become effective until 2014, for individuals to obtain, and employers to provide, insurance coverage. These mandates may reduce the financial impact of screening for and stabilizing emergency medical conditions. However, many factors are unknown regarding the impact of the Health Reform Law, including how many previously uninsured individuals will obtain coverage as a result of the new law or the change, if any, in the volume of inpatient and outpatient hospital services that are sought by and provided to previously uninsured individuals. In addition, it is difficult to predict the full impact of the Health Reform Law due to the law's complexity, lack of implementing regulations or interpretive guidance, gradual implementation and possible amendment.

We do not pursue collection of amounts due from uninsured patients that qualify for charity care under our guidelines (currently those uninsured patients whose incomes are equal to or less than 200% of the current federal poverty guidelines set forth by the Department of Health and Human Services). We exclude charity care accounts from revenues when we determine that the account meets our charity care guidelines. We provide expanded discounts from billed charges and alternative payment structures for uninsured patients who do not qualify for charity care but meet certain other minimum income guidelines, primarily those uninsured patients with incomes between 200% and 500% of the federal poverty guidelines. During our fiscal years ended June 30, 2008, 2009 and 2010, we deducted $86.1 million, $91.8 million and $87.7 million of charity care from gross charges, respectively.

Government Regulation and Other Factors

Overview

All participants in the healthcare industry are required to comply with extensive government regulation at the federal, state and local levels. In addition, these laws, rules and regulations are extremely complex and the healthcare industry has had the benefit of little or no regulatory or judicial interpretation of many of them. Although we believe we are in compliance in all material respects with such laws, rules and regulations, if a determination is made that we were in material violation of such laws, rules or regulations, our business, financial condition or results of operations could be materially adversely affected. If we fail to comply with applicable laws and regulations, we can be subject to criminal penalties and civil sanctions and our hospitals can lose their licenses and their ability to participate in the Medicare and Medicaid programs.

Licensing, Certification and Accreditation

Healthcare facility construction and operation is subject to federal, state and local regulations relating to the adequacy of medical care, equipment, personnel, operating policies and procedures, fire prevention, rate-setting and compliance with building codes and environmental protection laws. Our facilities also are subject to periodic inspection by governmental and other authorities to assure continued compliance with the various standards necessary for licensing and accreditation. We believe that all of our operating healthcare facilities are properly licensed under appropriate state healthcare laws.

All of our operating hospitals are certified under the Medicare program and are accredited by The Joint Commission (formerly, known as The Joint Commission on Accreditation of Healthcare Organizations), the effect of which is to permit the facilities to participate in the Medicare and Medicaid programs. If any facility loses its accreditation by The Joint Commission, or otherwise loses its certification under the Medicare program, then the facility will be unable to receive reimbursement from the Medicare and Medicaid programs. We intend to conduct our operations in compliance with current applicable federal, state, local and independent review body regulations and standards. The requirements for licensure, certification and accreditation are subject to change and, in order to remain qualified, we may need to make changes in our facilities, equipment, personnel and services.

Certificates of Need

In some states, the construction of new facilities, acquisition of existing facilities or addition of new beds or services may be subject to review by state regulatory agencies under a Certificate of Need program. Illinois and Massachusetts are the only states in which we currently operate that require approval under a Certificate of Need program. These laws generally require appropriate state agency determination of public need and approval prior to the addition of beds or services or other capital expenditures. Failure to obtain necessary state approval can result in the inability to expand facilities, add services, acquire a facility or change ownership. Further, violation of such laws may result in the imposition of civil sanctions or the revocation of a facility's license.

Utilization Review

Federal law contains numerous provisions designed to ensure that services rendered by hospitals to Medicare and Medicaid patients meet professionally recognized standards and are medically necessary and that claims for reimbursement are properly filed. These provisions include a requirement that a sampling of admissions of Medicare and Medicaid patients be reviewed by quality improvement organizations that analyze the appropriateness of Medicare and Medicaid patient admissions and discharges, quality of care provided, validity of diagnosis related group classifications and appropriateness of cases of extraordinary length of stay or cost. Quality improvement organizations may deny payment for services provided, assess fines and recommend to HHS that a provider not in substantial compliance with the standards of the quality improvement organization be excluded from participation in the Medicare program. Most non-governmental managed care organizations also require utilization review.

Federal Healthcare Program Statutes and Regulations

Participation in any federal healthcare program, such as the Medicare and Medicaid programs, is regulated heavily by statute and regulation. If a hospital provider fails to substantially comply with the numerous conditions of participation in the Medicare or Medicaid program or performs specific prohibited acts, the hospital's participation in the Medicare program may be terminated or civil or criminal penalties may be imposed upon it under provisions of the Social Security Act and other statutes.

Anti-Kickback Statute

A section of the Social Security Act known as the federal Anti-Kickback Statute prohibits providers and others from soliciting, receiving, offering or paying, directly or indirectly, any remuneration with the intent of generating referrals or orders for services or items covered by a federal healthcare program. Courts have interpreted this statute broadly and held that there is a violation of the Anti-Kickback Statute if just one purpose of the remuneration is to generate referrals, even if there are other lawful purposes regardless of knowledge of the Anti-Kickback Statute or intent to violate the Anti-Kickback Statute to be found guilty of a violation. Violation of this statute is a felony, including criminal penalties of imprisonment or criminal fines up to $25,000 for each violation, but it also includes civil money penalties of up to $50,000 per violation, damages up to three times the total amount of the improper payment to the referral source and exclusion from participation in Medicare, Medicaid or other federal healthcare programs. The Health Reform Law provides that submission of a claim for services or items generated in violation of the Anti-Kickback Statute constitutes a false or fraudulent claim and may be subject to additional penalties under the federal False Claims Act.

The Office of the Inspector General of the U.S. Department of Health and Human Services (the "OIG") has published final safe harbor regulations that outline categories of activities that are deemed protected from prosecution under the Anti-Kickback Statute. Currently there are safe harbors for various activities, including the following: investment interests, space rental, equipment rental, practitioner recruitment, personal services and management contracts, sale of practice, referral services, warranties, discounts, employees, group purchasing organizations, waiver of beneficiary coinsurance and deductible amounts, managed care arrangements, obstetrical malpractice insurance subsidies, investments in group practices, ambulatory surgery centers and referral agreements for specialty services.

The fact that conduct or a business arrangement does not fall within a safe harbor does not automatically render the conduct or business arrangement illegal under the Anti-Kickback Statute. The conduct or business arrangement, however, does increase the risk of scrutiny by government enforcement authorities. We may be less willing than some of our competitors to take actions or enter into business arrangements that do not clearly satisfy the safe harbors. As a result, this unwillingness may put us at a competitive disadvantage.

The OIG, among other regulatory agencies, is responsible for identifying and eliminating fraud, abuse and waste. The OIG carries out this mission through a nationwide program of audits, investigations and inspections. In order to provide guidance to healthcare providers, the OIG has from time to time issued "fraud alerts" that, although they do not have the force of law, identify features of a transaction that may indicate that the transaction could violate the Anti-Kickback Statute or other federal healthcare laws. The OIG has identified several incentive arrangements as potential violations, including:

- payment of any incentive by the hospital when a physician refers a patient to the hospital
- use of free or significantly discounted office space or equipment for physicians in facilities usually located close to the hospital;
- provision of free or significantly discounted billing, nursing or other staff services;
- free training for a physician's office staff, including management and laboratory techniques;
- guarantees that provide that, if the physician's income fails to reach a predetermined level, the hospital will pay any portion of the remainder;
- low-interest or interest-free loans, or loans which may be forgiven if a physician refers patients to the hospital;
- payment of the costs of a physician's travel and expenses for conferences or a physician's continuing education courses;
- coverage on the hospital's group health insurance plans at an inappropriately low cost to the physician;
- rental of space in physician offices, at other than fair market value terms, by persons or entities to which physicians refer;
- payment of services which require few, if any, substantive duties by the physician, or payment for services in excess of the fair market value of the services rendered; or
- "gain sharing," the practice of giving physicians a share of any reduction in a hospital's costs for patient care attributable in part to the physician's efforts.

The OIG has encouraged persons having information about hospitals who offer the above types of incentives to physicians to report such information to the OIG. The OIG also issues "Special Advisory Bulletins" as a means of providing guidance to healthcare providers. These bulletins, along with other "fraud alerts," have focused on certain arrangements between physicians and providers that could be subject to heightened scrutiny by government enforcement authorities, including, "suspect" joint ventures where physicians may become investors with the provider in a newly formed joint venture entity where the investors refer their patients to this new entity, and are paid by the entity in the form of "profit distributions." These subject joint ventures may be intended not so much to raise investment capital legitimately to start a business, but to lock up a stream of referrals from the physician investors and to compensate them indirectly for these referrals. Because physician investors can benefit financially from their referrals, unnecessary procedures and tests may be ordered or performed, resulting in unnecessary Medicare expenditures.

Similarly, in a Special Advisory Bulletin issued in April 2003, the OIG focused on "questionable" contractual arrangements where a healthcare provider in one line of business (the "Owner") expands into a related healthcare business by contracting with an existing provider of a related item or service (the "Manager/Supplier") to provide the new item or service to the Owner's existing patient population, including federal healthcare program patients (so called "suspect Contractual Joint Ventures"). The Manager/Supplier not only manages the new line of business, but may also supply it with inventory, employees, space, billing, and other services. In other words, the Owner contracts out substantially the entire operation of the related line of business to the Manager/Supplier—otherwise a potential competitor—receiving in return the profits of the business as remuneration for its federal program referrals. The Bulletin lists the following features of these "questionable" contractual relationships. First, the Owner expands into a related line of business, which is dependent on referrals from, or other business generated by, the Owner's existing business. Second, the Owner neither operates the new business itself nor commits substantial financial, capital or human resources to the venture. Instead, it contracts out substantially all the operations of the new business. The Manager/Supplier typically agrees to provide not only management services, but also a range of other services, such as the inventory necessary to run the business, office and healthcare personnel, billing support, and space. Third, the Manager/Supplier is an established provider of the same services as the Owner's new line of business. In other words, absent the contractual arrangement, the Manager/Supplier would be a competitor of the new line of business, providing items and services in its own right, billing insurers and patients in its own name, and collecting reimbursement. Fourth, the Owner and the Manager/Supplier share in the economic benefit of the Owner's new business. The Manager/Supplier takes its share in the form of payments under the various contracts with the Owner; the Owner receives its share in the form of the residual profit from the new business. Fifth, aggregate

payments to the Manager/Supplier typically vary with the value or volume of business generated for the new business by the Owner. We monitor carefully our contracts with other healthcare providers and attempt to not allow our facilities to enter into these suspect Contractual Joint Ventures.

In addition to issuing fraud alerts and Special Advisory Bulletins, the OIG from time to time issues compliance program guidance for certain types of healthcare providers. In January 2005, the OIG published a Supplemental Compliance Guidance for Hospitals, supplementing its 1998 guidance for the hospital industry. In the supplemental guidance, the OIG identifies a number of risk areas under federal fraud and abuse statutes and regulations. These areas of risk include compensation arrangements with physicians, recruitment arrangements with physicians and joint venture relationships with physicians. In addition, the Health Reform Law includes provisions that would revise the scienter requirements such that a person need not have actual knowledge of the Anti-Kickback Statute or intent to violate the Anti-Kickback Statute to be found guilty of a violation.

We have a variety of financial relationships with physicians who refer patients to our hospitals. As of June 30, 2010, physicians owned interests in two of our free-standing surgery centers in California and seven of our diagnostic imaging centers in Texas. We may sell ownership interests in certain other of our facilities to physicians and other qualified investors in the future. We also have contracts with physicians providing for a variety of financial arrangements, including employment contracts, leases and professional service agreements. We have provided financial incentives to recruit physicians to relocate to communities served by our hospitals, including income and collection guarantees and reimbursement of relocation costs, and will continue to provide recruitment packages in the future. Although we have established policies and procedures to ensure that our arrangements with physicians comply with current law and applicable regulations, we cannot assure you that regulatory authorities that enforce these laws will not determine that some of these arrangements violate the Anti-Kickback Statute or other applicable laws. An adverse determination could subject us to liabilities under the Social Security Act, including criminal penalties, civil monetary penalties and exclusion from participation in Medicare, Medicaid or other federal healthcare programs, any of which could have a material adverse effect in our business, financial condition or results of operations.

Other Fraud and Abuse Provisions

The Social Security Act also imposes criminal and civil penalties for submitting false claims to Medicare and Medicaid. False claims include, but are not limited to, billing for services not rendered, misrepresenting actual services rendered in order to obtain higher reimbursement and cost report fraud. Like the Anti-Kickback Statute, these provisions are very broad. Further, the Social Security Act contains civil penalties for conduct including improper coding and billing for unnecessary goods and services. Under the Health Reform Law, civil penalties may be imposed for the failure to report and return an overpayment within 60 days of identifying the overpayment or by the date a corresponding cost report is due, whichever is later. To avoid liability, providers must, among other things, carefully and accurately code claims for reimbursement, promptly return overpayments and accurately prepare cost reports.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") broadened the scope of the fraud and abuse laws by adding several criminal provisions for healthcare fraud offenses that apply to all health benefit programs. This Act also created new enforcement mechanisms to combat fraud and abuse, including the Medicaid Integrity Program and an incentive program under which individuals can receive up to $1,000 for providing information on Medicare fraud and abuse that leads to the recovery of at least $100 of Medicare funds. In addition, federal enforcement officials now have the ability to exclude from Medicare and Medicaid any investors, officers and managing employees associated with business entities that have committed healthcare fraud. Additionally, this Act establishes a violation for the payment of inducements to Medicare or Medicaid beneficiaries in order to influence those beneficiaries to order or receive services from a particular provider or practitioner.

Some of these provisions, including the federal Civil Monetary Penalty Law, require a lower burden of proof than other fraud and abuse laws, including the Anti-Kickback Statute. Civil monetary penalties that may be imposed under the federal Civil Monetary Penalty Law range from $10,000 to $50,000 per act, and in some cases may result in penalties of up to three times the remuneration offered, paid, solicited or received. In addition, a violator may be subject to exclusion from federal and state healthcare programs. Federal and state governments increasingly use the federal Civil Monetary Penalty Law, especially where they believe they cannot meet the higher burden of proof requirements under the Anti-Kickback Statute.

The Stark Law

The Social Security Act also includes a provision commonly known as the "Stark Law." This law prohibits physicians from referring Medicare and (to an extent) Medicaid patients to entities with which they or any of their immediate family members have a financial relationship for the provision of certain designated health services that are reimbursable by Medicare or Medicaid, including inpatient and outpatient hospital services. The law also prohibits the entity from billing the Medicare program for any items or services that stem from a prohibited referral. Sanctions for violating the Stark Law include denial of payment, refunding amounts received for services provided pursuant to prohibited referrals, civil money penalties up to $15,000 per item or service improperly billed and exclusion from the federal healthcare programs. The statute also provides for a penalty of up to $100,000 for a circumvention scheme. There are a number of exceptions to the self-referral prohibition for many of the customary financial arrangements between physicians and providers, including employment contracts, leases, professional services agreements, non-cash gifts having an annual value of no more than $355 in calendar year 2010 and recruitment agreements. Unlike safe harbors under the Anti-Kickback Statute with which compliance is voluntary, an arrangement must comply with every requirement of a Stark Law exception or the arrangement is in violation of the Stark Law. Although there is an exception for a physician's ownership interest in an entire hospital, the Health Reform Law prohibits newly created physician-owned hospitals from billing for Medicare patients referred by their physician owners. As a result, the new law will effectively prevent the formation of physician-owned hospitals after December 31, 2010. While the new law grandfathers existing physician-owned hospitals, it does not allow these hospitals to increase the percentage of physician ownership and significantly restricts their ability to expand services.

CMS has issued three phases of final regulations implementing the Stark Law. Phases I and II became effective in January 2002 and July 2004, respectively, and Phase III became effective in December 2007. While these regulations help clarify the requirements of the exceptions to the Stark Law, it is unclear how the government will interpret many of these exceptions for enforcement purposes. In addition, in July 2007 CMS proposed far-reaching changes to the regulations implementing the Stark Law that would further restrict the types of arrangements that hospitals and physicians may enter, including additional restrictions on certain leases, percentage compensation arrangements and agreements under which a hospital purchases services under arrangements. On July 31, 2008, CMS issued a final rule which, in part, finalized and responded to public comments regarding some of its July 2007 proposed major changes to the Stark Law regulations. The most far-reaching of the changes made in this final July 2008 rule effectively prohibit, as of a delayed effective date of October 1, 2009, many "under arrangements" ventures between a hospital and any referring physician or entity owned, in whole or in part, by a referring physician and unit-of-service-based or "per click" compensation and percentage-based compensation in office space and equipment leases between a hospital and any referring physician or entity owned, in whole or in part, by a referring physician. We examined all of our "under arrangement" ventures and space and equipment leases with physicians to identify those arrangements which would have failed to conform to these new Stark regulations as of October 1, 2009, and we restructured or terminated all such non-conforming arrangements so identified prior to October 1, 2009.

Because the Stark Law and its implementing regulations are relatively new, we do not always have the benefit of significant regulatory or judicial interpretation of this law and its regulations. We attempt to structure our relationships to meet an exception to the Stark Law, but the regulations implementing the exceptions are detailed and complex, and we cannot assure that every relationship complies fully with the Stark Law. In addition, in the July 2008 final Stark rule CMS indicated that it will continue to enact further regulations tightening aspects of the Stark Law that it perceives allow for Medicare program abuse, especially those regulations that still permit physicians to profit from their referrals of ancillary services. There can be no assurance that the arrangements entered into by us and our facilities with physicians will be found to be in compliance with the Stark Law, as it ultimately may be implemented or interpreted.

Similar State Laws, etc.

Many of the states in which we operate also have adopted laws that prohibit payments to physicians in exchange for referrals similar to the federal Anti-Kickback Statute or that otherwise prohibit fraud and abuse activities. Many states also have passed self-referral legislation, similar to the Stark Law, prohibiting the referral of patients to entities with which the physician has a financial relationship. Often these state laws are broad in scope and they may apply regardless of the source of payment for care. These statutes typically provide criminal and civil penalties, as well as loss of licensure. Little precedent exists for the interpretation or enforcement of these state laws.

Certain Implications of these Fraud and Abuse Laws or New Laws

Our operations could be adversely affected by the failure of our arrangements to comply with the Anti-Kickback Statute, the Stark Law, billing laws and regulations, current state laws or other legislation or regulations in these areas adopted in the future. We are unable to predict whether other legislation or regulations at the federal or state level in any of these areas will be adopted, what form such legislation or regulations may take or how they may impact our operations. We are continuing to enter into new financial arrangements with physicians and other providers in a manner structured to comply in all material respects with these laws. We cannot assure you, however, that governmental officials responsible for enforcing these laws will not assert

that we are in violation of them or that such statutes or regulations ultimately will be interpreted by the courts in a manner consistent with our interpretation.

The Federal False Claims Act and Similar Laws

Another trend affecting the healthcare industry today is the increased use of the federal False Claims Act, and, in particular, actions being brought by individuals on the government's behalf under the False Claims Act's "*qui tam*" or whistleblower provisions. Whistleblower provisions allow private individuals to bring actions on behalf of the government alleging that the defendant has defrauded the federal government. If the government intervenes in the action and prevails, the party filing the initial complaint may share in any settlement or judgment. If the government does not intervene in the action, the whistleblower plaintiff may pursue the action independently, and may receive a larger share of any settlement or judgment. When a private party brings a *qui tam* action under the False Claims Act, the defendant generally will not be made aware of the lawsuit until the government makes a determination whether it will intervene

The Health Reform Law significantly increased the rights of whistleblowers to bring False Claims Act actions by materially narrowing the so-called "public disclosure" bar to their False Claims Act actions. Until the Health Reform Law was enacted, a whistleblower was not entitled to pursue publicly disclosed claims unless he or she was a direct and independent source of the information on which his or her allegations of misconduct were based. Under new Health Reform Law provisions:

- It will now be enough that the whistleblower has independent knowledge that materially adds to publicly disclosed allegations.
- Furthermore, the Health Reform Law limits the type of activity that counts as a "public disclosure" to disclosures made in a federal setting; disclosure in state reports or state proceedings will no longer qualify.
- Even if all requirements are met to bar a whistleblower's suit, the Health Reform Act permits the United States to waive application of the bar at its discretion so that the whistleblower can proceed with his or her complaint.

When a defendant is determined by a court of law to be liable under the False Claims Act, the defendant must pay three times the actual damages sustained by the government, plus mandatory civil penalties of between $5,500 to $11,000 for each separate false claim. Settlements entered into prior to litigation usually involve a less severe calculation of damages. There are many potential bases for liability under the False Claims Act. Typically, each fraudulent bill submitted by a provider is considered a separate false claim, and thus the penalties under the False Claims Act may be substantial. Liability arises when an entity knowingly submits a false claim for reimbursement to the federal government or, since May 2009, when an entity knowingly or improperly retains an overpayment that it has an obligation to refund. The False Claims Act defines the term "knowingly" broadly. Thus, simple negligence will not give rise to liability under the False Claim Act, but submitting a claim with reckless disregard to its truth or falsity can constitute "knowingly" submitting a false claim and result in liability. The Fraud Enforcement and Recovery Act of 2009 expanded the scope of the False Claims Act by, among other things, creating liability for knowingly and improperly avoiding repayment of an overpayment received from the government and broadening protections for whistleblowers. Under the Health Reform Law, the False Claims Act is implicated by the knowing failure to report and return an overpayment within 60 days of identifying the overpayment or by the date a corresponding cost report is due, whichever is later. Further, the Health Reform Law expands the scope of the False Claims Act to cover payments in connection with the new health insurance exchanges to be created by the Health Reform Law, if those payments include any federal funds.

In some cases, whistleblowers or the federal government have taken the position that providers who allegedly have violated other statutes and have submitted claims to a governmental payer during the time period they allegedly violated these other statutes, have thereby submitted false claims under the False Claims Act. Such other statutes include the Anti-Kickback Statute and the Stark Law. Courts have held that violations of these statutes can properly form the basis of a False Claims Act case. The Health Reform Law clarifies this issue with respect to the Anti-Kickback Statute by providing that submission of claims for services or items generated in violation of the Anti-Kickback Statute constitutes a false or fraudulent claim under the False Claims Act.

A number of states, including states in which we operate, have adopted their own false claims provisions as well as their own whistleblower provisions whereby a private party may file a civil lawsuit in state court. From time to time, companies in the healthcare industry, including ours, may be subject to actions under the False Claims Act or similar state laws.

Provisions in the DRA that went into effect on January 1, 2007 give states significant financial incentives to enact false claims laws modeled on the federal False Claims Act. Additionally, the DRA requires every entity that receives annual payments of at least $5 million from a state Medicaid plan to establish written policies for its employees that provide detailed information about federal and state false claims statutes and the whistleblower protections that exist under those laws. Both provisions of the DRA are expected to result in increased false claims litigation against healthcare providers. We have complied with the written policy requirements.

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Corporate Practice of Medicine and Fee Splitting

The states in which we operate have laws that prohibit unlicensed persons or business entities, including corporations, from employing physicians or laws that prohibit certain direct or indirect payments or fee-splitting arrangements between physicians and unlicensed persons or business entities. Possible sanctions for violations of these restrictions include loss of a physician's license, civil and criminal penalties and rescission of business arrangements that may violate these restrictions. These statutes vary from state to state, are often vague and seldom have been interpreted by the courts or regulatory agencies. Although we exercise care to structure our arrangements with healthcare providers to comply with the relevant state law, and believe these arrangements comply with applicable laws in all material respects, we cannot assure you that governmental officials responsible for enforcing these laws will not assert that we, or transactions in which we are involved, are in violation of such laws, or that such laws ultimately will be interpreted by the courts in a manner consistent with our interpretations.

The Health Insurance Portability and Accountability Act of 1996

The Administrative Simplification Provisions of HIPAA require the use of uniform electronic data transmission standards for healthcare claims and payment transactions submitted or received electronically. These provisions are intended to encourage electronic commerce in the healthcare industry. HHS has issued regulations implementing the HIPAA Administrative Simplification Provisions and compliance with these regulations is mandatory for our facilities. In January 2009, CMS published a final rule regarding updated standard code sets for certain diagnoses and procedures known as ICD-10 code sets and related changes to the formats used for certain electronic transactions. While use of the ICD-10 code sets is not mandatory until October 1, 2013, we will be modifying our payment systems and processes to prepare for the implementation. In addition, HIPAA requires that each provider use a National Provider Identifier. While use of the ICD-10 code sets will require significant administrative changes, we believe that the cost of compliance with these regulations has not had and is not expected to have a material, adverse effect on our cash flows, financial position or results of operations. The Health Reform Law requires HHS to adopt standards for additional electronic transactions and to establish operating rules to promote uniformity in the implementation of each standardized electronic transaction.

The privacy and security regulations promulgated pursuant to HIPAA extensively regulate the use and disclosure of individually identifiable health information and require covered entities, including our hospitals and health plans, to implement administrative, physical and technical safeguards to protect the security of such information. The Health Information Technology for Economic and Clinical Health Act ("HITECH Act") — one part of the American Recovery and Reinvestment Act of 2009 ("ARRA") — broadened the scope of the HIPAA privacy and security regulations. On August 24, 2009, HHS issued an Interim Final Rule addressing security breach notification requirements and, on October 30, 2009, issued an Interim Final Rule implementing amendments to the enforcement regulations under HIPAA.

Violations of the HIPAA privacy and security regulations may result in civil and criminal penalties, and the HITECH Act has strengthened the enforcement provisions of HIPAA, which may result in increased enforcement activity. For violations occurring on or after February 18, 2009, entities are subject to tiered ranges for civil money penalty amounts based upon the increasing levels of culpability associated with violations. Under the October 30, 2009, Interim Final Rule, the range of minimum penalty amounts for each offense increases from up to $100 to $100 to $50,000 (for violations due to willful neglect and not corrected during the 30-day period beginning on the first date the entity knew, or, by exercising reasonable diligence, would have known that the violation occurred). Similarly, the penalty amount available in a calendar year for identical violations is substantially increased from $25,000 to $1,500,000. In addition, the ARRA authorizes state attorney generals to bring civil actions seeking either injunction or damages in response to violations of HIPAA privacy and security regulations that threaten the privacy of state residents. Additionally, ARRA broadens the applicability of the criminal penalty provisions to employees of covered entities and requires HHS to impose penalties for violations resulting from willful neglect. Further, under ARRA, HHS is now required to conduct periodic compliance audits of covered entities and their business associates.

The HITECH Act and the HHS Rules described above provide a framework for security breach notification requirements to individuals affected by a breach and, in some cases, to HHS or to prominent media outlets. Specifically, the statute and Rules require covered entities to report breaches of unsecured protected health information to affected individuals without unreasonable delay but not to exceed 60 days of discovery of the breach by a covered entity or its agents. Notification must also be made to HHS and, in certain situations involving large breaches, to the media. HHS is required to publish on its website a list of all covered entities that report a breach involving more than 500 individuals. This reporting obligation applies broadly to breaches involving unsecured protected health information and became effective September 23, 2009. In addition, the HITECH Act extends the application of certain provisions of the security and privacy regulations to business associates (entities that handle identifiable health information on behalf of covered entities) and subjects business associates to civil and criminal penalties for violation of the regulations beginning February 17, 2010.

In addition, we remain subject to any state laws that relate to privacy or the reporting of security breaches that are more restrictive than the regulations issued under HIPAA and the requirements of the ARRA. For example, various state laws and regulations may require us to notify affected individuals in the event of a data breach involving certain individually identifiable health or financial information. In addition, the Federal Trade Commission has issued regulations requiring health providers and health plans to implement by December 31, 2010 written identity theft prevention programs to detect, prevent, and mitigate identity theft in connection with certain accounts. We are in the process of complying with these new Federal Trade Commission regulations requiring identity theft prevention programs in all of our hospitals and health plans.

Compliance with these standards has and will continue to require significant commitment and action by us and significant costs. We have appointed members of our management team to direct our compliance with these standards. Implementation has and will continue to require us to engage in extensive preparation and make significant expenditures. At this time we have appointed a corporate privacy officer and a privacy officer at each of our facilities, prepared privacy policies, trained our workforce on these policies and entered into business associate agreements with the appropriate vendors. However, failure by us or third parties on which we rely, including payers, to resolve HIPAA-related implementation or operational issues could have a material adverse effect on our results of operations and our ability to provide healthcare services. Consequently, we can give you no assurance that issues related to the full implementation of, or our operations under, HIPAA will not have a material adverse effect on our financial condition, results of operations or cash flows

Conversion Legislation

Many states have enacted laws affecting the conversion or sale of not-for-profit hospitals. These laws generally include provisions relating to attorney general approval, advance notification and community involvement. In addition, attorneys general in states without specific conversion legislation may exercise authority over these transactions based upon existing law. In many states, there has been an increased interest in the oversight of not-for-profit conversions. The adoption of conversion legislation and the increased review of not-for-profit hospital conversions may increase the cost and difficulty or prevent the completion of transactions with or acquisitions of not-for-profit organizations in various states.

The Emergency Medical Treatment and Active Labor Act

The Federal Emergency Medical Treatment and Active Labor Act ("EMTALA") was adopted by the U.S. Congress in response to reports of a widespread hospital emergency room practice of "patient dumping." At the time of the enactment, patient dumping was considered to have occurred when a hospital capable of providing the needed care sent a patient to another facility or simply turned the patient away based on such patient's inability to pay for his or her care. The law imposes requirements upon physicians, hospitals and other facilities that provide emergency medical services. Such requirements pertain to what care must be provided to anyone who comes to such facilities seeking care before they may be transferred to another facility or otherwise denied care. The government broadly interprets the law to cover situations in which patients do not actually present to a hospital's emergency department, but present to a hospital-based clinic that treats emergency medical conditions on an urgent basis or are transported in a hospital-owned ambulance, subject to certain exceptions. EMTALA does not generally apply to patients admitted for inpatient services. Sanctions for violations of this statute include termination of a hospital's Medicare provider agreement, exclusion of a physician from participation in Medicare and Medicaid programs and civil monetary penalties. In addition, the law creates private civil remedies that enable an individual who suffers personal harm as a direct result of a violation of the law, and a medical facility that suffers a financial loss as a direct result of another participating hospital's violation of the law, to sue the offending hospital for damages and equitable relief. Although we believe that our practices are in substantial compliance with the law, we cannot assure you that governmental officials responsible for enforcing the law will not assert from time to time that our facilities are in violation of this statute.

Antitrust Laws

The federal government and most states have enacted antitrust laws that prohibit certain types of conduct deemed to be anti-competitive. These laws prohibit price fixing, agreements to fix wages, concerted refusal to deal, market monopolization, price discrimination, tying arrangements, acquisitions of competitors and other practices that have, or may have, an adverse effect on competition. Violations of federal or state antitrust laws can result in various sanctions, including criminal and civil penalties. Antitrust enforcement in the healthcare industry is currently a priority of the Federal Trade Commission. We believe we are in compliance with such federal and state laws, but there can be no assurance that a review of our practices by courts or regulatory authorities will not result in a determination that could adversely affect our operations.

Healthcare Reform

The Health Reform Law will change how healthcare services are covered, delivered and reimbursed through expanded coverage of uninsured individuals, reduced growth in Medicare program spending, reductions in Medicare and Medicaid DSH payments, and the establishment of programs where reimbursement is tied to quality and integration. In addition, the new law reforms certain aspects of health insurance, expands existing efforts to tie Medicare and Medicaid payments to performance and quality and contains provisions intended to strengthen fraud and abuse enforcement.

Expanded Coverage

Based on the Congressional Budget Office ("CBO") and CMS estimates, by 2019, the Health Reform Law will expand coverage to 32 to 34 million additional individuals (resulting in coverage of an estimated 94% of the legal U.S. population). This increased coverage will occur through a combination of public program expansion and private sector health insurance and other reforms.

Medicaid Expansion. The primary public program coverage expansion will occur through changes in Medicaid, and to a lesser extent, expansion of the Children's Health Insurance Program ("CHIP"). The most significant changes will expand the categories of individuals eligible for Medicaid coverage and permit individuals with relatively higher incomes to qualify. The federal government reimburses the majority of a state's Medicaid expenses, and it conditions its payment on the state meeting certain requirements. The federal government currently requires that states provide coverage for only limited categories of low-income adults under 65 years old (e.g., women who are pregnant, and the blind or disabled). In addition, the income level required for individuals and families to qualify for Medicaid varies widely from state to state.

The Health Reform Law materially changes the requirements for Medicaid eligibility. Commencing January 1, 2014, all state Medicaid programs are required to provide, and the federal government will subsidize, Medicaid coverage to virtually all adults under 65 years old with incomes at or under 133% of the Federal Poverty Level ("FPL"). This expansion will create a minimum Medicaid eligibility threshold that is uniform across states. Further, the Health Reform Law also requires states to apply a "5% income disregard" to the Medicaid eligibility standard, so that Medicaid eligibility will effectively be extended to those with incomes up to 138% of the FPL. These new eligibility requirements will expand Medicaid and CHIP coverage by an estimated 16 to 18 million persons nationwide. A disproportionately large percentage of the new Medicaid coverage is likely to be in states that currently have relatively low income eligibility requirements.

As Medicaid is a joint federal and state program, the federal government provides states with "matching funds" in a defined percentage, known as the federal medical assistance percentage ("FMAP"). Beginning in 2014, states will receive an enhanced FMAP for the individuals enrolled in Medicaid pursuant to the Health Reform Law. The FMAP percentage is as follows: 100% for calendar years 2014 through 2016, 95% for 2017; 94% in 2018; 93% in 2019; and 90% in 2020 and thereafter.

The Health Reform Law also provides that the federal government will subsidize states that create non-Medicaid plans for residents whose incomes are greater than 133% of the FPL but do not exceed 200% of the FPL. Approved state plans will be eligible to receive federal funding. The amount of that funding per individual will be equal to 95% of subsidies that would have been provided for that individual had he or she enrolled in a health plan offered through one of the Exchanges, as discussed below.

Historically, states often have attempted to reduce Medicaid spending by limiting benefits and tightening Medicaid eligibility requirements. Effective March 23, 2010, the Health Reform Law requires states to at least maintain Medicaid eligibility standards established prior to the enactment of the law for adults until January 1, 2014 and for children until October 1, 2019. States with budget deficits may, however, seek exemptions from this requirement, but only to address eligibility standards that apply to adults making more than 133% of the FPL.

Private Sector Expansion. The expansion of health coverage through the private sector as a result of the Health Reform Law will occur through new requirements on health insurers, employers and individuals. Commencing January 1, 2014, health insurance companies will be prohibited from imposing annual coverage limits, dropping coverage, excluding persons based upon pre-existing conditions or denying coverage for any individual who is willing to pay the premiums for such coverage. Effective January 1, 2011, each health plan must keep its annual non-medical costs lower than 15% of premium revenue for the group market and lower than 20% in the small group and individual markets or rebate its enrollees the amount spent in excess of the percentage. In addition, effective September 23, 2010, health insurers will not be permitted to deny coverage to children based upon a pre-existing condition and must allow dependent care coverage for children up to 26 years old.

Larger employers will be subject to new requirements and incentives to provide health insurance benefits to their full time employees. Effective January 1, 2014, employers with 50 or more employees that do not offer health insurance will be held subject to a penalty if an employee obtains coverage through an Exchange if the coverage is subsidized by the government. The employer penalties will range from $2,000 to $3,000 per employee, subject to certain thresholds and conditions.

The Health Reform Law uses various means to induce individuals who do not have health insurance to obtain coverage. By January 1, 2014, individuals will be required to maintain health insurance for a minimum defined set of benefits or pay a tax penalty. The penalty in most cases is $95 in 2014, $325 in 2015, $695 in 2016, and indexed to a cost of living adjustment in subsequent years. The IRS, in consultation with HHS, is responsible for enforcing the tax penalty, although the Health Reform Law limits the availability of certain IRS enforcement mechanisms. In addition, for individuals and families below 400% of the FPL, the cost of obtaining health insurance will be subsidized by the federal government. Those with lower incomes will be eligible to receive greater subsidies. It is anticipated that those at the lowest income levels will have the majority of their premiums subsidized by the federal government, in some cases in excess of 95% of the premium amount.

To facilitate the purchase of health insurance by individuals and small employers, each state must establish an Exchange by January 1, 2014. Based on CBO and CMS estimates, between 29 and 31 million individuals will obtain their health insurance coverage through an Exchange by 2019. Of that amount, an estimated 16 million will be individuals who were previously uninsured, and 13 to 15 million will be individuals who switched from their prior insurance coverage to a plan obtained through the Exchange. The Health Reform Law requires that the Exchanges be designed to make the process of evaluating, comparing and acquiring coverage simple for consumers. For example, each state's Exchange must maintain an internet website through which consumers may access health plan ratings that are assigned by the state based on quality and price, view governmental health program eligibility requirements and calculate the actual cost of health coverage. Health insurers participating in the Exchange must offer a set of minimum benefits to be defined by HHS and may offer more benefits. Health insurers must offer at least two, and up to five, levels of plans that vary by the percentage of medical expenses that must be paid by the enrollee. These levels are referred to as platinum, gold, silver, bronze and catastrophic plans, with gold and silver being the two mandatory levels of plans. Each level of plan must require the enrollee to share the following percentages of medical expenses up to the deductible/co-payment limit: platinum, 10%; gold, 20%; silver, 30%, bronze, 40%; and catastrophic, 100%. Health insurers may establish varying deductible/co-payment levels, up to the statutory maximum (estimated to be between $6,000 and $7,000 for an individual). The health insurers must cover 100% of the amount of medical expenses in excess of the deductible/co-payment limit. For example, an individual making 100% to 200% of the FPL will have co-payments and deductibles reduced to about one-third of the amount payable by those with the same plan with incomes at or above 400% of the FPL.

Public Program Spending

The Health Reform Law provides for Medicare, Medicaid and other federal healthcare program spending reductions between 2010 and 2019. The CBO estimates that these will include $196 billion in Medicare fee-for-service market basket and productivity reimbursement reductions for all providers, the majority of which will come from hospitals; CMS sets this estimate at $233 billion. The CBO estimates also include an additional $36 billion in reductions of Medicare and Medicaid disproportionate share funding ($22 billion for Medicare and $14 billion for Medicaid). CMS estimates include an additional $64 billion in reductions of Medicare and Medicaid DSH funding, with $50 billion of the reductions coming from Medicare

Payments for Hospitals

Inpatient Market Basket and Productivity Adjustment. Under the Medicare program, hospitals receive reimbursement under a PPS for general, acute care hospital inpatient services. CMS establishes fixed PPS payment amounts per inpatient discharge based on the patient's assigned MS-DRG. These MS-DRG rates are updated each federal fiscal year, which begins October 1, using the market basket, which takes into account inflation experienced by hospitals and other entities outside the healthcare industry in purchasing goods and services.

The Health Reform Law provides for three types of annual reductions in the market basket. The first is a general reduction of a specified percentage each federal fiscal year starting in 2010 and extending through 2019. These reductions are as follows: federal fiscal year 2010, 0.25% for discharges occurring on or after April 1, 2010, 2011 (0.25%); 2012 (0.1%); 2013 (0.1%); 2014 (0.3%); 2015 (0.2%); 2016 (0.2%); 2017 (0.75%), 2018 (0.75%), and 2019 (0.75%).

The second type of reduction to the market basket is a "productivity adjustment" that will be implemented by HHS beginning in federal fiscal year 2012. The amount of that reduction will be the projected nationwide productivity gains over the preceding 10 years. To determine the projection, HHS will use the Bureau of Labor Statistics ("BLS") 10-year moving average of changes in specified economy-wide productivity (the BLS data is typically a few years old). The Health Reform Law does not contain guidelines for HHS to use in projecting the productivity figure. Based upon the latest available data, federal fiscal year 2012 market basket reductions resulting from this productivity adjustment are likely to range from 1% to 1.4%.

The third type of reduction is in connection with the value-based purchasing program discussed in more detail below. Beginning in federal fiscal year 2013, CMS will reduce the inpatient PPS payment amount for all discharges by the following: 1% for 2013; 1.25% for 2014; 1.5% for 2015; 1.75% for 2016; and 2% for 2017 and subsequent years. For each federal fiscal year, the total amount collected from these reductions will be pooled and used to fund payments to hospitals that satisfy certain quality metrics. While some or all of these reductions may be recovered if a hospital satisfies these quality metrics, the recovery amounts may be delayed.

If the aggregate of the three market basket reductions described above is more than the annual market basket adjustments made to account for inflation, there will be a reduction in the MS-DRG rates paid to hospitals. For example, if market basket increases to account for inflation would result in a 2% market basket update and the aggregate Health Reform Law market basket adjustments would result in a 3% reduction, then the rates paid to a hospital for inpatient services would be 1% less than rates paid for the same services in the prior year.

Quality-Based Payment Adjustments and Reductions for Inpatient Services. The Health Reform Law establishes or expands three provisions to promote value-based purchasing and to link payments to quality and efficiency. First, in federal fiscal year 2013, HHS is directed to implement a value-based purchasing program for inpatient hospital services. This program will reward hospitals that meet certain quality performance standards established by HHS. The Health Reform Law provides HHS considerable discretion over the value-based purchasing program. For example, HHS will have the authority to determine the quality performance measures, the standards hospitals must achieve in order to meet the quality performance measures, and the methodology for calculating payments to hospitals that meet the required quality threshold. HHS will also determine how much money each hospital will receive from the pool of dollars created by the reductions related to the value-based purchasing program as described above. Because the Health Reform Law provides that the pool will be fully distributed, hospitals that meet or exceed the quality performance standards set by HHS will receive greater reimbursement under the value-based purchasing program than they would have otherwise. On the other hand, hospitals that do not achieve the necessary quality performance will receive reduced Medicare inpatient hospital payments.

Second, beginning in federal fiscal year 2013, inpatient payments will be reduced if a hospital experiences "excessive readmissions" within a 30-day period of discharge for heart attack, heart failure, pneumonia or other conditions designated by HHS. Hospitals with what HHS defines as "excessive readmissions" for these conditions will receive reduced payments for all inpatient discharges, not just discharges relating to the conditions subject to the excessive readmission standard. Each hospital's performance will be publicly reported by HHS. HHS has the discretion to determine what "excessive readmissions" means, the amount of the payment reduction and other terms and conditions of this program.

Third, reimbursement will be reduced based on a facility's hospital acquired condition, or HAC, rates. HACs represent a condition that is acquired by a patient while admitted as an inpatient in a hospital, such as a surgical site infection. Beginning in federal fiscal year 2015, hospitals that rank in the top 25% nationally of HACs for all hospitals in the previous year will receive a 1% reduction in their total Medicare payments. In addition, effective July 1, 2011, the Health Reform Law prohibits the use of federal funds under the Medicaid program to reimburse providers for medical services provided to treat HACs.

Outpatient Market Basket and Productivity Adjustment. Hospital outpatient services paid under PPS are classified into APCs. The APC payment rates are updated each calendar year based on the market basket. The first two market basket changes outlined above — the general reduction and the productivity adjustment — apply to outpatient services as well as inpatient services, although these are applied on a calendar year basis. The percentage changes specified in the Health Reform Law summarized above as the general reduction for inpatients — e.g., 0.2% in 2015 — are the same for outpatients.

Medicare and Medicaid Disproportionate Share Hospital Payments. The Medicare DSH program provides for additional payments to hospitals that treat a disproportionate share of low-income patients. Under the Health Reform Law, beginning in federal fiscal year 2014, Medicare DSH payments will be reduced to 25% of the amount they otherwise would have been absent the new law. The remaining 75% of the amount that would otherwise be paid under Medicare DSH will be effectively pooled, and this pool will be reduced further each year by a formula that reflects reductions in the national level of uninsured who are under 65 years of age. In other words, the greater the level of coverage for the uninsured nationally, the more the Medicare DSH payment pool will be reduced. Each hospital will then be paid, out of the reduced DSH payment pool, an amount allocated based upon its level of uncompensated care.

It is difficult to predict the full impact of the Medicare DSH reductions, and CBO and CMS estimates differ by $28 billion. The Health Reform Law does not mandate what data source HHS must use to determine the reduction, if any, in the uninsured population nationally. In addition, the Health Reform Law does not contain a definition of "uncompensated care." As a result, it is unclear how a hospital's share of the Medicare DSH payment pool will be calculated. CMS could use the definition of "uncompensated care" used in connection with hospital cost reports.

However, in July 2009, CMS proposed material revisions to the definition of "uncompensated care" used for cost report purposes. Those revisions would exclude certain significant costs that had historically been covered, such as unreimbursed costs of Medicaid services. CMS has not issued a final rule, and the Health Reform Law does not require HHS to use this definition, even if finalized, for DSH purposes. How CMS ultimately defines "uncompensated care" for purposes of these DSH funding provisions could have a material effect on a hospital's Medicare DSH reimbursements.

In addition to Medicare DSH funding, hospitals that provide care to a disproportionately high number of low-income patients may receive Medicaid DSH payments. The federal government distributes federal Medicaid DSH funds to each state based on a statutory formula. The states then distribute the DSH funding among qualifying hospitals. Although Federal Medicaid law defines some level of hospitals that must receive Medicaid DSH funding, states have broad discretion to define additional hospitals that also may qualify for Medicaid DSH payments and the amount of such payments. The Health Reform Law will reduce funding for the Medicaid DSH hospital program in federal fiscal years 2014 through 2020 by the following amounts: 2014 ($500 million); 2015 ($600 million); 2016 ($600 million); 2017 ($1.8 billion); 2018 ($5 billion); 2019 ($5.6 billion); and 2020 ($4 billion). How such cuts are allocated among the states, and how the states allocate these cuts among providers, have yet to be determined.

Accountable Care Organizations. The Health Reform Law requires HHS to establish a Medicare Shared Savings Program that promotes accountability and coordination of care through the creation of ACOs. Beginning no later than January 1, 2012, the program will allow providers (including hospitals), physicians and other designated professionals and suppliers to form ACOs and voluntarily work together to invest in infrastructure and redesign delivery processes to achieve high quality and efficient delivery of services. The program is intended to produce savings as a result of improved quality and operational efficiency. ACOs that achieve quality performance standards established by HHS will be eligible to share in a portion of the amounts saved by the Medicare program. HHS has significant discretion to determine key elements of the program, including what steps providers must take to be considered an ACO, how to decide if Medicare program savings have occurred and what portion of such savings will be paid to ACOs. In addition, HHS will determine to what degree hospitals, physicians and other eligible participants will be able to form and operate an ACO without violating certain existing laws, including the Civil Monetary Penalty Law, the Anti-kickback Statute and the Stark Law. However, the Health Reform Law does not authorize HHS to waive other laws that may impact the ability of hospitals and other eligible participants to participate in ACOs, such as antitrust laws.

Bundled Payment Pilot Programs. The Health Reform Law requires HHS to establish a five-year, voluntary national bundled payment pilot program for Medicare services beginning no later than January 1, 2013. Under the program, providers would agree to receive one payment for services provided to Medicare patients for certain medical conditions or episodes of care. HHS will have the discretion to determine how the program will function. For example, HHS will determine what medical conditions will be included in the program and the amount of the payment for each condition. In addition, the Health Reform Law provides for a five-year bundled payment pilot program for Medicaid services to begin January 1, 2012. HHS will select up to eight states to participate based on the potential to lower costs under the Medicaid program while improving care. State programs may target particular categories of beneficiaries, selected diagnoses or geographic regions of the state. The selected state programs will provide one payment for both hospital and physician services provided to Medicaid patients for certain episodes of inpatient care. For both pilot programs, HHS will determine the relationship between the programs and restrictions in certain existing laws, including the Civil Monetary Penalty Law, the Anti-kickback Statute, the Stark Law and the HIPAA privacy, security and transaction standard requirements. However, the Health Reform Law does not authorize HHS to waive other laws that may impact the ability of hospitals and other eligible participants to participate in the pilot programs, such as antitrust laws.

Medicare Managed Care (Medicare Advantage or "MA"). Under the MA program, the federal government contracts with private health plans to provide inpatient and outpatient benefits to beneficiaries who enroll in such plans. Nationally, approximately 24% of Medicare beneficiaries have elected to enroll in MA plans. Effective in 2014, the Health Reform Law requires MA plans to keep annual administrative costs lower than 15% of annual premium revenue. The Health Reform Law reduces, over a three year period, premium payments to the MA Plans such that CMS' managed care per capita premium payments are, on average, equal to traditional Medicare. As a result of these changes, payments to MA plans will be reduced by $138 to $145 billion between 2010 and 2019. These reductions to MA plan premium payments may cause some plans to raise premiums or limit benefits, which in turn might cause some Medicare beneficiaries to terminate their MA coverage and enroll in traditional Medicare.

Specialty Hospital Limitations

Over the last decade, we have faced significant competition from hospitals that have physician ownership. The Health Reform Law prohibits newly created physician-owned hospitals from billing for Medicare patients referred by their physician owners. As a result, the new law will effectively prevent the formation of physician-owned hospitals after December 31, 2010. While the new law grandfathers existing physician-owned hospitals, it does not allow these hospitals to increase the percentage of physician ownership and significantly restricts their ability to expand services.

Program Integrity and Fraud and Abuse

The Health Reform Law makes several significant changes to healthcare fraud and abuse laws, provides additional enforcement tools to the government, increases cooperation between agencies by establishing mechanisms for the sharing of information and enhances criminal and administrative penalties for non-compliance. For example, the Health Reform Law: (1) provides $350 million in increased federal funding over the next 10 years to fight healthcare fraud, waste and abuse; (2) expands the scope of the RAC program to include MA plans and Medicaid; (3) authorizes HHS, in consultation with the OIG, to suspend Medicare and Medicaid payments to a provider of services or a supplier "pending an investigation of a credible allegation of fraud;" (4) provides Medicare contractors with additional flexibility to conduct random prepayment reviews; and (5) tightens up the requirements for returning overpayments made by governmental health programs and expands False Claims Act liability to include failure to report and return an overpayment within 60 days of identifying the overpayment or by the date a corresponding cost report is due, whichever is later.

Impact of Health Reform Law on Us

The expansion of health insurance coverage under the Health Reform Law may result in a material increase in the number of patients using our facilities who have either private or public program coverage. In addition, a disproportionately large percentage of the new Medicaid coverage is likely to be in states that currently have relatively low income eligibility requirements. Two such states are Texas and Illinois, where as of June 30, 2010 over 50% of our licensed beds were located. Further, the Health Reform Law provides for a value-based purchasing program, the establishment of ACOs and bundled payment pilot programs, which will create possible sources of additional revenue.

However, it is difficult to predict the size of the potential revenue gains to us as a result of these elements of the Health Reform Law, because of uncertainty surrounding a number of material factors, including the following:

- how many previously uninsured individuals will obtain coverage as a result of the Health Reform Law (while the CBO estimates 32 million, CMS estimates almost 34 million; both agencies made a number of assumptions to derive that figure, including how many individuals will ignore substantial subsidies and decide to pay the penalty rather than obtain health insurance and what percentage of people in the future will meet the new Medicaid income eligibility requirements);
- what percentage of the newly insured patients will be covered under the Medicaid program and what percentage will be covered by private health insurers
- the extent to which states will enroll new Medicaid participants in managed care programs;
- the pace at which insurance coverage expands, including the pace of different types of coverage expansion;
- the change, if any, in the volume of inpatient and outpatient hospital services that are sought by and provided to previously uninsured individuals;
- the rate paid to hospitals by private payers for newly covered individuals, including those covered through the newly created Exchanges and those who might be covered under the Medicaid program under contracts with the state;
- the rate paid by state governments under the Medicaid program for newly covered individuals;
- how the value-based purchasing and other quality programs will be implemented;
- the percentage of individuals in the Exchanges who select the high deductible plans, since health insurers offering those kinds of products have traditionally sought to pay lower rates to hospitals;
- the extent to which the net effect of the Health Reform Law, including the prohibition on excluding individuals based on pre-existing conditions, the requirement to keep medical costs lower than a specified percentage of premium revenue, other health insurance reforms and the annual fee applied to all health insurers, will put pressure on the profitability of health insurers, which in turn might cause them to seek to reduce payments to hospitals with respect to both newly insured individuals and their existing business; and
- the possibility that implementation of provisions expanding health insurance coverage will be delayed or even blocked due to court challenges or revised or eliminated as a result of efforts to repeal or amend the new law.

On the other hand, the Health Reform Law provides for significant reductions in the growth of Medicare spending, reductions in Medicare and Medicaid DSH payments and the establishment of programs where reimbursement is tied to quality and integration. Since approximately 57% of our revenues during our fiscal year ended June 30, 2010 were from Medicare and Medicaid (including Medicare and Medicaid managed plans), reductions to these programs may significantly impact us and could offset any positive effects of the Health Reform Law. It is difficult to predict the size of the revenue reductions to Medicare and Medicaid spending, because of uncertainty regarding a number of material factors, including the following:

- the amount of overall revenues we will generate from Medicare and Medicaid business when the reductions are implemented;
- whether reductions required by the Health Reform Law will be changed by statute prior to becoming effective;
- the size of the Health Reform Law's annual productivity adjustment to the market basket beginning in 2012 payment years;
- the amount of the Medicare DSH reductions that will be made, commencing in federal fiscal year 2014;
- the allocation to our hospitals of the Medicaid DSH reductions, commencing in federal fiscal year 2014;
- what the losses in revenues will be, if any, from the Health Reform Law's quality initiatives;
- how successful ACOs, in which we participate, will be at coordinating care and reducing costs;
- the scope and nature of potential changes to Medicare reimbursement methods, such as an emphasis on bundling payments or coordination of care programs;

- whether our revenues from UPL programs will be adversely affected, because there may be fewer indigent, non-Medicaid patients for whom we provide services pursuant to UPL programs; and
- reductions to Medicare payments CMS may impose for "excessive readmissions.

Because of the many variables involved, we are unable to predict the net effect on us of the expected decreases in uninsured individuals using our facilities, the reductions in Medicare spending and reductions in Medicare and Medicaid DSH Funding and numerous other provisions in the Health Reform Law that may affect us.

Healthcare Industry Investigations

Significant media and public attention has focused in recent years on the hospital industry. In recent years, increased attention has been paid to hospitals with high Medicare outlier payments and to recruitment arrangements with physicians. Further, there are numerous ongoing federal and state investigations regarding multiple issues. These investigations have targeted hospital companies as well as their executives and managers. Like other hospital companies, we have substantial Medicare, Medicaid and other governmental billings and we engage in various arrangements with physicians, which could result in scrutiny of our operations. We continue to monitor these and all other aspects of our business and have developed a compliance program to assist us in gaining comfort that our business practices are consistent with both legal principles and current industry standards. However, because the law in this area is complex and constantly evolving, we cannot assure you that government investigations will not result in interpretations that are inconsistent with industry practices, including ours. In public statements surrounding current investigations, governmental authorities have taken positions on a number of issues, including some for which little official interpretation previously has been available, that appear to be inconsistent with practices that have been common within the industry and that previously have not been challenged in this manner. In some instances, government investigations that have in the past been conducted under the civil provisions of federal law may now be conducted as criminal investigations.

Many current healthcare investigations are national initiatives in which federal agencies target an entire segment of the healthcare industry. One example is the federal government's initiative regarding hospital providers' improper requests for separate payments for services rendered to a patient on an outpatient basis within three days prior to the patient's admission to the hospital, where reimbursement for such services is included as part of the reimbursement for services furnished during an inpatient stay. In particular, the government has targeted all hospital providers to ensure conformity with this reimbursement rule. The federal government also has undertaken a national investigative initiative targeting the billing of claims for inpatient services related to bacterial pneumonia, as the government has found that many hospital providers have attempted to bill for pneumonia cases under more complex and higher reimbursed diagnosis related groups codes. Further, the federal government continues to investigate Medicare overpayments to prospective payment hospitals that incorrectly report transfers of patients to other prospective payment system hospitals as discharges. The Health Reform Law includes additional federal funding of $350 million over the next 10 years to fight healthcare fraud, waste and abuse, including $95 million for federal fiscal year 2011, $55 million in federal fiscal year 2012 and additional increased funding through 2016. In addition, governmental agencies and their agents, such as the MACs, fiscal intermediaries and carriers, may conduct audits of our healthcare operations. Also, we are aware that prior to our acquisition of them, several of our hospitals were contacted in relation to certain government investigations relating to their operations. Although we take the position that, under the terms of the acquisition agreements, the prior owners of these hospitals retained any liability resulting from these government investigations, we cannot assure you that the prior owners' resolution of these matters or failure to resolve these matters, in the event that any resolution was deemed necessary, will not have a material adverse effect on our operations. Further, under the federal False Claims Act, private parties have the right to bring *"qui tam"* whistleblower lawsuits against companies that submit false claims for payments to the government. Some states have adopted similar state whistleblower and false claims provisions.

In addition to national enforcement initiatives, federal and state investigations commonly relate to a wide variety of routine healthcare operations such as: cost reporting and billing practices; financial arrangements with referral sources; physician recruitment activities; physician joint ventures; and hospital charges and collection practices for self-pay patients. We engage in many of these routine healthcare operations and other activities that could be the subject of governmental investigations or inquiries from time to time. For example, we have significant Medicare and Medicaid billings, we have numerous financial arrangements with physicians who are referral sources to our hospitals and we have joint venture arrangements involving physician investors.

While we are not currently aware of any material investigation of us under federal or state healthcare laws or regulations, it is possible that governmental entities may conduct investigations at facilities operated by us and that such investigations could result in significant penalties to us, as well as adverse publicity. It is also possible that our executives and managers, many of whom have worked at other healthcare companies that are or may become the subject of federal and state investigations and private litigation, could be included in governmental investigations or named as defendants in private litigation. The positions taken by authorities in any future investigations of us, our executives or managers or other healthcare providers and the liabilities or penalties that may be imposed could have a material adverse effect on our business, financial condition and results of operations.

Health Plan Regulatory Matters

Our health plans are subject to state and federal laws and regulations. CMS has the right to audit our health plans to determine the plans' compliance with such standards. In addition, AHCCCS has the right to audit PHP to determine PHP's compliance with such standards. Also, PHP is required to file periodic reports with AHCCCS, meet certain financial viability standards, provide its members with certain mandated benefits and meet certain quality assurance and improvement requirements. Our health plans also have to comply with the standardized formats for electronic transmissions and privacy and

security standards set forth in the Administrative Simplifications Provisions of HIPAA. Our health plans have implemented the necessary policies and procedures to comply with the final federal regulations on these matters and were in compliance with them by their deadlines.

The Anti-Kickback Statute has been interpreted to prohibit the payment, solicitation, offering or receipt of any form of remuneration in return for the referral of federal health program patients or any item or service that is reimbursed, in whole or in part, by any federal healthcare program. Similar statutes have been adopted in Illinois and Arizona that apply regardless of the source of reimbursement. The Department of Health and Human Services has adopted safe harbor regulations specifying certain relationships and activities that are deemed not to violate the Anti-Kickback Statute which specifically relate to managed care including:

- waivers by health maintenance organizations of Medicare and Medicaid beneficiaries' obligations to pay cost-sharing amounts or to provide other incentives in order to attract Medicare and Medicaid enrollees;
- certain discounts offered to prepaid health plans by contracting providers;
- certain price reductions offered to eligible managed care organizations; and
- certain price reductions offered by contractors with substantial financial risk to managed care providers.

We believe that the incentives offered by our health plans to their members and the discounts they receive contracting with healthcare providers satisfy the requirements of the safe harbor regulations. However, the failure to satisfy each criterion of the applicable safe harbor does not mean that the arrangement constitutes a violation of the law; rather, the safe harbor regulations provide that an arrangement which does not fit within a safe harbor must be analyzed on the basis of its specific facts and circumstances. We believe that our health plans' arrangements comply in all material respects with the federal Anti-Kickback Statute and similar state statutes.

Environmental Matters

We are subject to various federal, state and local laws and regulations including those relating to the protection of human health and the environment. Our hospitals are not highly regulated under environmental laws because we do not engage in any industrial activities at those locations. The principal environmental requirements and concerns applicable to our operations relate to:

- the proper handling and disposal of hazardous and low level medical radioactive waste;
- ownership or historical use of underground and above-ground storage tanks;
- management of impacts from leaks of hydraulic fluid or oil associated with elevators, chiller units or incinerators;
- appropriate management of asbestos-containing materials present or likely to be present at some locations; and
- the potential acquisition of, or maintenance of air emission permits for, boilers or other equipment.

We do not expect our compliance with environmental laws and regulations to have a material adverse effect on us. We may also be subject to requirements related to the remediation of substances that have been released into the environment from or into properties owned or operated or formerly owned properties by us or at properties where substances were sent for off-site treatment or disposal. These remediation requirements may be imposed without regard to fault and whether or not we owned or operated the property at the time that the relevant releases or discharges occurred. Liability for environmental remediation can be substantial.

General Economic and Demographic Factors

The United States economy continues to be weak. Depressed consumer spending and higher unemployment rates continue to pressure many industries. During economic downturns, governmental entities often experience budget deficits as a result of increased costs and lower than expected tax collections. These budget deficits have forced federal, state and local government entities to decrease spending for health and human service programs, including Medicare, Medicaid and similar programs, which represent significant payer sources for our hospitals. Other risks we face from general economic weakness include potential declines in the population covered under managed care agreements, patient decisions to postpone or cancel elective and non-emergency healthcare procedures, potential increases in the uninsured and underinsured populations and further difficulties in our collecting patient co-payment and deductible receivables. The Health Reform Law seeks to decrease over time the number of uninsured individuals, by among other things requiring employers to offer, and individuals to carry, health insurance or be subject to penalties. However, it is difficult to predict the full impact of the Health Reform Law due to the law's complexity, lack of implementing regulations or interpretive guidance, gradual implementation and possible amendment.

The healthcare industry is impacted by the overall United States financial pressures. The federal deficit, the growing magnitude of Medicare expenditures and the aging of the United States population will continue to place pressure on federal

healthcare programs.

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Item 1A. Risk Factors.

If any of the following events discussed in the following risks were to occur, our business, results of operations, financial condition, cash flows or prospects could be materially adversely affected. Additional risks and uncertainties not presently known, or currently deemed immaterial by us, may also constrain our business and operations.

Risks Related to Our Capital Structure

Our high level of debt and significant leverage may adversely affect our operations and our ability to grow and otherwise execute our business strategy.

On January 29, 2010, we completed a comprehensive refinancing plan (the "Refinancing"). Under the Refinancing, we entered into an $815.0 million senior secured term loan maturing in January 2016 (the "New Term Loan Credit Facility") and a $260.0 million revolving credit facility expiring in January 2015 (the "New Revolving Credit Facility" and together with the New Term Loan Credit Facility, the "New Credit Facilities"). Under the Refinancing, we also issued $950.0 million aggregate amount at maturity ($936.3 million cash proceeds) of 8.0% senior unsecured notes due February 2018 (the "8.0% Notes") in a private placement offering at an offering price of 98.555%. On July 14, 2010, we completed an add-on private placement offering of $225.0 million aggregate principal amount of additional 8.0% Notes (the "Add-on Offering") under the indenture governing the 8.0% Notes issued on January 29, 2010. The 8.0% Notes from the Add-on Offering were issued at an offering price of 96.250% plus accrued interest from January 29, 2010.

We continue to have substantial indebtedness after the Refinancing and the Add-on Offering. As of August 15, 2010, we had $1,966.7 million of outstanding debt, excluding letters of credit and guarantees. As of August 15, 2010, we also have $231.6 million of secured indebtedness available for borrowing under the New Revolving Credit Facility, after taking into account $28.4 million of outstanding letters of credit. In addition, we may request an incremental term loan facility to be added to the New Term Loan Credit Facility to issue additional term loans in such amounts as we determine subject to the receipt of lender commitments and subject to certain other conditions. Similarly, we may seek to increase the borrowing availability under the New Revolving Credit Facility to an amount larger than $260.0 million, subject to the receipt of lender commitments and subject to certain other conditions. The amount of our outstanding indebtedness is substantial compared to the net book value of our assets.

Our substantial indebtedness could have important consequences, including the following:

- our high level of indebtedness could make it more difficult for us to satisfy our obligations with respect to the 8.0% Notes, including any repurchase obligations that may arise thereunder;
- limit our ability to obtain additional financing to fund future capital expenditures, working capital, acquisitions or other needs;
- increase our vulnerability to general adverse economic, market and industry conditions and limit our flexibility in planning for, or reacting to, these conditions;
- make us vulnerable to increases in interest rates since all of our borrowings under our New Credit Facilities are, and additional borrowings may be, at variable interest rates;
- our flexibility to adjust to changing market conditions and ability to withstand competitive pressures could be limited, and we may be more vulnerable to a downturn in general economic or industry conditions or be unable to carry out capital spending that is necessary or important to our growth strategy and our efforts to improve operating margins;
- limit our ability to use operating cash in other areas of our business because we must use a substantial portion of these funds to make principal and interest payments; and
- limit our ability to compete with others who are not as highly-leveraged.

Our ability to make scheduled payments of principal and interest or to satisfy our other debt obligations, to refinance our indebtedness or to fund capital expenditures will depend on our future operating performance. Prevailing economic conditions (including interest rates) and financial, business and other factors, many of which are beyond our control, will also affect our ability to meet these needs. We may not be able to generate sufficient cash flows from operations or realize anticipated revenue growth or operating improvements, or obtain future borrowings in an amount sufficient to enable us to pay our debt, or to fund our other liquidity needs. We may need to refinance all or a portion of our debt on or before maturity. We may not be able to refinance any of our debt when needed on commercially reasonable terms or at all.

A breach of any of the restrictions or covenants in our debt agreements could cause a cross-default under other debt agreements. A significant portion of our indebtedness then may become immediately due and payable. We are not certain whether we would have, or be able to obtain, sufficient funds to make these accelerated payments. If any senior debt is accelerated, our assets may not be sufficient to repay in full such indebtedness and our other indebtedness.

Despite our current leverage, we may still be able to incur substantially more debt. This could further exacerbate the risks that we and our subsidiaries face.

We and our subsidiaries may be able to incur substantial additional indebtedness in the future. The terms of the indenture governing the 8.0% Notes and the New Credit Facilities do not fully prohibit us or our subsidiaries from doing so. Our New Revolving Credit Facility provides commitments of up to $260.0 million (not giving effect to any outstanding letters of credit, which would reduce the amount available under our New Revolving Credit Facility), of which $231.6 million is available for future borrowings as of August 15, 2010. In addition, we may seek to increase the borrowing availability under the New Revolving Credit Facility and to increase the amount of our New Term Loan Credit Facility as previously described. All of those borrowings would be senior and secured, and as a result, would be effectively senior to the 8.0% Notes and the guarantees of the 8.0% Notes by the guarantors. If we incur any additional indebtedness that ranks equally with the 8.0% Notes, the holders of that debt will be entitled to share ratably with the holders of the 8.0% Notes in any proceeds distributed in connection with any insolvency, liquidation, reorganization, dissolution or other winding-up of us. If new debt is added to our current debt levels, the related risks that we and our subsidiaries now face could intensify.

Operating and financial restrictions in our debt agreements limit our operational and financial flexibility.

The senior credit facilities and the indenture under which $1,175.0 million aggregate principal amount of our 8.0% Notes were issued as part of the Refinancing and the Add-on Offering contain a number of significant covenants that, among other things, restrict our ability to:

- incur additional indebtedness or issue preferred stock;
- pay dividends on or make other distributions or repurchase our capital stock or make other restricted payments;
- make investments;
- enter into certain transactions with affiliates;
- limit dividends or other payments by restricted subsidiaries to our restricted subsidiaries;
- create liens without securing the 8.0% Notes;
- designate our subsidiaries as unrestricted subsidiaries; and
- sell certain assets or merge with or into other companies or otherwise dispose of all or substantially all of our assets.

In addition, under the New Credit Facilities, we are required to satisfy and maintain specified financial ratios and tests. Events beyond our control may affect our ability to comply with those provisions, and we may not be able to meet those ratios and tests. The breach of any of these covenants would result in a default under the New Credit Facilities. In the event of default, the lenders could elect to declare all amounts borrowed under the New Credit Facilities, together with accrued interest, to be due and payable and could proceed against the collateral securing that indebtedness. Borrowings under the New Credit Facilities are senior in right of payment to the 8.0% Notes. If any of our indebtedness were to be accelerated, our assets may not be sufficient to repay in full that indebtedness and the 8.0% Notes.

Our capital expenditure and acquisition strategies require substantial capital resources. The building of new hospitals and the operations of our existing hospitals and newly acquired hospitals require ongoing capital expenditures for construction, renovation, expansion and the addition of medical equipment and technology. More specifically, we may in the future be contractually obligated to make significant capital expenditures relating to the facilities we acquire. Also, construction costs to build new hospitals are substantial and continue to increase. Our debt agreements may restrict our ability to incur additional indebtedness to fund these expenditures.

An increase in interest rates would increase the cost of servicing our debt and could reduce our profitability.

All of the borrowings under the New Credit Facilities bear interest at variable rates. As a result, an increase in interest rates, whether because of an increase in market interest rates or an increase in our own cost of borrowing, would increase the cost of servicing our debt and could materially reduce our profitability. A 0.25% increase in the expected rate of interest under the New Term Loan Credit Facility would increase our annual interest expense by approximately $2.0 million. The impact of such an increase would be more significant than it would be for some other companies because of our substantial debt. For a discussion of how we manage our exposure to changes in interest rates through the use of interest rate swap agreements on certain portions of our outstanding debt, see "Management's Discussion and Analysis of Financial Condition and Results of Operations — Quantitative and Qualitative Disclosures About Market Risks" included elsewhere in this Report.

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

Our ability to make scheduled payments or to refinance our debt obligations depends on our financial and operating performance, which is subject to prevailing economic and competitive conditions and to certain financial, business and other factors beyond our control. We may not be able to maintain a level of cash flows from operating activities sufficient to permit us to pay the principal, premium, if any, and interest on our indebtedness. In addition, the indenture governing the 8.0% Notes allows us to make significant dividend payments, investments and other restricted payments. The making of these payments could decrease available cash and adversely affect our ability to make principal and interest payments on our indebtedness. See "Management's Discussion and Analysis of Financial Condition and Results of Operations— Liquidity and Capital Resources" included elsewhere in this Report.

If our cash flows and capital resources are insufficient to fund our debt service obligations, we may be forced to reduce or delay capital expenditures, seek additional capital or seek to restructure or refinance our indebtedness. These alternative measures may not be successful and may not permit us to meet our scheduled debt service obligations. In the absence of such operating results and resources, we could face substantial liquidity problems and might be required to sell material assets or operations in an attempt to meet our debt service and other obligations. The New Credit Facilities and the indenture governing the 8.0% Notes restrict our ability to use the proceeds from asset sales. We may not be able to consummate those asset sales to raise capital or sell assets at prices that we believe are fair and proceeds that we do receive may not be adequate to meet any debt service obligations then due.

We are controlled by a small number of stockholders and they may have conflicts of interest with us in the future.

We are controlled by our principal equity sponsors, and they have the ability to control our policies and operations. The interests of our principal equity sponsors may not in all cases be aligned with our interests. For example, our principal equity sponsors could cause us to make acquisitions, divestitures and other transactions that, in their judgment, could enhance their equity investment in us, even though such transactions might reduce cash flows or capital reserves available to fund our debt service obligations. Additionally, our principal equity sponsors are in the business of making investments in companies and may from time to time acquire and hold interests in businesses that compete directly or indirectly with us. Accordingly, our principal equity sponsors may also pursue acquisitions that may be complementary to our business, and as a result, those acquisition opportunities may not be available to us. So long as our principal equity sponsors continue to own a significant amount of our equity interests, even if such amount is less than 50%, they will continue to be able to strongly influence or effectively control our decisions.

Risks Related to Our Business

The current challenging economic environment, along with difficult and volatile conditions in the capital and credit markets, could materially adversely affect our financial position, results of operations or cash flows, and we are unsure whether these conditions will improve in the near future.

The U.S. economy and global credit markets remain volatile. Declining consumer confidence and increased unemployment have increased concerns of prolonged economic weakness. While certain healthcare spending is considered non-discretionary and may not be significantly impacted by economic downturns, other types of healthcare spending may be significantly adversely impacted by such conditions. When patients are experiencing personal financial difficulties or have concerns about general economic conditions, they may choose to defer or forego elective surgeries and other non-emergent procedures, which are generally more profitable lines of business for hospitals. We are unable to determine the specific impact of the current economic conditions on our business at this time, but we believe that further deterioration or a prolonged period of recession will have an adverse impact on our operations. Other risk factors discussed herein describe some significant risks that may be magnified by the current economic conditions such as the following:

- Our concentration of operations in a small number of regions, and the impact of economic downturns in those

communities. To the extent the communities in and around San Antonio, Texas; Phoenix, Arizona; Chicago, Illinois or certain communities in Massachusetts experience a greater degree of economic weakness than average, the adverse impact on our operations could be magnified.

- Our revenues may decline if federal or state programs reduce our Medicare or Medicaid payments or managed care companies (including managed Medicare and managed Medicaid payers) reduce our reimbursement. Current economic conditions have accelerated and increased the budget deficits for most states, including those in which we operate. These budgetary pressures may result in healthcare payment reductions under state Medicaid plans or reduced benefits to participants in those plans. Also, governmental, managed Medicare or managed Medicaid payers may defer payments to us to conserve cash. Managed care companies may also seek to reduce payment rates or limit payment rate increases to hospitals in response to reductions in enrolled participants.

- Our hospitals face a growth in uncompensated care as the result of the inability of uninsured patients to pay for healthcare services and difficulties in collecting patient portions of insured accounts. Higher unemployment, Medicaid benefit reductions and employer efforts to reduce employee healthcare costs may increase our exposure to uncollectible accounts for uninsured patients or those patients with higher co-pay and deductible limits.

- Under extreme market conditions, there can be no assurance that funds necessary to run our business will be available to us on favorable terms or at all. Most of our cash and borrowing capacity under our New Credit Facilities will be held with a limited number of financial institutions, which could increase our liquidity risk if one or more of those institutions become financially strained or are no longer able to operate.

We are unable to predict if the condition of the U.S. economy, the local economies in the communities we serve or global credit conditions will improve in the near future or when such improvements may occur.

We are unable to predict the impact of the Health Reform Law, which represents significant change to the healthcare industry.

The Health Reform Law will change how healthcare services are covered, delivered, and reimbursed through expanded coverage of uninsured individuals, reduced growth in Medicare program spending, reductions in Medicare and Medicaid DSH payments and the establishment of programs where reimbursement is tied to quality and integration. In addition, the new law reforms certain aspects of health insurance, expands existing efforts to tie Medicare and Medicaid payments to performance and quality and contains provisions intended to strengthen fraud and abuse enforcement.

The expansion of health insurance coverage under the Health Reform Law may result in a material increase in the number of patients using our facilities who have either private or public program coverage. In addition, a disproportionately large percentage of the new Medicaid coverage is likely to be in states that currently have relatively low income eligibility requirements. Two such states are Texas and Illinois, where over 50% of our licensed beds as of June 30, 2010 are located. Further, the Health Reform Law provides for a value-based purchasing program, the establishment of Accountable Care Organizations ("ACOs") and bundled payment pilot programs, which will create possible sources of additional revenue.

However, it is difficult to predict the size of the potential revenue gains to us as a result of these elements of the Health Reform Law because of uncertainty surrounding a number of material factors including the following:

- how many previously uninsured individuals will obtain coverage as a result of the Health Reform Law (while the Congressional Budget Office ("CBO") estimates 32 million, the Centers for Medicare & Medicaid Services ("CMS") estimates almost 34 million; both agencies made a number of assumptions to derive that figure, including how many individuals will ignore substantial subsidies and decide to pay the penalty rather than obtain health insurance and what percentage of people in the future will meet the new Medicaid income eligibility requirements);

- what percentage of the newly insured patients will be covered under the Medicaid program and what percentage will be covered by private health insurers;

- the extent to which states will enroll new Medicaid participants in managed care programs;

- the pace at which insurance coverage expands, including the pace of different types of coverage expansion;

- the change, if any, in the volume of inpatient and outpatient hospital services that are sought by and provided to previously uninsured individuals;

- the rate paid by state governments under the Medicaid program for newly covered individuals;

- how the value-based purchasing and other quality programs will be implemented;

- the percentage of individuals in the Exchanges who select the high deductible plans, since health insurers offering those kinds of products have traditionally sought to pay lower rates to hospitals;
- the extent to which the net effect of the Health Reform Law, including the prohibition on excluding individuals based on pre-existing conditions, the requirement to keep medical costs lower than a specified percentage of premium revenue, other health insurance reforms and the annual fee applied to all health insurers, will put pressure on the profitability of health insurers, which in turn might cause them to seek to reduce payments to hospitals with respect to both newly insured individuals and their existing business; and
- the possibility that implementation of provisions expanding health insurance coverage will be delayed or even blocked due to court challenges or revised or eliminated as a result of efforts to repeal or amend the new law.

On the other hand, the Health Reform Law provides for significant reductions in the growth of Medicare spending, reductions in Medicare and Medicaid DSH payments and the establishment of programs where reimbursement is tied to quality and integration. Since approximately 55%, 56% and 57% of our revenues during our fiscal years ended June 30, 2008, 2009 and 2010, respectively, were from Medicare and Medicaid (including Medicare and Medicaid managed plans), reductions to these programs may significantly impact us and could offset any positive effects of the Health Reform Law. It is difficult to predict the size of the revenue reductions to Medicare and Medicaid spending because of uncertainty regarding a number of material factors including the following:

- the amount of overall revenues we will generate from Medicare and Medicaid business when the reductions are implemented,
- whether reductions required by the Health Reform Law will be changed by statute prior to becoming effective;
- the size of the Health Reform Law's annual productivity adjustment to the market basket beginning in 2012 payment years;
- the amount of the Medicare DSH reductions that will be made, commencing in federal fiscal year 2014;
- the allocation to our hospitals of the Medicaid DSH reductions, commencing in federal fiscal year 2014;
- what the losses in revenues will be, if any, from the Health Reform Law's quality initiatives;
- how successful ACOs, in which we participate, will be at coordinating care and reducing costs
- the scope and nature of potential changes to Medicare reimbursement methods, such as an emphasis on bundling payments or coordination of care programs;
- whether our revenues from upper payment limit ("UPL") programs will be adversely affected, because there may be fewer indigent, non-Medicaid patients for whom we provides service pursuant to UPL programs in which we participate; and
- reductions to Medicare payments CMS may impose for "excessive readmissions."

Because of the many variables involved, we are unable to predict the net effect on us of the expected decreases in uninsured individuals using our facilities, the reductions in Medicare spending, reductions in Medicare and Medicaid DSH funding and numerous other provisions in the Health Reform Law that may affect us.

If we are unable to enter into favorable contracts with managed care plans, our operating revenues may be reduced.

Our ability to negotiate favorable contracts with health maintenance organizations, insurers offering preferred provider arrangements and other managed care plans significantly affects the revenues and operating results of our hospitals. Revenues derived from health maintenance organizations, insurers offering preferred provider arrangements and other managed care plans, including managed Medicare and managed Medicaid plans, accounted for approximately 56%, 58% and 59% of our net patient revenues for the years ended June 30, 2008, 2009 and 2010, respectively. Managed care organizations offering prepaid and discounted medical services packages represent a significant portion of our admissions. In addition, private payers are increasingly attempting to control healthcare costs through direct contracting with hospitals to provide services on a discounted basis, increased utilization review and greater enrollment in managed care programs such as health maintenance organizations and preferred provider organizations. The trend towards consolidation among private managed care payers tends to increase their bargaining prices over fee structures. In most cases, we negotiate our managed care contracts annually as they come up for renewal at various times during the year. Our future success will depend, in part, on our ability to renew existing managed care

contracts and enter into new managed care contracts on terms favorable to us. Other healthcare companies, including some with greater financial resources, greater geographic coverage or a wider range of services, may compete with us for these opportunities. For example, some of our competitors may negotiate exclusivity provisions with managed care plans or otherwise restrict the ability of managed care companies to contract with us. It is not clear what impact, if any, the increased obligations on managed care payers and other payers imposed by the Health Reform Law will have on our ability to negotiate reimbursement increases. If we are unable to contain costs through increased operational efficiencies or to obtain higher reimbursements and payments from managed care payers, our results of operations and cash flows will be materially adversely affected.

Our revenues may decline if federal or state programs reduce our Medicare or Medicaid payments.

Approximately 55%, 56% and 57% of our net patient revenues for the years ended June 30, 2008, 2009 and 2010, respectively, came from the Medicare and Medicaid programs, including Medicare and Medicaid managed plans. In recent years federal and state governments have made significant changes to the Medicare and Medicaid programs. Some of those changes adversely affect the reimbursement we receive for certain services. In addition, due to budget deficits in many states, significant decreases in state funding for Medicaid programs have occurred or are being proposed.

DRG rates are updated and MS-DRG weights are recalibrated each federal fiscal year. The index used to update the market basket gives consideration to the inflation experienced by hospitals and entities outside the healthcare industry in purchasing goods and services. The Medicare Inpatient Hospital Prospective System Final Rule for federal fiscal year 2010 provides for a 2.1% market basket update for hospitals that submit certain quality patient care indicators and a 0.1% update for hospitals that do not submit this data. The Health Reform Law provides for a 0.25% reduction in this 2.1% market basket update for discharges occurring on or after April 1, 2010. While we will endeavor to comply with all quality data submission requirements, our submissions may not be deemed timely or sufficient to entitle us to the full market basket adjustment for all our hospitals. Medicare payments to hospitals in federal fiscal year 2009 were reduced by 0.9% to eliminate what CMS estimates will be the effect of coding or classification changes as a result of hospitals implementing the MS-DRG system. After earlier proposing an increase in the "documentation and coding adjustment" to 1.9% for federal fiscal year 2010, on July 31, 2009 CMS announced that it had decided not to make any adjustment in federal fiscal year 2010 since it did not know whether federal fiscal year 2009 spending from documentation and coding is more or less than earlier projected. However, the U.S. Congress gave CMS the ability to continue to retrospectively determine if the documentation and coding adjustment levels for federal fiscal years 2008 and 2009 were adequate to account for changes in payments not related to changes in case mix. Indeed, in the final rule for hospital inpatient PPS for federal fiscal year 2011 CMS found the levels to have been inadequate, and CMS has imposed an aggregate 5.8% decrease to payments for federal fiscal years 2011 and 2012 (as further explained in the next paragraph of this report). This evaluation of changes in case-mix based on actual claims data may yield a higher documentation and coding adjustment thereby potentially reducing our revenues and impacting our results of operations in ways that cannot be quantified at this time. Additionally, Medicare payments to hospitals are subject to a number of other adjustments, and the actual impact on payments to specific hospitals may vary. In some cases, commercial third-party payers and other payers such as some state Medicaid programs rely on all or portions of the Medicare DRG system to determine payment rates. The change from traditional Medicare DRGs to MS-DRGs could adversely impact those payment rates if any other payers adopt MS-DRGs.

On July 30, 2010, CMS issued a final rule related to the federal fiscal year 2011 hospital inpatient PPS. In this rule, CMS increased the MS-DRG rate for federal fiscal year 2011 by 2.35% which reflects the full market basket of 2.6% adjusted by the 0.25% reduction required by the Health Reform Law. However, CMS has also applied a documentation and coding adjustment of negative 2.9% in federal fiscal year 2011. This reduction represents half of the documentation and coding adjustment required to recover the increase in aggregate payments made in 2008 and 2009 during implementation of the MS-DRG system. CMS plans to recover the remaining 2.9% and interest in federal fiscal year 2012. The market basket update, the documentation and coding adjustment and the decrease mandated by the Health Reform Law together show the aggregate market basket adjustment for federal fiscal year 2011 to be negative 0.55%. CMS has also announced that an additional prospective negative adjustment of 3.9% will be needed to avoid increased Medicare spending unrelated to patient severity of illness. CMS is not proposing this additional 3.9% reduction at this time but has stated that it will be required in the future.

Further, the Health Reform Law provides for material reductions in the growth of Medicare program spending, including reductions in Medicare market basket updates and DSH funding. Reductions to our reimbursement under the Medicare and Medicaid programs by the Health Reform Law could adversely affect our business and results of operations to the extent such reductions are not offset by anticipated increases in revenues from providing care to previously uninsured individuals.

The federal government and many states have recently adopted or are currently considering reducing the level of Medicaid funding (including upper payment limit, provider tax assessment or similar community benefit supplemental funds) or program eligibility that could adversely affect future levels of Medicaid reimbursement received by our hospitals. Since states must operate with balanced budgets and since the Medicaid program is often a state's largest program, a number of states have adopted, or are considering adopting, legislation designed to reduce their Medicaid expenditures. The Deficit Reduction Act of 2005 ("DRA") includes cuts to the federal Medicaid and State Children's Health Insurance Programs of approximately $21.6 billion over the next five years. Additionally, on May 29, 2007, CMS published a final rule entitled "Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership" which is estimated to reduce federal Medicaid funding from $12 billion to $20 billion over five years. The U.S. Congress enacted two moratoria in respect of this rule that delayed six of seven proposed Medicaid regulations in this final CMS rule until July 1, 2009. On June 30, 2009, three more of the Medicaid regulations that had been under a congressional moratorium set to expire July 1, 2009 were officially rescinded, all or in part, by CMS, and CMS also delayed until June 30, 2010 the enforcement of the fourth of the six regulations. As a result of these changes in implementing the final rule, the impact on us of the final rule cannot be quantified. States in which we operate have also adopted, or are considering adopting, legislation designed to reduce coverage and program eligibility, enroll Medicaid recipients in managed care programs and/or impose additional taxes on hospitals to help finance or expand the states' Medicaid systems. For example, Arizona has frozen hospital inpatient and outpatient reimbursements at the October 1, 2008 rates and discontinued a state health benefits program for low-income parents. Additional Medicaid spending cuts may be implemented in the future in the states in which we operate, including reductions in supplemental Medicaid reimbursement programs. Our Texas hospitals participate in private supplemental Medicaid reimbursement programs that are structured to expand the community safety net by providing indigent healthcare services and result in additional revenues for participating hospitals. We cannot predict whether the Texas private supplemental Medicaid reimbursement programs will continue or guarantee that revenues recognized from the programs will not decrease. Effective March 23, 2010, the Health Reform Law requires states to at least maintain Medicaid eligibility standards established prior to the enactment of the law for adults until January 1, 2014 and for children until October 1, 2019. However, states with budget deficits may seek exceptions from this requirement to address eligibility standards that apply to adults making more than 133% of the federal poverty level. The Health Reform Law also provides for significant expansions to the Medicaid program, but these changes are not required until 2014. In addition, the Health Reform Law will result in increased state legislative and regulatory changes in order for states to comply with new federal mandates, such as the requirement to establish health insurance exchanges, and to participate in grants and other incentive opportunities. Future legislation or other changes in the administration or interpretation of government health programs could have a material adverse effect on our financial position and results of operations.

In recent years, both the Medicare program and several large managed care companies have changed our reimbursement to link some of their payments, especially their annual increases in payments, to performance of quality of care measures. We expect this trend to "pay-for-performance" to increase in the future. If we are unable to meet these performance measures, our financial position, results of operations and cash flows will be materially adversely affected.

We conduct business in a heavily regulated industry, and changes in regulations or violations of regulations may result in increased costs or sanctions that could reduce our revenues and profitability.

The healthcare industry is subject to extensive federal, state and local laws and regulations relating to licensing, the conduct of operations, the ownership of facilities, the addition of facilities and services, financial arrangements with physicians and other referral sources, confidentiality, maintenance and security issues associated with medical records, billing for services and prices for services. If a determination were made that we were in material violation of such laws or regulations, our operations and financial results could be materially adversely affected.

In many instances, the industry does not have the benefit of significant regulatory or judicial interpretations of these laws and regulations. This is particularly true in the case of the Medicare and Medicaid statute codified under Section 1128B(b) of the Social Security Act and known as the "Anti-Kickback Statute." This statute prohibits providers and other person or entities from soliciting, receiving, offering or paying, directly or indirectly, any remuneration with the intent to generate referrals of orders for services or items reimbursable under Medicare, Medicaid and other federal healthcare programs. Courts have interpreted this statute broadly and held that there is a violation of the Anti-Kickback Statute if just one purpose of the remuneration is to generate referrals, even if there are other lawful purposes. Furthermore, the Health Reform Law provides that knowledge of the law or the intent to violate the law is not required. As authorized by the U.S. Congress, HHS has issued regulations which describe certain conduct and business relationships immune from prosecution under the Anti-Kickback Statute. The fact that a given business arrangement does not fall within one of these "safe harbor" provisions does not render the arrangement illegal, but business arrangements of healthcare service providers that fail to satisfy the applicable safe harbor criteria risk increased scrutiny by enforcement authorities.

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The safe harbor requirements are generally detailed, extensive, narrowly drafted and strictly construed. Many of the financial arrangements that our facilities maintain with physicians do not meet all of the requirements for safe harbor protection. The regulatory authorities that enforce the Anti-Kickback Statute may in the future determine that one or more of these arrangements violate the Anti-Kickback Statute or other federal or state laws. A determination that a facility has violated the Anti-Kickback Statute or other federal laws could subject us to liability under the Social Security Act, including criminal and civil penalties, as well as exclusion of the facility from participation in government programs such as Medicare and Medicaid or other federal healthcare programs.

In addition, the portion of the Social Security Act commonly known as the "Stark Law" prohibits physicians from referring Medicare and (to an extent) Medicaid patients to providers of certain "designated health services" if the physician or a member of his or her immediate family has an ownership or investment interest in, or compensation arrangement with, that provider. In addition, the provider in such arrangements is prohibited from billing for all of the designated health services referred by the physician, and, if paid for such services, is required to promptly repay such amounts. Most of the services furnished by our facilities are "designated health services" for Stark Law purposes, including inpatient and outpatient hospital services. There are multiple exceptions to the Stark Law, among others, for physicians having a compensation relationship with the facility as a result of employment agreements, leases, physician recruitment and certain other arrangements. However, each of these exceptions applies only if detailed conditions are met. An arrangement subject to the Stark Law must qualify for an exception in order for the services to be lawfully referred by the physician and billed by the provider. Although there is an exception for a physician's ownership interest in an entire hospital, the Health Reform Law prohibits newly created physician-owned hospitals from billing for Medicare patients referred by their physician owners. As a result, the new law will effectively prevent the formation of physician-owned hospitals after December 31, 2010. While the new law grandfathers existing physician-owned hospitals, it does not allow these hospitals to increase the percentage of physician ownership and significantly restricts their ability to expand services.

CMS has issued three phases of final regulations implementing the Stark Law. Phases I and II became effective in January 2002 and July 2004, respectively, and Phase III became effective in December 2007. While these regulations help clarify the requirements of the exceptions to the Stark Law, it is unclear how the government will interpret many of these exceptions for enforcement purposes. In addition, in July 2007 CMS proposed far-reaching changes to the regulations implementing the Stark Law that would further restrict the types of arrangements that hospitals and physicians may enter, including additional restrictions on certain leases, percentage compensation arrangements, and agreements under which a hospital purchases services under arrangements. On July 31, 2008, CMS issued a final rule which, in part, finalized and responded to public comments regarding some of its July 2007 proposed major changes to the Stark Law regulations. The most far-reaching of the changes made in this final July 2008 rule effectively prohibit, as of a delayed effective date of October 1, 2009, both "under arrangements" ventures between a hospital and any referring physician or entity owned, in whole or in part, by a referring physician and unit-of-service-based "per click" compensation and percentage-based compensation in office space and equipment leases between a hospital and any referring physician or entity owned, in whole or in part, by a referring physician. We examined all of our "under arrangement" ventures and space and equipment leases with physicians to identify those arrangements which would have failed to conform to these new Stark regulations as of October 1, 2009, and we restructured or terminated all such non-conforming arrangements so identified prior to October 1, 2009. Because the Stark Law and its implementing regulations are relatively new, we do not always have the benefit of significant regulatory or judicial interpretation of this law and its regulations. We attempt to structure our relationships to meet an exception to the Stark Law, but the regulations implementing the exceptions are detailed and complex, and we cannot assure you that every relationship complies fully with the Stark Law. In addition, in the July 2008 final Stark rule CMS indicated that it will continue to enact further regulations tightening aspects of the Stark Law that it perceives allow for Medicare program abuse, especially those regulations that still permit physicians to profit from their referrals of ancillary services. We cannot assure you that the arrangements entered into by our hospitals with physicians will be found to be in compliance with the Stark Law, as it ultimately may be implemented or interpreted.

Additionally, if we violate the Anti-Kickback Statute or Stark Law, or if we improperly bill for our services, we may be found to violate the False Claims Act, either under a suit brought by the government or by a private person under a *qui tam*, or "whistleblower," suit.

If we fail to comply with the Anti-Kickback Statute, the Stark Law, the False Claims Act or other applicable laws and regulations, or if we fail to maintain an effective corporate compliance program, we could be subjected to liabilities, including civil penalties (including the loss of our licenses to operate one or more facilities), exclusion of one or more facilities from participation in the Medicare, Medicaid and other federal and state healthcare programs and, for violations of certain laws and regulations, criminal penalties. See "Business — Government Regulation and Other Factors" included elsewhere in this Report.

All of the states in which we operate have adopted or have considered adopting similar anti-kickback and physician self-referral legislation, some of which extends beyond the scope of the federal law to prohibit the payment or receipt of remuneration for the referral of patients and physician self-referrals, regardless of the source of payment for the care. Little precedent exists for the interpretation or enforcement of these laws. Both federal and state government agencies have announced heightened and coordinated civil and criminal enforcement efforts.

Government officials responsible for enforcing healthcare laws could assert that one or more of our facilities, or any of the transactions in which we are involved, are in violation of the Anti-Kickback Statute or the Stark Law and related state law exceptions. It is also possible that the courts could ultimately interpret these laws in a manner that is different from our interpretations. Moreover, other healthcare companies, alleged to have violated these laws, have paid significant sums to settle such allegations and entered into "corporate integrity agreements" because of concern that the government might exercise its authority to exclude those providers from governmental payment programs (e.g., Medicare, Medicaid, TRICARE). A determination that one or more of our facilities has violated these laws, or the public announcement that we are being investigated for possible violations of these laws, could have a material adverse effect on our business, financial condition, results of operations or prospects, and our business reputation could suffer significantly.

Federal law permits the Department of Health and Human Services Office of Inspector General ("OIG") to impose civil monetary penalties, assessments and to exclude from participation in federal healthcare programs, individuals and entities who have submitted false, fraudulent or improper claims for payment. Improper claims include those submitted by individuals or entities who have been excluded from participation, or an order to prescribe a medical or other item or service during a period a person was excluded from participation, where the person knows or should know that the claim would be made to a federal healthcare program. These penalties may also be imposed on providers or entities who employ or enter into contracts with excluded individuals to provide services to beneficiaries of federal healthcare programs. Furthermore, if services are provided by an excluded individual or entity, the penalties may apply even if the payment is made directly to a non-excluded entity. Employers of, or entities that contract with, excluded individuals or entities for the provision of services may be liable for up to $10,000 for each item or service furnished by the excluded individual or entity, an assessment of up to three times the amount claimed and program exclusions. In order for the penalties to apply, the employer or contractor must have known or should have known that the person or entity was excluded from participation. On October 12, 2009, we voluntarily reported to OIG that two of our employees had been excluded from participation in Medicare at certain times during their employment. See "Business — Legal Proceedings" included elsewhere in this Report for further discussion.

Illinois and Massachusetts require governmental determinations of need ("Certificates of Need") prior to the purchase of major medical equipment or the construction, expansion, closure, sale or change of control of healthcare facilities. We believe our facilities have obtained appropriate certificates wherever applicable. However, if a determination were made that we were in material violation of such laws, our operations and financial results could be materially adversely affected. The governmental determinations, embodied in Certificates of Need, can also affect our facilities' ability to add bed capacity or important services. We cannot predict whether we will be able to obtain required Certificates of Need in the future. A failure to obtain any required Certificates of Need may impair our ability to operate the affected facility profitably.

The laws, rules and regulations described above are complex and subject to interpretation. If we are in violation of any of these laws, rules or regulations, or if further changes in the regulatory framework occur, our results of operations could be significantly harmed. For a more detailed discussion of the laws, rules and regulations, see "Business — Government Regulation and Other Factors" included elsewhere in this Report.

Some of our hospitals will be required to submit to CMS information on their relationships with physicians and this submission could subject such hospitals and us to liability.

CMS announced in 2007 that it intended to collect information on ownership, investment and compensation arrangements with physicians from 500 (pre-selected) hospitals by requiring these hospitals to submit to CMS Disclosure of Financial Relationship Reports ("DFRR") from each selected hospital. CMS also indicated that at least 10 of our hospitals would be among these 500 hospitals required to submit a DFRR because these 10 hospitals did not respond to CMS' voluntary survey instrument on this topic purportedly submitted to these hospitals via email by CMS in 2006. CMS intended to use this data to determine whether these hospitals were in compliance with the Stark Law and implementing regulations during the reporting period, and CMS has indicated it may share this information with other government agencies and with congressional committees. Many of these agencies have not previously analyzed this information and have the authority to bring enforcement actions against the hospitals. However, in July 2008 CMS announced that, based on its further review and expected further public comments on this matter, CMS may decide in the future to decrease (but not increase) the number of hospitals to which it will send the DFRR below the 500 hospitals originally designated. Moreover, in June 2010 CMS announced that it had determined that mandating hospitals to complete the DFRR may duplicate some of the reporting obligations related to physician ownership or investment in hospitals set forth in the Health Reform Law, and, as a result, it had decided to delay implementation of the DFRR and instead focus on implementation of these new reporting provisions as to physician-owned hospitals only. CMS also explained in this June 2010 announcement that it remained interested in analyzing physicians' compensation relationships with hospitals, and that after it collected and examined information related to ownership and investment interests of physicians in hospitals pursuant to the reporting obligations in the Health Reform Law, it would determine if it was necessary to capture information related to compensation arrangements from non-physician owned hospitals as well pursuant to reimplementation of its DFRR initiative. We have no physician ownership in our hospitals, so our hospitals will not be subject to these new physician ownership and investment reporting obligations under the Health Reform Law.

Once a hospital receives this request for a DFRR, the hospital will have 60 days to compile a significant amount of information relating to its financial relationships with physicians. The hospital may be subject to civil monetary penalties of up to $10,000 per day if it is unable to assemble and report this information within the required timeframe or if CMS or any other government agency determines that the submission is inaccurate or incomplete. The hospital may be the subject of investigations or enforcement actions if a government agency determines that any of the information indicates a potential violation of law.

Depending on the final format of the DFRR, responding hospitals may be subject to substantial penalties as a result of enforcement actions brought by government agencies and whistleblowers acting pursuant to the False Claims Act and similar state laws, based on such allegations like failure to respond within required deadlines, that the response is inaccurate or contains incomplete information or that the response indicates a potential violation of the Stark Law or other requirements.

Any governmental investigation or enforcement action which results from the DFRR process could materially adversely affect our results of operations.

Providers in the healthcare industry have been the subject of federal and state investigations, whistleblower lawsuits and class action litigation, and we may become subject to investigations, whistleblower lawsuits or class action litigation in the future.

Both federal and state government agencies have heightened and coordinated civil and criminal enforcement efforts as part of numerous ongoing investigations of hospital companies, as well as their executives and managers. These investigations relate to a wide variety of topics, including:

- cost reporting and billing practices;
- laboratory and home healthcare services;
- physician ownership of, and joint ventures with, hospitals;
- physician recruitment activities; and
- other financial arrangements with referral sources.

The Health Reform Law includes additional federal funding of $350 million over the next 10 years to fight healthcare fraud, waste and abuse, including $95 million for federal fiscal year 2011, $55 million in federal fiscal year 2012 and additional increased funding through 2016.

In addition, the federal False Claims Act permits private parties to bring *qui tam*, or whistleblower, lawsuits against companies. Whistleblower provisions allow private individuals to bring actions on behalf of the government alleging that the defendant has defrauded the federal government. Because *qui tam* lawsuits are filed under seal, we could be named in one or more such lawsuits of which we are not aware. Defendants determined to be liable under the False Claims Act may be required to pay three times the actual damages sustained by the government, plus mandatory civil penalties of between $5,500 and $11,000 for each separate false claim. Typically, each fraudulent bill submitted by a provider is considered a separate false claim, and thus the penalties under the False Claims Act may be substantial. Liability arises when an entity knowingly submits a false claim for reimbursement to the federal government. The Fraud Enforcement and Recovery Act, which became law on May 20, 2009, changes the scienter requirements for liability under the False Claims Act. An entity may now violate the False Claims Act if it "knowingly and improperly avoids or decreases an obligation" to pay money to the United States. This includes obligations based on an "established duty . . . arising from . . . the retention of any overpayment." Thus, if a provider is aware that it has retained an overpayment that it has an obligation to refund, this may form the basis of a False Claims Act violation even if the provider did not know the claim was "false" when it was submitted. The Health Reform Law expressly requires healthcare providers and others to report and return overpayments. The term overpayment is defined as "any funds that a person receives or retains under title XVIII or XIX to which the person, after applicable reconciliation, is not entitled under such title." The Health Reform Law also defines the period of time in which an overpayment must be reported and returned to the government. The Health Reform Law provides that "[a]n overpayment must be reported and returned" within "60 days after the date on which the overpayment was identified," or "the date any corresponding cost report is due," whichever is later. The provision explicitly states that if the overpayment is retained beyond the 60-day period, it becomes an "obligation" sufficient for reverse false claim liability under the False Claims Act, and is therefore subject to treble damages and penalties if there is a "knowing and improper" failure to return the overpayment. In some cases, courts have held that violations of the Stark Law and Anti-Kickback Statute can properly form the basis of a False Claims Act case, finding that in cases where providers allegedly violated other statutes and have submitted claims to a governmental payer during the time period they allegedly violated these other statutes, the providers thereby submitted false claims under the False Claims Act. Some states have adopted similar whistleblower and false claims provisions. The Health Reform Law now explicitly links violations of the Anti-Kickback Statute to the False Claims Act.

The Health Reform Law changes the intent requirement for healthcare fraud under 18 U.S.C. § 1347, such that "a person need not have actual knowledge or specific intent to commit a violation." In addition, the Health Reform Law significantly changes the False Claims Act by removing the jurisdictional bar for allegations based on publicly disclosed information and by loosening the requirements for a qui tam relator to qualify as an "original source." These changes will effectively increase False Claims Act exposure by enabling a greater number of whistleblowers to bring a claim.

As required by statute, CMS is in the process of implementing the Recovery Audit Contractor ("RAC") program on a nationwide basis. Under the program, CMS contracts with RACs to conduct post-payment reviews to detect and correct improper payments in the fee-for-service Medicare program. The Health Reform Law expands the RAC program's scope to include managed Medicare plans and to include Medicaid claims by requiring all states to enter into contracts with RACs by December 31, 2010. In addition, CMS employs Medicaid Integrity Contractors ("MICs") to perform post-payment audits of Medicaid claims and identify overpayments. Throughout 2010, MIC audits will continue to expand. The Health Reform Law increases federal funding for the MIC program for federal fiscal year 2011 and later years. In addition to RACs and MICs, several other contractors, including the state Medicaid agencies, have increased their review activities.

The Office of the Inspector General of the U.S. Department of Health and Human Services and the U.S. Department of Justice have, from time to time, established national enforcement initiatives that focus on specific billing practices or other suspected areas of abuse. Initiatives include a focus on hospital billing for outpatient charges associated with inpatient services, as well as hospital laboratory, home health and durable medical equipment billing practices. As a result of these initiatives, some of our activities could become the subject of governmental investigations or inquiries. For example, we have significant Medicare and Medicaid billings, we provide some durable medical equipment and home healthcare services, and we have joint venture arrangements involving physician investors. We also have a variety of other financial arrangements with physicians and other potential referral sources including recruitment arrangements and leases. In addition, our executives and managers, many of whom have worked at other healthcare companies that are or may become the subject of federal and state investigations and private litigation, could be included in governmental investigations or named as defendants in private litigation. We are aware that several of our hospitals or their related healthcare operations were and may still be under investigation in connection with activities conducted prior to our acquisition of them. Under the terms of our various acquisition agreements, the prior owners of our hospitals are responsible for any liabilities arising from pre-closing violations. The prior owners' resolution of these matters or failure to resolve these matters, in the event that any resolution was deemed necessary, may have a material adverse effect on our business, financial condition or results of operations. Any investigations of us, our executives, managers, facilities or operations could result in significant liabilities or penalties to us, as well as adverse publicity.

We maintain a voluntary compliance program to address health regulatory and other compliance requirements. This program includes initial and periodic ethics and compliance training, a toll-free hotline for employees to report, without fear of retaliation, any suspected legal or ethical violations, annual "fraud and abuse" audits to look at our financial relationships with

physicians and other referral sources and annual "coding audits" to make sure our hospitals bill the proper service codes in respect of obtaining payment from the Medicare and Medicaid programs.

As an element of our corporate compliance program and our internal compliance audits, from time to time we make voluntary disclosures and repayments to the Medicare and Medicaid programs and/or to the federal and/or state regulators for these programs in the ordinary course of business. At the current time, we know of no active investigations by any of these programs or regulators in respect of our disclosures or repayments. All of these voluntary actions on our part could lead to an investigation by the regulators to determine whether any of our facilities have violated the Stark Law, the Anti-Kickback Statute, the False Claims Act or similar state law. Either an investigation or initiation of administrative or judicial actions could result in a public announcement of possible violations of the Stark Law, the Anti-Kickback Statute or the False Claims Act or similar state law. Such determination or announcements could have a material adverse effect on our business, financial condition, results of operations or prospects, and our business reputation could suffer significantly.

Additionally, several hospital companies have in recent years been named defendants in class action litigation alleging, among other things, that their charge structures are fraudulent and, under state law, unfair or deceptive practices, insofar as those hospitals charge insurers lower rates than those charged to uninsured patients. We cannot assure you that we will not be named as a defendant in litigation of this type. Furthermore, the outcome of these suits may affect the industry standard for charity care policies and any response we take may have a material adverse effect on our financial results.

In June 2006, we and two other hospital systems operating in San Antonio, Texas had a putative class action lawsuit brought against all of us alleging that we and the other defendants had conspired with one another and with other unidentified San Antonio area hospitals to depress the compensation levels of registered nurses employed at the competing hospitals within the San Antonio area by engaging in certain activities that violated the federal antitrust laws. On the same day that this litigation was brought against us and two other hospital systems in San Antonio, substantially similar class action litigation was brought against multiple hospitals or hospital systems in three other cities (Chicago, Illinois, Albany, New York; and Memphis, Tennessee), with a fifth suit instituted against hospitals or hospital systems in Detroit, Michigan later in 2006, one of which hospital systems was DMC. See "Business — Legal Proceedings" included elsewhere in this Report for further discussion of these lawsuits.

Competition from other hospitals or healthcare providers (especially specialty hospitals) may reduce our patient volumes and profitability.

The healthcare business is highly competitive and competition among hospitals and other healthcare providers for patients has intensified in recent years. Generally, other hospitals in the local communities served by most of our hospitals provide services similar to those offered by our hospitals. In addition, CMS publicizes on its Medicare website performance data related to quality measures and data on patient satisfaction surveys hospitals submit in connection with their Medicare reimbursement. Federal law provides for the future expansion of the number of quality measures that must be reported. Additional quality measures and future trends toward clinical transparency may have an unanticipated impact on our competitive position and patient volumes. Further, the Health Reform Law requires all hospitals to annually establish, update and make public a list of the hospital's standard charges for items and services. If any of our hospitals achieve poor results (or results that are lower than our competitors) on these quality measures or on patient satisfaction surveys or if our standard charges are higher than our competitors, our patient volumes could decline.

In addition, we believe the number of freestanding specialty hospitals and surgery and diagnostic centers in the geographic areas in which we operate has increased significantly in recent years. As a result, most of our hospitals operate in an increasingly competitive environment. Some of the hospitals that compete with our hospitals are owned by governmental agencies or not-for-profit corporations supported by endowments and charitable contributions and can finance capital expenditures and operations on a tax-exempt basis. Increasingly, we are facing competition from physician-owned specialty hospitals and freestanding surgery centers that compete for market share in high margin services and for quality physicians and personnel. If ambulatory surgery centers are better able to compete in this environment than our hospitals, our hospitals may experience a decline in patient volume, and we may experience a decrease in margin, even if those patients use our ambulatory surgery centers. Further, if our competitors are better able to attract patients, recruit physicians, expand services or obtain favorable managed care contracts at their facilities than our hospitals and ambulatory surgery centers, we may experience an overall decline in patient volume. See "Business — Competition" included elsewhere in this Report.

Our Phoenix Health Plan unit ("PHP") also faces competition within the Arizona markets that it serves. As in the case of our hospitals, some of our health plan competitors in these markets are owned by governmental agencies or not-for-profit corporations that have greater financial resources than we do. The revenues we derive from PHP could significantly decrease if new plans operating in the Arizona Health Care Cost Containment System ("AHCCCS"), which is Arizona's state Medicaid program, enter these markets or other existing AHCCCS plans increase their number of members. Moreover, a failure to attract future members may negatively impact our ability to maintain our profitability in these markets.

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We may be subject to liabilities from claims brought against our facilities.

We operate in a highly regulated and litigious industry. As a result, various lawsuits, claims and legal and regulatory proceedings have been instituted or asserted against us, including those outside of the ordinary course of business such as class actions and those in the ordinary course of business such as malpractice lawsuits. Some of these actions may involve large claims as well as significant defense costs. See "Item 3 — Legal Proceedings" included elsewhere in this Report for additional information.

We maintain professional and general liability insurance with unrelated commercial insurance carriers to provide for losses in excess of our self-insured retention (such retention maintained by our captive insurance subsidiary and/or other of our subsidiaries) of $10.0 million through June 30, 2010 but increased to $15.0 million for our Illinois hospitals subsequent to June 30, 2010. As a result, a few successful claims against us that are within our self-insured retention amounts could have an adverse effect on our results of operations, cash flows, financial condition or liquidity. We also maintain umbrella coverage for an additional $65.0 million above our self-insured retention with independent third party carriers. There can be no assurance that one or more claims may exceed the scope of this third-party coverage.

Additionally, we experienced unfavorable claims development during fiscal 2010, which is reflected in our professional and general liability costs. The relatively high cost of professional liability insurance and, in some cases, the lack of availability of such insurance coverage, for physicians with privileges at our hospitals increases our risk of vicarious liability in cases where both our hospital and the uninsured or underinsured physician are named as co-defendants. As a result, we are subject to greater self-insured risk and may be required to fund claims out of our operating cash flows to a greater extent than during fiscal year 2010. We cannot assure you that we will be able to continue to obtain insurance coverage in the future or that such insurance coverage, if it is available, will be available on acceptable terms.

While we cannot predict the likelihood of future claims or inquiries, we expect that new matters may be initiated against us from time to time. Moreover, the results of current claims, lawsuits and investigations cannot be predicted, and it is possible that the ultimate resolution of these matters, individually or in the aggregate, may have a material adverse effect on our business (both in the near and long term), financial position, results of operations or cash flows.

Our hospitals face a growth in uncompensated care as the result of the inability of uninsured patients to pay for healthcare services and difficulties in collecting patient portions of insured accounts.

Like others in the hospital industry, we have experienced an increase in uncompensated care. Our combined provision for doubtful accounts, uninsured discounts and charity care deductions as a percentage of patient service revenues (prior to these adjustments) was 12.0% during both fiscal 2008 and 2009. This ratio increased to 15.8% for the year ended June 30, 2010. Approximately 330 basis points of this increase from fiscal 2009 to fiscal 2010 related to the uninsured discount and Medicaid pending policy changes implemented in our Illinois hospitals effective April 1, 2009 and in our Phoenix and San Antonio hospitals effective July 1, 2009. Our self-pay discharges as a percentage of total discharges were approximately 3.3% during each of the past three fiscal years (as adjusted for our Medicaid pending policy changes in Illinois on April 1, 2009 and in Phoenix and San Antonio on July 1, 2009). Our hospitals remain at risk for increases in uncompensated care as a result of price increases, the continuing trend of increases in coinsurance and deductible portions of managed care accounts and increases in uninsured patients as a result of potential state Medicaid funding cuts or general economic weakness. Although we continue to seek ways of improving point of service collection efforts and implementing appropriate payment plans with our patients, if we continue to experience growth in self-pay revenues prior to the Health Reform Law being fully implemented, our results of operations could be materially adversely affected. Further, our ability to improve collections for self-pay patients may be limited by regulatory and investigatory initiatives, including private lawsuits directed at hospital charges and collection practices for uninsured and underinsured patients.

The Health Reform Law seeks to decrease over time the number of uninsured individuals. Among other things, the Health Reform Law will, effective January 1, 2014, expand Medicaid and incentivize employers to offer, and require individuals to carry, health insurance or be subject to penalties. However, it is difficult to predict the full impact of the Health Reform Law due to the law's complexity, lack of implementing regulations or interpretive guidance, gradual implementation and possible amendment, as well as our inability to foresee how individuals and businesses will respond to the choices afforded them by the law. In addition, even after implementation of the Health Reform Law, we may continue to experience bad debts and have to provide uninsured discounts and charity care for undocumented aliens who are not permitted to enroll in a health insurance exchange or government healthcare programs.

Our performance depends on our ability to recruit and retain quality physicians.

Physicians generally direct the majority of hospital admissions. Thus, the success of our hospitals depends in part on the following factors:

- the number and quality of the physicians on the medical staffs of our hospitals;
- the admitting practices of those physicians; and
- the maintenance of good relations with those physicians.

Most physicians at our hospitals also have admitting privileges at other hospitals. Our efforts to attract and retain physicians are affected by our managed care contracting relationships, national shortages in some specialties, such as anesthesiology and radiology, the adequacy of our support personnel, the condition of our facilities and medical equipment, the availability of suitable medical office space and federal and state laws and regulations prohibiting financial relationships that may have the effect of inducing patient referrals. If facilities are not staffed with adequate support personnel or technologically advanced equipment that meets the needs of patients, physicians may be discouraged from referring patients to our facilities, which could adversely affect our profitability.

In an effort to meet community needs in the markets in which we operate, we have implemented a strategy to employ physicians both in primary care and in certain specialties. As of June 30, 2010, we employed more than 300 practicing physicians, excluding residents. A physician employment strategy includes increased salary and benefits costs, physician integration risks and difficulties associated with physician practice management. While we believe this strategy is consistent with industry trends, we cannot be assured of the long-term success of such a strategy. In addition, if we raise wages in response to our competitors' wage increases and are unable to pass such increases on to our clients, our margins could decline, which could adversely affect our business, financial condition and results of operations.

We may be unable to achieve our acquisition and growth strategies and we may have difficulty acquiring not-for-profit hospitals due to regulatory scrutiny.

An important element of our business strategy is expansion by acquiring hospitals in our existing and in new urban and suburban markets and by entering into partnerships or affiliations with other healthcare service providers. The competition to acquire hospitals is significant, including competition from healthcare companies with greater financial resources than ours. On August 1, 2010, we acquired two hospitals in suburban Chicago, Illinois. In June 2010, we entered into a definitive agreement to purchase the 8-hospital DMC system located in and around Detroit, Michigan that we expect to close during our second quarter of fiscal year 2011. In August 2010, we entered into a definitive agreement to purchase Arizona Heart Hospital and Arizona Heart Institute both located in Phoenix, Arizona. There is no guarantee that we will be able to successfully integrate these or any other hospital acquisitions, which limit our ability to complete future acquisitions.

Potential future acquisitions may be on less than favorable terms. We may have difficulty obtaining financing, if necessary, for future acquisitions on satisfactory terms. The pending DMC acquisition includes and other future acquisitions may include significant capital or other funding commitments that we may not be able to finance through operating cash flows or additional debt or equity proceeds. We sometimes agree not to sell an acquired hospital for some period of time (currently no longer than 10 years) after purchasing it and/or grant the seller a right of first refusal to purchase the hospital if we agree to sell it to a third party.

Additionally, many states, including some where we have hospitals and others where we may in the future attempt to acquire hospitals, have adopted legislation regarding the sale or other disposition of hospitals operated by not-for-profit entities. In other states that do not have specific legislation, the attorneys general have demonstrated an interest in these transactions under their general obligations to protect charitable assets from waste. These legislative and administrative efforts focus primarily on the appropriate valuation of the assets divested and the use of the sale proceeds by the not-for-profit seller. These review and approval processes can add time to the consummation of an acquisition of a not-for-profit hospital, and future actions on the state level could seriously delay or even prevent future acquisitions of not-for-profit hospitals. Furthermore, as a condition to approving an acquisition, the attorney general of the state in which the hospital is located may require us to maintain specific services, such as emergency departments, or to continue to provide specific levels of charity care, which may affect our decision to acquire or the terms upon which we acquire one of these hospitals.

The consummation of the acquisition of DMC is subject to a number of closing conditions that could prevent us from consummating the transaction in accordance with our current expectations, if at all.

Our acquisition of DMC is subject to a number of closing conditions, including the approval of the Michigan Attorney General. Among other matters being reviewed, the Michigan Attorney General has announced that his office will attempt to determine whether DMC will receive from the Vanguard acquisition companies fair value for all assets proposed to be sold by DMC. In this regard in June 2010 the Michigan Attorney General announced that it had hired two financial consulting firms (AlixPartners and Focus Management Group) to assist his office in its review and that such firms are to report their findings to the Attorney General by August 15, 2010, with the Attorney General also announcing that his office currently intends to issue a decision on the DMC transaction by September 15, 2010. The Michigan Attorney General held a public hearing on the DMC transaction on August 18, 2010 during which his office entertained questions and statements about the proposed transaction from the public.

If the approval from the Michigan Attorney General is not received or any other condition to closing is not satisfied by November 1, 2010, each of the Vanguard acquisition companies and DMC has the right to terminate the purchase agreement, as long as such failure to consummate was not caused by a breach by the terminating party of the purchase agreement. The Vanguard acquisition companies currently expect to consummate the DMC transaction during Vanguard's second quarter of fiscal year 2011. However, we cannot assure you that the Vanguard acquisition companies will consummate the DMC acquisition on this timetable, if at all.

If the DMC acquisition is consummated, we may not be able to successfully integrate our acquisition of DMC or realize the potential benefits of the acquisition, which could cause our business to suffer.

We may not be able to combine successfully the operations of DMC with our operations and, even if such integration is accomplished, we may never realize the potential benefits of the acquisition. The integration of DMC with our operations requires significant attention from management and may impose substantial demands on our operations or other projects. The integration of DMC also involves a significant capital commitment, and the return that we achieve on any capital invested may be less than the return that we would achieve on our other projects or investments. Any of these factors could cause delays or increased costs of combining the companies, which could adversely affect our operations, financial results and liquidity.

Future acquisitions or joint ventures may use significant resources, may be unsuccessful and could expose us to unforeseen liabilities.

As part of our growth strategy, we may pursue acquisitions or joint ventures of hospitals or other related healthcare facilities and services. These acquisitions or joint ventures may involve significant cash expenditures, debt incurrence, additional operating losses and expenses that could have a material adverse effect on our financial condition, results of operations and cash flows. Acquisitions or joint ventures involve numerous risks, including:

- difficulty and expense of integrating acquired personnel into our business,
- diversion of management's time from existing operations,
- potential loss of key employees or customers of acquired companies; and
- assumption of the liabilities and exposure to unforeseen liabilities of acquired companies, including liabilities for failure to comply with healthcare regulations.

We cannot assure you that we will succeed in obtaining financing for acquisitions or joint ventures at a reasonable cost, or that such financing will not contain restrictive covenants that limit our operating flexibility. We also may be unable to operate acquired hospitals profitably or succeed in achieving improvements in their financial performance.

The cost of our malpractice insurance and the malpractice insurance of physicians who practice at our facilities remains volatile. Successful malpractice or tort claims asserted against us, our physicians or our employees could materially adversely affect our financial condition and profitability.

Physicians, hospitals and other healthcare providers are subject to legal actions alleging malpractice, general liability or related legal theories. Many of these actions involve large monetary claims and significant defense costs. Hospitals and physicians have typically maintained a special type of insurance (commonly called malpractice or professional liability insurance) to protect against the costs of these types of legal actions. We created a captive insurance subsidiary on June 1, 2002, to assume a substantial portion of the professional and general liability risks of our facilities. For claims incurred between June 1, 2002 and June 30, 2010, we self-insured our professional and general liability risks, either through our captive subsidiary or through another of our subsidiaries, in respect of losses up to $10.0 million. For claims subsequent to June 30, 2010, we increased this self-insured retention to $15.0 million for our Illinois hospitals. We have also purchased umbrella excess policies for professional and general liability insurance for all periods through June 30, 2011 with unrelated commercial carriers to provide an additional $65.0 million of coverage in the aggregate above our self-insured retention. While our premium prices have not fluctuated significantly during the past few years, the total cost of professional and general liability insurance remains sensitive to the volume and severity of cases reported. There is no guarantee that excess insurance coverage will continue to be available in the future at a cost allowing us to maintain adequate levels of such insurance. Moreover, due to the increased retention limits insured by us and our captive subsidiary, if actual payments of claims materially exceed our projected estimates of malpractice claims, our financial condition, results of operations and cash flows could be materially adversely affected.

Physicians' professional liability insurance costs in certain markets have dramatically increased to the point where some physicians are either choosing to retire early or leave those markets. If physician professional liability insurance costs continue to escalate in markets in which we operate, some physicians may choose not to practice at our facilities, which could reduce our patient volumes and revenues. Our hospitals may also incur a greater percentage of the amounts paid to claimants if physicians are unable to obtain adequate malpractice coverage since we are often sued in the same malpractice suits brought against physicians on our medical staffs who are not employed by us.

We expect to continue to employ additional physicians during the near future. A significant increase in employed physicians could significantly increase our professional and general liability risks and related costs in future periods since for employed physicians there is no insurance coverage from unaffiliated insurance companies.

Our facilities are concentrated in a small number of regions. If any one of the regions in which we operate experiences a regulatory change, economic downturn or other material change, our overall business results may suffer.

Among our operations as of June 30, 2010, five hospitals and various related healthcare businesses were located in San Antonio, Texas; five hospitals and related healthcare businesses were located in metropolitan Phoenix, Arizona; two hospitals and related healthcare businesses were located in metropolitan Chicago, Illinois; and three hospitals and related healthcare businesses were located in Massachusetts. We acquired two additional hospitals in metropolitan Chicago, Illinois effective August 1, 2010.

For the years ended June 30, 2008, 2009 and 2010, our total revenues were generated as follows:

	Year ended June 30,		
	2008	2009	2010
San Antonio	32.1%	29.6%	26.8%
Phoenix Health Plan and Abrazo Advantage Health Plan	14.1%	19.3%	23.1%
Massachusetts	19.7%	18.3%	18.2%
Metropolitan Phoenix, excluding Phoenix Health Plan and Abrazo Advantage Health Plan	18.8%	17.9%	17.5%
Metropolitan Chicago (1)	14.9%	14.6%	14.1%
Other	0.4%	0.3%	0.3%
	100.0%	100.0%	100.0%

(1) Includes MacNeal Health Providers

Any material change in the current demographic, economic, competitive or regulatory conditions in any of these regions could adversely affect our overall business results because of the significance of our operations in each of these regions to our overall operating performance. Moreover, due to the concentration of our revenues in only four regions, our business is less diversified and, accordingly, is subject to greater regional risk than that of some of our larger competitors.

If we are unable to control our healthcare costs at Phoenix Health Plan and Abrazo Advantage Health Plan, if the health plans should lose their governmental contracts or if budgetary cuts reduce the scope of Medicaid or dual-eligibility coverage, our profitability may be adversely affected.

For the years ended June 30, 2008, 2009 and 2010, PHP generated approximately 12.7%, 18.1% and 22.1% of our total revenues, respectively. PHP derives substantially all of its revenues through a contract with AHCCCS. AHCCCS pays capitated rates to PHP, and PHP subcontracts with physicians, hospitals and other healthcare providers to provide services to its members. If we fail to effectively manage our healthcare costs, these costs may exceed the payments we receive. Many factors can cause actual healthcare costs to exceed the capitated rates paid by AHCCCS, including

- our ability to contract with cost-effective healthcare providers
- the increased cost of individual healthcare services,
- the type and number of individual healthcare services delivered, and
- the occurrence of catastrophes, epidemics or other unforeseen occurrences.

Our current contract with AHCCCS began October 1, 2008 and expires September 30, 2011. This contract is terminable without cause on 90 days' written notice from AHCCCS or for cause upon written notice from AHCCCS if we fail to comply with any term or condition of the contract or fail to take corrective action as required to comply with the terms of the contract. AHCCCS may also terminate the contract with PHP in the event of unavailability of state or federal funding. If our AHCCCS contract is terminated, our profitability would be adversely affected by the loss of these revenues and cash flows. Also, should the scope of the Medicaid program be reduced as a result of state budgetary cuts or other political factors, our results of operations could be adversely affected.

For the years ended June 30, 2008, 2009 and 2010, AAHP generated 1.4%, 1.2% and 1.0% of our total revenues, respectively. AAHP began providing healthcare coverage to Medicare and Medicaid dual-eligible members on January 1, 2006. Most of AAHP's members were formerly enrolled in PHP. AAHP's contract with CMS went into effect on January 1, 2006, for a term of one year, with a provision for successive one year renewals, and has currently been renewed through December 31, 2010. If we fail to effectively manage AAHP's healthcare costs, these costs may exceed the payments we receive.

We are dependent on our senior management team and local management personnel, and the loss of the services of one or more of our senior management team or key local management personnel could have a material adverse effect on our business.

The success of our business is largely dependent upon the services and management experience of our senior management team, which includes Charles N. Martin, Jr., our Chairman and Chief Executive Officer; Kent H. Wallace, our President and Chief Operating Officer; Keith B. Pitts, our Vice Chairman; Phillip W. Roe, our Executive Vice President, Chief Financial Officer and Treasurer; Bradley A. Perkins, MD, our Executive Vice President and Chief Transformation Officer and Joseph D. Moore, Executive Vice President. In addition, we depend on our ability to attract and retain local managers at our hospitals and related facilities, on the ability of our senior officers and key employees to manage growth successfully and on our ability to attract and retain skilled employees. We do not maintain key man life insurance policies on any of our officers. If we were to lose any of our senior management team or members of our local management teams, or if we are unable to attract other necessary personnel in the future, it could have a material adverse effect on our business, financial condition and results of operations. If we were to lose the services of one or more members of our senior management team or a significant portion of our hospital management staff at one or more of our hospitals, we would likely experience a significant disruption in our operations and failure of the affected hospitals to adhere to their respective business plans.

Controls designed to reduce inpatient services may reduce our revenues.

Controls imposed by Medicare and commercial third-party payers designed to reduce admissions and lengths of stay, commonly referred to as "utilization review," have affected and are expected to continue to affect our facilities. Utilization review entails the review of the admission and course of treatment of a patient by managed care plans. Inpatient utilization, average lengths of stay and occupancy rates continue to be negatively affected by payer-required preadmission authorization and utilization review and by payer pressures to maximize outpatient and alternative healthcare delivery services for less acutely ill patients. Efforts to impose more stringent cost controls are expected to continue. For example, the Health Reform Law potentially expands the use of prepayment review by Medicare contractors by eliminating statutory restrictions on their use. Although we are unable to predict the effect these changes will have on our operations, significant limits on the scope of services reimbursed and on reimbursement rates and fees could have a material, adverse effect on our business, financial position and results of operations.

The industry trend towards value-based purchasing may negatively impact our revenues.

There is a trend in the healthcare industry towards value-based purchasing of healthcare services. These value-based purchasing programs include both public reporting of quality data and preventable adverse events tied to the quality and efficiency of care provided by facilities. Governmental programs including Medicare and Medicaid currently require hospitals to report certain quality data to receive full reimbursement updates. In addition, Medicare does not reimburse for care related to certain preventable adverse events (also called "never events"). Many large commercial payers currently require hospitals to report quality data, and several commercial payers do not reimburse hospitals for certain preventable adverse events.

The Health Reform Law contains a number of provisions intended to promote value-based purchasing. Effective July 1, 2011, the Health Reform Law will prohibit the use of federal funds under the Medicaid program to reimburse providers for medical assistance provided to treat hospital acquired conditions ("HACs"). Beginning in federal fiscal year 2015, hospitals that fall into the top 25% of national risk-adjusted HAC rates for all hospitals in the previous year will receive a 1% reduction in their total Medicare payments. Hospitals with excessive readmissions for conditions designated by the Department of Health and Human Services ("HHS") will receive reduced payments for all inpatient discharges, not just discharges relating to the conditions subject to the excessive readmission standard.

The Health Reform Law also requires HHS to implement a value-based purchasing program for inpatient hospital services. Beginning in federal fiscal year 2013, HHS will reduce inpatient hospital payments for all discharges by a percentage specified by statute ranging from 1% to 2% and pool the total amount collected from these reductions to fund payments to reward hospitals that meet or exceed certain quality performance standards established by HHS. HHS will determine the amount each hospital that meets or exceeds the quality performance standards will receive from the pool of dollars created by these payment reductions.

We expect value-based purchasing programs, including programs that condition reimbursement on patient outcome measures, to become more common and to involve a higher percentage of reimbursement amounts. We are unable at this time to predict how this trend will affect our results of operations, but it could negatively impact our revenues.

Our facilities are subject to extensive federal and state laws and regulations relating to the privacy of individually identifiable information.

The Health Insurance Portability and Accountability Act of 1996 required HHS to adopt standards to protect the privacy and security of individually identifiable health-related information. The department released final regulations containing privacy standards in December 2000 and published revisions to the final regulations in August 2002. The Health Information Technology for Economic and Clinical Health Act ("HITECH Act") — one part of the American Recovery and Reinvestment Act of 2009 ("ARRA") — broadened the scope of the HIPAA privacy and security regulations. On August 24, 2009, HHS issued an Interim Final Rule addressing security breach notification requirements and, on October 30, 2009, issued an Interim Final Rule implementing amendments to the enforcement regulations under HIPAA. The privacy regulations extensively regulate the use and disclosure of individually identifiable health-related information. The regulations also provide patients with significant rights related to understanding and controlling how their health information is used or disclosed. The security regulations require healthcare providers to implement administrative, physical and technical practices to protect the security of individually identifiable health information that is maintained or transmitted electronically.

Violations of HIPAA could result in civil or criminal penalties. An investigation or initiation of civil or criminal actions could have a material adverse effect on our business, financial condition, results of operations or prospects and our business reputation could suffer significantly. In addition, there are numerous federal and state laws and regulations addressing patient and consumer privacy concerns, including unauthorized access or theft of personal information. State statutes and regulations vary from state to state and could impose additional penalties. We have developed a comprehensive set of policies and procedures in our efforts to comply with HIPAA and other privacy laws. Our compliance officers are responsible for

implementing and monitoring compliance with our privacy and security policies and procedures at our facilities. We believe that the cost of our compliance with HIPAA and other federal and state privacy laws will not have a material adverse effect on our business, financial condition, results of operations or cash flows.

As a result of increased post-payment reviews of claims we submit to Medicare for our services, we may incur additional costs and may be required to repay amounts already paid to us.

We are subject to regular post-payment inquiries, investigations and audits of the claims we submit to Medicare for payment for our services. These post-payment reviews are increasing as a result of new government cost-containment initiatives, including enhanced medical necessity reviews for Medicare patients admitted to long-term care hospitals, and audits of Medicare claims under the Recovery Audit Contractor program ("RAC"). The RAC program began as a demonstration project in 2005 in three states (New York, California and Florida) and was expanded into the three additional states of Arizona, Massachusetts and South Carolina in July 2007. The program was made permanent by the Tax Relief and Health Care Act of 2006 enacted in December 2006. CMS ended the demonstration project in March 2008 and commenced the permanent RAC program in all states beginning in 2009 with plans to have RACs in full operation in all 50 states by 2010.

RACs utilize a post-payment targeted review process employing data analysis techniques in order to identify those Medicare claims most likely to contain overpayments, such as incorrectly coded services, incorrect payment amounts, non-covered services and duplicate payments. The RAC review is either "automated", for which a decision can be made without reviewing a medical record, or "complex", for which the RAC must contact the provider in order to procure and review the medical record to make a decision about the payment. CMS has given RACs the authority to look back at claims up to three years old, provided that the claim was paid on or after October 1, 2007. Claims identified as overpayments will be subject to the Medicare appeals process.

These additional post-payment reviews may require us to incur additional costs to respond to requests for records and to pursue the reversal of payment denials, and ultimately may require us to refund amounts paid to us by Medicare that are determined to have been overpaid. We are subject to regular post-payment inquiries, investigations and audits of the claims we submit to Medicare for payment for our services. These post-payment reviews are increasing as a result of new government cost-containment initiatives, including enhanced medical necessity reviews for Medicare patients admitted to long-term care hospitals, and audits of Medicare claims under the RAC program. The RAC program began as a demonstration project in 2005 in three states (New York, California and Florida) and was expanded into the three additional states of Arizona, Massachusetts and South Carolina in July 2007. The program was made permanent by the Tax Relief and Health Care Act of 2006 enacted in December 2006. CMS ended the demonstration project in March 2008 and commenced the permanent RAC program in all states beginning in 2009 with plans to have RACs in full operation in all 50 states by 2010.

If we fail to continually enhance our hospitals with the most recent technological advances in diagnostic and surgical equipment, our ability to maintain and expand our markets will be adversely affected.

Technological advances with respect to computed axial tomography (CT), magnetic resonance imaging (MRI) and positron emission tomography (PET) equipment, as well as other equipment used in our facilities, are continually evolving. In an effort to compete with other healthcare providers, we must constantly evaluate our equipment needs and upgrade equipment as a result of technological improvements. Such equipment costs typically range from $1.0 million to $3.0 million, exclusive of construction or build-out costs. If we fail to remain current with the technological advancements of the medical community, our volumes and revenue may be negatively impacted.

Our hospitals face competition for staffing especially as a result of the national shortage of nurses and the increased imposition on us of nurse-staffing ratios, which has in the past and may in the future increase our labor costs and materially reduce our profitability.

We compete with other healthcare providers in recruiting and retaining qualified management and staff personnel responsible for the day-to-day operations of each of our hospitals, including most significantly nurses and other non-physician healthcare professionals. In the healthcare industry generally, including in our markets, the national shortage of nurses and other medical support personnel has become a significant operating issue. This shortage has caused us in the past and may require us in the future to increase wages and benefits to recruit and retain nurses and other medical support personnel or to hire more expensive temporary personnel. We have voluntarily raised on several occasions in the past, and expect to raise in the future, wages for our nurses and other medical support personnel.

In addition, union-mandated or state-mandated nurse-staffing ratios significantly affect not only labor costs, but may also cause us to limit patient admissions with a corresponding adverse effect on revenues if we are unable to hire the appropriate number of nurses to meet the required ratios. While we do not currently operate in any states with mandated nurse-staffing ratios, the states in which we operate could adopt mandatory nurse-staffing ratios at any time. In those instances where our nurses are unionized, it is our experience that new union contracts often impose significant new additional staffing ratios by contract on our hospitals. This was the case with the increased staffing ratios imposed on us in our union contract with our nurses at Saint Vincent Hospital in Worcester, Massachusetts negotiated in 2007.

The U.S. Congress is currently considering a bill called the Employee Free Choice Act of 2009 ("EFCA"), which organized labor, a major supporter of the Obama administration, has called its number one legislative objective. EFCA would amend the National Labor Relations Act to establish a procedure whereby the National Labor Relations Board ("NLRB") would certify a union as the bargaining representative of employees, without a NLRB-supervised secret ballot election, if a majority of unit employees signs valid union authorization cards (the "card-check provision"). Additionally, under EFCA, parties that are unable to reach a first contract within 90 days of collective bargaining could refer the dispute to mediation by the Federal Mediation and Conciliation Service (the "Service"). If the Service is unable to bring the parties to agreement within 30 days, the dispute then would be referred to binding arbitration. Also, the bill would provide for increased penalties for labor law violations by employers. In July 2009, due to intense opposition from the business community, alternative draft legislation became public, dropping the card-check provision, but putting in its place new provisions making it easier for employees to organize including provisions to require shorter unionization campaigns, faster elections and limitations on employer-sponsored anti-unionization meetings, which employees are required to attend. This legislation, if passed, would make it easier for our nurses or other groups of hospital employees to unionize, which could materially increase our labor costs.

If our labor costs continue to increase, we may not be able to raise our payer reimbursement levels to offset these increased costs, including the significantly increased costs that we will incur for wage increases and nurse-staffing ratios under our new union contract with our nurses at Saint Vincent Hospital. Because substantially all of our net patient revenues consist of payments based on fixed or negotiated rates, our ability to pass along increased labor costs is materially constrained. Our failure to recruit and retain qualified management, nurses and other medical support personnel, or to control our labor costs, could have a material adverse effect on our profitability.

Compliance with Section 404 of the Sarbanes-Oxley Act may negatively impact our results of operations and failure to comply may subject us to regulatory scrutiny and a loss of investors' confidence in our internal control over financial reporting.

Section 404 of the Sarbanes-Oxley Act of 2002 ("Section 404") requires us to perform an evaluation of our internal control over financial reporting and file management's attestation with our annual report. We have evaluated, tested and implemented internal controls over financial reporting to enable management to report on such internal controls under Section 404. However, we cannot assure you that the conclusions we will reach in our June 30, 2010 management report will represent conclusions we reach in future periods. Failure on our part to comply with Section 404 may subject us to regulatory scrutiny and a loss of public confidence in the reliability of our financial statements. In addition, we may be required to incur costs in improving our internal control over financial reporting and hiring additional personnel. Any such actions could negatively affect our results of operations.

A failure of our information systems would adversely affect our ability to properly manage our operations.

We rely on our advanced information systems and our ability to successfully use these systems in our operations. These systems are essential to the following areas of our business operations, among others:

- patient accounting, including billing and collection of patient service revenues;
- financial, accounting, reporting and payroll;
- coding and compliance;
- laboratory, radiology and pharmacy systems;

- remote physician access to patient data;
- negotiating, pricing and administering managed care contracts; and
- monitoring quality of care.

If we are unable to use these systems effectively, we may experience delays in collection of patient service revenues and may not be able to properly manage our operations or oversee compliance with laws or regulations.

If we fail to effectively and timely implement electronic health record systems, our operations could be adversely affected.

As required by ARRA, HHS is in the process of developing and implementing an incentive payment program for eligible hospitals and health care professionals that adopt and meaningfully use certified electronic health record ("EHR") technology. If our hospitals and employed professionals are unable to meet the requirements for participation in the incentive payment program, we will not be eligible to receive incentive payments that could offset some of the costs of implementing EHR systems. Further, beginning in 2015, eligible hospitals and professionals that fail to demonstrate meaningful use of certified EHR technology will be subject to reduced payments from Medicare. Failure to implement EHR systems effectively and in a timely manner could have a material, adverse effect on our financial position and results of operations.

Difficulties with current construction projects or new construction projects such as additional hospitals or major expansion projects may involve significant capital expenditures that could have an adverse impact on our liquidity.

During fiscal year 2010, we entered into a contract to construct a replacement facility for our Southeast Baptist Hospital in San Antonio, and we may decide to construct an additional hospital or hospitals in the future or construct additional major expansion projects to existing hospitals in order to achieve our growth objectives. Our ability to complete construction of new hospitals or new expansion projects on budget and on schedule would depend on a number of factors, including, but not limited to:

- our ability to control construction costs,
- the failure of general contractors or subcontractors to perform under their contracts,
- adverse weather conditions,
- shortages of labor or materials;
- our ability to obtain necessary licensing and other required governmental authorizations; and
- other unforeseen problems and delays.

As a result of these and other factors, we cannot assure you that we will not experience increased construction costs on our construction projects or that we will be able to construct our current or any future construction projects as originally planned. In addition, our current and any future major construction projects would involve a significant commitment of capital with no revenues associated with the projects during construction, which also could have a future adverse impact on our liquidity.

If the costs for construction materials and labor continue to rise, such increased costs could have an adverse impact on the return on investment relating to our expansion projects.

The cost of construction materials and labor has significantly increased over the past years as a result of global and domestic events. We have experienced significant increases in the cost of steel due to the demand in China for such materials and an increase in the cost of lumber due to multiple factors. Increases in oil and gas prices have increased costs for oil-based products and for transporting materials to job sites. As we continue to invest in modern technologies, emergency rooms and operating room expansions, we expend large sums of cash generated from operating activities. We evaluate the financial viability of such projects based on whether the projected cash flow return on investment exceeds our cost of capital. Such returns may not be achieved if the cost of construction continues to rise significantly or anticipated volumes do not materialize.

State efforts to regulate the construction or expansion of hospitals could impair our ability to operate and expand our operations.

Some states require healthcare providers to obtain prior approval, known as certificates of need, for:

- the purchase, construction or expansion of healthcare facilities;
- capital expenditures exceeding a prescribed amount; or
- changes in services or bed capacity

In giving approval, these states consider the need for additional or expanded healthcare facilities or services. Illinois and Massachusetts are the only states in which we currently own hospitals that have certificate-of-need laws. The failure to obtain any required certificate of need could impair our ability to operate or expand operations in these states.

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

Blackstone acquired our predecessor company during fiscal 2005. We recorded a significant portion of the purchase price as goodwill. At June 30, 2010, we had approximately $649.1 million of goodwill recorded on our financial statements. There is no guarantee that we will be able to recover the carrying value of this goodwill through our future cash flows. On an ongoing basis, we evaluate, based on the fair value of our reporting units, whether the carrying value of our goodwill is impaired. During fiscal 2007, we recorded a $123.8 million ($110.5 million, net of tax benefit) impairment charge to goodwill to reduce the carrying values of our Illinois hospitals to their fair values. Our two Illinois hospitals have experienced deteriorating economic factors that have negatively impacted their results of operations and cash flows. While various initiatives mitigated the impact of these economic factors during fiscal 2008 and 2009, the operating results of the Illinois hospitals did not improve to the level anticipated during the first half of fiscal 2010. After having the opportunity to evaluate the operating results of the Illinois hospitals for the first six months of fiscal year 2010 and to reassess the market trends and economic factors, we concluded that it was unlikely that previously projected cash flows for these hospitals would be achieved. We performed an interim goodwill impairment test during the quarter ended December 31, 2009 and, based upon revised projected cash flows, market participant data and appraisal information, we determined that the $43.1 million remaining goodwill related to this reporting unit was impaired. We recorded the $43.1 million ($31.8 million, net of taxes) non-cash impairment loss during the quarter ended December 31, 2009.

Our hospitals are subject to potential responsibilities and costs under environmental laws that could lead to material expenditures or liability.

We are subject to various federal, state and local environmental laws and regulations, including those relating to the protection of human health and the environment. We could incur substantial costs to maintain compliance with these laws and regulations. To our knowledge, we have not been and are not currently the subject of any investigations relating to noncompliance with environmental laws and regulations. We could become the subject of future investigations, which could lead to fines or criminal penalties if we are found to be in violation of these laws and regulations. The principal environmental requirements and concerns applicable to our operations relate to proper management of regulated materials, hazardous waste and medical waste, above-ground and underground storage tanks, operation of boilers, chillers and other equipment, and management of building conditions, such as the presence of mold, lead-based paint or asbestos. Our hospitals engage independent contractors for the transportation, handling and disposal of hazardous waste, and we require that our hospitals be named as additional insureds on the liability insurance policies maintained by these contractors.

We also may be subject to requirements related to the remediation of substances that have been released into the environment at properties owned or operated by us or our predecessors or at properties where substances were sent for off-site treatment or disposal. These remediation requirements may be imposed without regard to fault, and liability for environmental remediation can be substantial.

Additional Risk Factors

See the additional risks related to our business in "Item 7 — Management's Discussion and Analysis of Financial Conditions and Results of Operations — Operating Environment" included elsewhere in this Report which are incorporated by reference in this Item 1A as if fully set forth herein.

Available Information

The public may read and copy any materials we file with the SEC at the SEC's Public Reference Room at 100 F Street, N.E., Washington, DC 20549. The public may obtain information on the operation of the Public Reference Room by calling the SEC at 1-800-SEC-0330. We are an electronic filer and the SEC maintains an Internet site at http://www.sec.gov that contains the reports and other information we file electronically. Our Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q, Current Reports on Form 8-K and amendments to those reports are also available free of charge on our internet website at www.vanguardhealth.com under "Investor Relations-SEC Filings-SEC Filings on the Edgar Database" as soon as reasonably practicable after such reports are electronically filed with or furnished to the SEC. Please note that our website address is provided as an inactive textual reference only. Also, the information provided on our website is not part of this report, and is therefore not incorporated by reference unless such information is specifically referenced elsewhere in this report.

Item 1B. Unresolved Staff Comments.

Not applicable.

Item 2. Properties.

A listing of our owned acute hospitals is included in Item 1 of this report under the caption "Business-Our Facilities". We also own or lease space for outpatient service facilities complementary to our hospitals and own and operate a limited number of medical office buildings (some of which are joint ventures) associated with our hospitals that are occupied primarily by physicians who practice at our hospitals. The most significant of these complementary outpatient healthcare facilities are two surgery centers in Orange County, California, five diagnostic imaging centers in metropolitan Phoenix, Arizona and a 50% interest in seven diagnostic imaging centers in San Antonio, Texas. Most of these outpatient facilities are in leased facilities, and the diagnostic imaging centers in San Antonio are owned and operated in joint ventures where we have minority partners.

As of June 30, 2010, we leased approximately 53,200 square feet of office space at 20 Burton Hills Boulevard, Nashville, Tennessee, for our corporate headquarters.

Our headquarters, hospitals and other facilities are suitable for their respective uses and are, in general, adequate for our present needs. Our obligations under our senior credit facilities are secured by a pledge of substantially all of our assets, including first priority mortgages on each of our hospitals. Also, our properties are subject to various federal, state and local statutes and ordinances regulating their operation. Management does not believe that compliance with such statutes and ordinances will materially affect our financial position or results from operations.

Item 3. Legal Proceedings.

We operate in a highly regulated and litigious industry. As a result, various lawsuits, claims and legal and regulatory proceedings have been instituted or asserted against us. While we cannot predict the likelihood of future claims or inquiries, we expect that new matters may be initiated against us from time to time. The results of claims, lawsuits and investigations cannot be predicted, and it is possible that the ultimate resolution of these matters, individually or in the aggregate, may have a material adverse effect on our business (both in the near and long term), financial position, results of operations or cash flows. We recognize that, where appropriate, our interests may be best served by resolving certain matters without litigation. If non-litigated resolution is not possible or appropriate with respect to a particular matter, we will continue to defend ourselves vigorously.

Currently pending and recently settled legal proceedings and investigations that are not in the ordinary course of business are set forth below. Where specific amounts are sought in any pending legal proceeding, those amounts are disclosed. For all other matters, where the possible loss or range of loss is reasonably estimable, an estimate is provided. Where no estimate is provided, the possible amount of loss is not reasonably estimable at this time. We record reserves for claims and lawsuits when they are probable and reasonably estimable. For matters where the likelihood or extent of a loss is not probable or cannot be reasonably estimated, we have not recognized in our consolidated financial statements potential liabilities that may result. We undertake no obligation to update the following disclosures for any new developments

Sherman Act Antitrust Class Action Litigation — Maderazo, et al v. VHS San Antonio Partners, L.P. d/b/a Baptist Health Systems, et. al., Case No. 5:06cv00535 (United States District Court, Western District of Texas, San Antonio Division, filed June 20, 2006 and amended August 29, 2006)

On June 20, 2006, a federal antitrust class action suit was filed in San Antonio, Texas against our Baptist Health System subsidiary in San Antonio, Texas and two other large hospital systems in San Antonio. In the complaint, plaintiffs allege that the three hospital system defendants conspired with each other and with other unidentified San Antonio area hospitals to depress the compensation levels of registered nurses employed at the conspiring hospitals within the San Antonio area by engaging in certain activities that violated the federal antitrust laws. The complaint alleges two separate claims. The first count asserts that the defendant hospitals violated Section 1 of the federal Sherman Act, which prohibits agreements that unreasonably restrain competition, by conspiring to depress nurses' compensation. The second count alleges that the defendant hospital systems also violated Section 1 of the Sherman Act by participating in wage, salary and benefits surveys for the purpose, and having the effect, of depressing registered nurses' compensation or limiting competition for nurses based on their compensation. The class on whose behalf the plaintiffs filed the complaint is alleged to comprise all registered nurses employed by the defendant hospitals since June 20, 2002. The suit seeks unspecified damages, trebling of this damage amount pursuant to federal law, interest, costs and attorneys fees. From 2006 through April 2008 we and the plaintiffs worked on producing documents to each other relating to, and supplying legal briefs to the court in respect of, the issue of whether the court will certify a class in this suit. In April 2008 the case was stayed by the judge pending his ruling on plaintiffs' motion for class certification. We believe that the allegations contained within this putative class action suit are without merit, and we have vigorously worked to defeat class certification. If a class is certified, we will continue to defend vigorously against the litigation.

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On the same date in 2006 that this suit was filed against us in federal district court in San Antonio, the same attorneys filed three other substantially similar putative class action lawsuits in federal district courts in Chicago, Illinois, Albany, New York and Memphis, Tennessee against some of the hospitals or hospital systems in those cities (none of such hospitals or hospital systems being owned by us). The attorneys representing the plaintiffs in all four of these cases said in June 2006 that they may file similar complaints in other jurisdictions and in December 2006 they brought a substantially similar class action lawsuit against eight hospitals or hospital systems in the Detroit, Michigan metropolitan area, one of which systems is DMC. Since representatives of the Service Employees International Union joined plaintiffs' attorneys in announcing the filing of all four complaints on June 20, 2006, and as has been reported in the media, we believe that SEIU's involvement in these actions appears to be part of a corporate campaign to attempt to organize nurses in these cities, including San Antonio. The nurses in our hospitals in San Antonio are currently not members of any union. Of the four other similar cases filed in 2006, only the Chicago case has been concluded, following the court's denial of plaintiffs' motion to certify a class, with the plaintiffs not appealing the court's ruling denying class certification and then the parties settling the case, with all but one of the defendant hospitals or health systems paying $10,000 each to the two plaintiffs while expressly denying any liability or wrongdoing. In the suit in Detroit, the plaintiffs have filed a motion for class certification and DMC has filed a motion for summary judgment and both motions are currently pending before the trial judge. The other two suits have progressed at somewhat different paces and remain pending. To date, in all five suits, the plaintiffs have yet to persuade any court to certify a class of registered nurses as alleged in their complaints.

If the plaintiffs (1) are successful in obtaining class certification and (2) are able to prove substantial damages which are then trebled under Section 1 of the Sherman Act, such a result could materially affect our business, financial condition or results of operations. However, in the opinion of management, the ultimate resolution of this matter is not expected to have a material adverse effect on our financial position or results of operations.

Self-Disclosure of Employment of Excluded Persons

Federal law permits the Department of Health and Human Services Office of Inspector General ("OIG") to impose civil monetary penalties, assessments and/or to exclude from participation in federal healthcare programs, individuals and entities who have submitted false, fraudulent or improper claims for payment. Improper claims include those submitted by individuals or entities who have been excluded from participation. Civil monetary penalties of up to $10,000 for each item or service furnished by the excluded individual or entity, an assessment of up to three times the amount claimed and program exclusions also be imposed on providers or entities who employ or enter into contracts with excluded individuals to provide services to beneficiaries of federal healthcare programs. On October 12, 2009, we voluntarily disclosed to the OIG that two employees had been excluded from participation in Medicare at certain times during their employment. We are diligently investigating the circumstances surrounding the employment of these two excluded individuals, and intend to submit a voluntary disclosure pursuant to the Provider Self-Disclosure Protocol once the necessary information is obtained. If the OIG were to impose all potentially available sanctions and penalties against us in this matter, such a result could materially affect our business, financial condition or results of operations. However, in the opinion of management, the ultimate resolution of this matter is not expected to have a material adverse effect on our financial position or results of operations.

Claims in the ordinary course of business

We are also subject to claims and lawsuits arising in the ordinary course of business, including potential claims related to care and treatment provided at our hospitals and outpatient services facilities. Although the results of these claims and lawsuits cannot be predicted with certainty, we believe that the ultimate resolution of these ordinary course claims and lawsuits will not have a material adverse effect on our business, financial condition or results of operations.

Item 4. (Removed and Reserved).

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PART II

Item 5. Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities.

There is no established public trading market for our common stock. At August 1, 2010, there were five holders of record of our common stock. These holders are VHS Holdings LLC and four investment funds affiliated with Blackstone.

We have not declared or paid any dividends on our common stock in our two most recent fiscal years. We did, on the other hand, in January 2010, repurchase 242,659 shares of our common stock from our stockholders, at a per share price of $1,238.58, or $300,552,407 in the aggregate. However, in the future, we intend to retain all current and foreseeable future earnings to support operations and finance expansion. Our senior secured credit facility and the indenture governing our 8.0% Notes restrict our ability to pay cash dividends on our common stock.

There were no unregistered sales of our equity securities during the quarter ended June 30, 2010.

Information regarding our equity compensation plans is set forth in this report under "Item 12 — Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters — Equity Compensation Plan Information", which information is incorporated herein by reference.

Item 6. Selected Financial Data.

The following table sets forth our selected historical financial and operating data for, or as of the end of, each of the five years ended June 30, 2010. The selected historical financial data as of and for the year ended June 30, 2006 were derived from our consolidated financial statements that have been audited by Ernst & Young LLP, an independent registered public accounting firm, adjusted for the retrospective presentation impact of changes in guidance related to non-controlling interests. The selected historical financial data as of and for the years ended June 30, 2007, 2008, 2009 and 2010 were derived from our consolidated financial statements that have been audited by Ernst & Young LLP, an independent registered public accounting firm. Dispositions completed during fiscal 2007 and fiscal 2010 have been excluded from all periods presented. See "Executive Overview" included in "Item 7 — Management's Discussion and Analysis of Financial Condition and Results of Operations." This table should be read in conjunction with the consolidated financial statements and notes thereto.

	Year ended June 30,				
	2006	2007	2008	2009	2010
Statement of Operations Data (millions):					
Total revenues	$ 2,400.2	$ 2,563.9	$ 2,775.6	$ 3,185.4	$ 3,376.9
Costs and expenses:					
Salaries and benefits (includes stock compensation of $1.7, $1.2, $2.5, $4.4 and $4.2, respectively)	985.0	1,061.4	1,146.2	1,233.8	1,296.2
Health plan claims expense	270.3	297.0	328.2	525.6	665.8
Supplies	392.9	420.8	433.7	455.5	456.1
Provision for doubtful accounts	156.6	174.8	205.5	210.3	152.5
Other operating expenses	345.2	367.6	398.5	461.9	483.9
Depreciation and amortization	98.7	117.0	129.3	128.9	139.6
Interest, net	103.8	123.8	122.1	111.6	115.5
Impairment loss	—	123.8	—	6.2	43.1
Debt extinguishment costs	0.1	—	—	—	73.5
Other expenses	6.5	0.2	6.5	2.7	9.1
Subtotal	2,359.1	2,686.4	2,770.0	3,136.5	3,435.3
Income (loss) from continuing operations before income taxes	41.1	(122.5)	5.6	48.9	(58.4)
Income tax benefit (expense)	(16.2)	11.6	(2.2)	(16.8)	13.8
Income (loss) from continuing operations	24.9	(110.9)	3.4	32.1	(44.6)
Loss from discontinued operations, net of taxes	(9.4)	(19.2)	(1.1)	(0.3)	(1.7)
Net income (loss)	15.5	(130.1)	2.3	31.8	(46.3)
Less: Net income attributable to non-controlling interests	(2.6)	(2.6)	(3.0)	(3.2)	(2.9)
Net income (loss) attributable to Vanguard Health Systems, Inc. stockholders	$ 12.9	$ (132.7)	$ (0.7)	$ 28.6	$ (49.2)
Balance Sheet Data (millions):					
Cash and cash equivalents	$ 123.6	$ 120.1	$ 141.6	$ 308.2	$ 257.6
Assets	2,650.5	2,538.1	2,582.3	2,731.1	2,729.6
Long-term debt, including current portion	1,519.2	1,528.7	1,537.5	1,551.6	1,752.0
Working capital	193.0	156.4	217.8	251.6	105.0
Other Financial Data (millions):					
Adjusted EBITDA (a)	$ 251.9	$ 243.5	$ 266.0	$ 302.7	$ 326.6
Capital expenditures	275.5	164.3	119.8	132.0	155.9
Cash provided by operating activities	152.4	125.6	176.3	313.1	315.2
Cash used in investing activities	(245.4)	(118.5)	(143.8)	(133.6)	(156.5)
Cash provided by (used in) financing					

activities	137.4	(10.6)	(11.0)	(12.9)	(209.3)

	Year ended June 30,				
	2006	2007	2008	2009	2010
Unaudited Operating Data - continuing operations:					
Number of hospitals, end of period	15	15	15	15	15
Number of licensed beds, end of period (b)	3,937	4,143	4,181	4,135	4,135
Discharges (c)	162,446	166,873	169,668	167,880	168,370
Adjusted discharges (d)	274,451	277,231	283,250	288,807	295,702
Adjusted discharges-hospitals (e)	261,056	264,698	270,076	274,767	280,437
Net revenue per adjusted discharge (f)	$ 7,230	$ 7,674	$ 8,047	$ 8,503	$ 8,408
Net revenue per adjusted discharge-hospitals (g)	$ 7,319	$ 7,766	$ 8,110	$ 8,623	$ 8,516
Patient days (h)	701,307	721,832	734,838	709,952	701,265
Average length of stay (i)	4.32	4.33	4.33	4.23	4.17
Inpatient surgeries (j)	36,606	37,227	37,538	37,970	37,320
Outpatient surgeries (k)	76,437	76,606	73,339	76,378	75,969
Emergency room visits (l)	554,250	572,946	588,246	605,729	626,237
Occupancy rate (m)	49%	48%	48%	47%	46%
Member lives (n)	146,200	145,600	149,600	218,700	241,200

(a) We define Adjusted EBITDA as income before interest expense (net of interest income), income taxes, depreciation and amortization, non-controlling interests, equity method income, stock compensation, gain or loss on sale of assets, monitoring fees and expenses, realized holding losses on investments, impairment losses, debt extinguishment costs, acquisition related expenses and discontinued operations, net of taxes. Monitoring fees and expenses represent fees and reimbursed expenses paid to affiliates of The Blackstone Group and Metalmark Subadvisor LLC for advisory and oversight services. Adjusted EBITDA should not be considered as a substitute for net income (loss) attributable to Vanguard Health Systems, Inc. stockholders, operating cash flows or other cash flow statement data determined in accordance with accounting principles generally accepted in the United States. Adjusted EBITDA, as presented by us, may not be comparable to similarly titled measures of other companies due to varying methods of calculation. We believe that Adjusted EBITDA provides useful information about our financial performance to investors, lenders, financial analysts and rating agencies since these groups have historically used EBITDA-related measures in the healthcare industry, along with other measures, to estimate the value of a company, to make informed investment decisions, to evaluate a company's leverage capacity and its ability to meet its debt service requirements. Adjusted EBITDA eliminates the uneven effect of non-cash depreciation of tangible assets and amortization of intangible assets, much of which results from acquisitions accounted for under the purchase method of accounting. Adjusted EBITDA also eliminates the effects of changes in interest rates which management believes relate to general trends in global capital markets, but are not necessarily indicative of a company's operating performance. Adjusted EBITDA is also used by us to measure individual performance for incentive compensation purposes and as an analytical indicator for purposes of allocating resources to our operating businesses and assessing their performance, both internally and relative to our peers, as well as to evaluate the performance of our operating management teams. The following table sets forth a reconciliation of Adjusted EBITDA to net income (loss) attributable to Vanguard Health Systems, Inc. stockholders for the respective periods presented (in millions).

	Year ended June 30,				
	2006	2007	2008	2009	2010
Net income (loss) attributable to Vanguard Health Systems, Inc. stockholders	$ 12.9	$ (132.7)	$ (0.7)	$ 28.6	$ (49.2)
Interest, net	103.8	123.8	122.1	111.6	115.5
Income tax expense (benefit)	16.2	(11.6)	2.2	16.8	(13.8)
Depreciation and amortization	98.7	117.0	129.3	128.9	139.6
Non-controlling interests	2.6	2.6	3.0	3.2	2.9
Equity method income	(0.2)	(1.0)	(0.7)	(0.8)	(0.9)
Stock compensation	1.7	1.2	2.5	4.4	4.2
Loss (gain) on disposal of assets	1.5	(4.0)	0.8	(2.3)	1.8
Realized holding losses on investments	—	—	—	0.6	—
Monitoring fees and expenses	5.2	5.2	6.4	5.2	5.1
Impairment loss	—	123.8	—	6.2	43.1
Debt extinguishment costs	0.1	—	—	—	73.5

Acquisition related expenses	—	—	—	—	3.1
Loss from discontinued operations net of taxes	9.4	19.2	1.1	0.3	1.7
Adjusted EBITDA	$ 251.9	$ 243.5	$ 266.0	$ 302.7	$326.6

(b) Licensed beds are those beds for which a facility has been granted approval to operate from the applicable state licensing agency.

(c) Discharges represent the total number of patients discharged (in the facility for a period in excess of 23 hours) from our hospitals and is used by management and certain investors as a general measure of inpatient volumes.

(d) Adjusted discharges is used by management and certain investors as a general measure of consolidated inpatient and outpatient volumes. Adjusted discharges is computed by multiplying discharges by the sum of gross inpatient revenues and gross outpatient revenues and then dividing the result by gross inpatient revenues.

(e) Adjusted discharges-hospitals is used by management and certain investors as a general measure of combined hospital inpatient and outpatient volumes. Adjusted discharges-hospitals is computed by multiplying discharges by the sum of gross hospital inpatient and gross hospital outpatient revenues and then dividing the result by gross hospital inpatient revenues. This computation enables management to assess hospital volumes by a combined measure of hospital inpatient and outpatient utilization.

(f) Net revenue per adjusted discharge is calculated by dividing net patient revenues by adjusted discharges and measures the average net payment expected to be received for an episode of service provided to a patient.

(g) Net revenue per adjusted discharge-hospitals is calculated by dividing hospital net patient revenues by adjusted discharges-hospitals and measures the average net payment expected to be received for a patient's stay in the hospital.

(h) Patient days represent the number of days (calculated as overnight stays) our beds were occupied by patients during the periods.

(i) Average length of stay represents the average number of days an admitted patient stays in our hospitals.

(j) Inpatient surgeries represent the number of surgeries performed in our hospitals where overnight stays are necessary.

(k) Outpatient surgeries represent the number of surgeries performed at hospitals or ambulatory surgery centers on an outpatient basis (patient overnight stay not necessary).

(l) Emergency room visits represent the number of patient visits to a hospital or freestanding emergency room where treatment is received, regardless of whether an overnight stay is subsequently required.

(m) Occupancy rate represents the percentage of hospital licensed beds occupied by patients. Occupancy rate provides a measure of the utilization of inpatient rooms.

(n) Member lives represent the total number of members in PHP, AAHP and MHP as of the end of the respective period.

Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations.

You should read the following discussion together with our historical financial statements and related notes included elsewhere herein and the information set forth under "Item 6 — Selected Financial Data." The discussion contains forward-looking statements that involve risks and uncertainties. For additional information regarding some of the risks and uncertainties that affect our business and the industry in which we operate, please read "Item 1A — Risk Factors" included elsewhere in this Report. Our actual results may differ materially from those estimated or projected in any of these forward-looking statements.

Executive Overview

As of June 30, 2010, we owned and operated 15 hospitals with a total of 4,135 licensed beds, and related outpatient service facilities complementary to the hospitals in San Antonio, Texas; metropolitan Phoenix, Arizona; metropolitan Chicago, Illinois, and Massachusetts; and two surgery centers in Orange County, California. As of June 30, 2009 and 2010, we also owned three health plans as set forth in the following table.

Health Plan	Location	Membership 2009	Membership 2010
Phoenix Health Plan ("PHP") — managed Medicaid	Arizona	176,200	201,400
Abrazo Advantage Health Plan ("AAHP") — managed Medicare and Dual Eligible	Arizona	2,800	2,700
MacNeal Health Providers ("MHP") — capitated outpatient and physician services	Illinois	39,700	37,100
		218,700	241,200

During fiscal 2010, our revenue growth was limited by significant challenges including less demand for elective services, some of which related to a weakened general economy, a shift from services provided to managed care enrollees to uninsured patients or those covered by lower paying Medicaid plans and increased competition primarily in San Antonio. We were successful in reducing certain costs to offset the impact of the limited revenue growth, but we are not sure these cost reduction measures will be sustainable if economic weakness persists during fiscal 2011 and beyond. Our comprehensive debt refinancing (the "Refinancing") during fiscal 2010 extended the maturities of our debt by up to five years and will be essential to the success of our long-term growth strategies. However, costs associated with the Refinancing were significant and resulted in a net loss attributable to our shareholders during the current fiscal year.

Our mission is to help people in the communities we serve achieve health for life by delivering an ideal patient-centered experience in a high performance environment of integrated care. We plan to grow our business by continually improving quality of care, transforming the delivery of care to a fee per episode basis, expanding services and strengthening the financial performance of our existing operations and selectively acquiring other hospitals where we see an opportunity to improve operating performance and expand our mission. This business strategy is a framework for long-term success in an industry that is undergoing significant change, but we may continue to experience operating challenges in the short term until the general economy improves and our initiatives are fully implemented.

Recent Acquisition Activity

On June 10, 2010, we entered into a definitive agreement to purchase the Detroit Medical Center ("DMC"), which owns and operates eight hospitals in and around Detroit, Michigan with 1,734 licensed beds, including Children's Hospital of Michigan, Detroit Receiving Hospital, Harper University Hospital, Huron Valley-Sinai Hospital, Hutzel Women's Hospital, Rehabilitation Institute of Michigan, Sinai-Grace Hospital and DMC Surgery Hospital.

Under the purchase agreement, we will acquire all of DMC's assets (other than donor restricted assets and certain other assets) and assume all of its liabilities (other than its outstanding bonds and notes and certain other liabilities) for $417.0 million in cash, which will be used to repay all of such non-assumed debt. The $417.0 million cash payment represents our full cash funding obligations to DMC in order to close the transaction, except for our assumption or payment of DMC's usual and customary transaction expenses. The assumed liabilities include a pension liability under a "frozen" defined benefit pension plan of DMC estimated at $184 million as of December 31, 2009 that we anticipate we will fund over seven years based upon actuarial assumptions and estimates, as adjusted periodically by actuaries. We will also commit to spend $500.0 million in capital expenditures in the DMC facilities during the five years subsequent to closing of the transaction, which amount relates to a specific project list agreed to between the DMC board of representatives and us. In addition, we will commit to spend $350.0 million during this five-year period relating to the routine capital needs of the DMC facilities. The acquisition is pending review and approval by the Michigan Attorney General. Assuming such approval is obtained, we expect the transaction to close during our second quarter of fiscal year 2011.

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In August 2010, we entered into definitive agreements to purchase certain assets and assume certain liabilities of the Arizona Heart Hospital and of the Arizona Heart Institute both located in Phoenix, Arizona. We expect these acquisitions to provide us a base upon which to expand our cardiology service offerings in the metropolitan Phoenix market. We expect both of these acquisitions to close during the second quarter of fiscal 2011. However, the Arizona Health Institute acquisition could be delayed since that entity recently made a voluntary filing with the U.S. Bankruptcy Court for the District of Arizona under Chapter 11 of the Bankruptcy Code for a reorganization of its business and the sale of its assets is now subject to the prior approval of such court.

On August 1, 2010, we completed the purchase of Westlake Hospital and West Suburban Medical Center in the western suburbs of Chicago, Illinois from Resurrection Health Care. Westlake Hospital is a 225-bed acute care facility located in Melrose Park, Illinois, and West Suburban Medical Center is a 234-bed acute care facility located in Oak Park, Illinois. Both of these facilities are located less than 10 miles from our MacNeal Hospital and will enable us to achieve a market presence in the western suburban area of Chicago. As part of the purchase, we acquired substantially all of the assets (other than cash on hand) and assumed certain liabilities of these hospitals for a total cash purchase price of approximately $45.0 million.

Operating Environment

We believe that the operating environment for hospital operators continues to evolve, which presents both challenges and opportunities for us. In order to remain competitive in the markets we serve, we must transform our operating strategies to not only accommodate changing environmental factors but to make them operating advantages for us relative to our peers. These factors will require continued focus on quality of care initiatives. As consumers become more involved in their healthcare decisions, we believe perceived quality of care will become an even greater factor in determining where physicians choose to practice and where patients choose to receive care. The changes to the healthcare landscape that have begun or that we expect to begin in the immediate future are outlined below.

Payer Mix Shifts

During fiscal 2010, we provided more healthcare services to patients who were uninsured or had coverage under Medicaid or managed Medicaid programs and provided less healthcare services to patients who had managed care coverage than in previous years. Much of this shift resulted from general economic weakness in the markets we serve. As individuals lost their coverage under employer-sponsored managed care plans, many became eligible for state Medicaid or managed Medicaid programs or else became uninsured. We are uncertain how long the economic weakness will continue, but believe that conditions may not improve significantly during fiscal 2011.

Health Reform Law

The provisions included in the Health Reform Law include, among other things, increased access to health benefits for a significant number of uninsured individuals through the creation of health exchanges and expanded Medicaid programs; reductions in future Medicare reimbursement including market basket and disproportionate share payment decreases; development of a payment bundling pilot program and similar programs to promote accountability and coordination of care; continued efforts to tie reimbursement to quality of care including penalties for excessive readmissions and hospital-acquired conditions; and changes to premiums paid and the establishment of profit restrictions on Medicare managed care plans and exchange insurance plans. We are unable to predict how the Health Reform Law will impact our future financial position, operating results or cash flows, but we have begun the process of transforming our delivery of care to adapt to the changes from the Health Reform Law that will be transitioned during the next several years.

Physician Alignment

Our ability to attract skilled physicians to our hospitals is critical to our success. Coordination of care and alignment of care strategies between hospitals and physicians will become more critical as reimbursement becomes more episode-based. During fiscal year 2010, we added 70 physicians to our physician network (net of physicians who left our network). We expect to continue to add physicians during fiscal 2011 but at a lesser rate than during fiscal 2010. Our fiscal 2011 recruitment goals primarily emphasize recruiting physicians specializing in family practice, internal medicine and inpatient hospital care (hospitalists) with a limited number of selected specialists. We have invested heavily in the infrastructure necessary to coordinate our physician alignment strategies and manage our physician operations. Our hospitalist employment strategy is a key element in coordination of patient-centered care. Because these initiatives require significant upfront investment and may take years to fully implement, our operating results could be negatively impacted during the short-term.

Cost pressures

In order to demonstrate a highly reliable environment of care, we must hire and retain nurses who share our ideals and beliefs and who have access to the training necessary to implement our clinical quality initiatives. While the national nursing shortage has abated somewhat during the past two years as a result of general economic weakness, the nursing workforce remains volatile. As a result, we expect continuing pressures on nursing salaries and benefits costs. These pressures include higher than normal base wage increases, demands for flexible working hours and other increased benefits and higher nurse to patient ratios necessary to improve quality of care. We have begun multiple initiatives to stabilize our nursing workforce including a nurse leadership professional practice model and employee engagement strategies. We have seen our nursing voluntary turnover decrease from approximately 12% during the year ended June 30, 2009 to 10% during the year ended June 30, 2010. During fiscal year 2010, we achieved the 72nd percentile for employee engagement within the Gallup Organization Employee Engagement Database. These results reflect progress towards both achieving stability in our nursing workforce and improving employee engagement since we began monitoring employee engagement during fiscal year 2008, our baseline year. Inflationary pressures and technological advancements continue to drive supplies costs higher. We have implemented multiple supply chain initiatives including consolidation of low-priced vendors, establishment of value analysis teams, stricter adherence to pharmacy formularies and coordination of care efforts with physicians to reduce physician preference items, but we are uncertain if we can sustain these reductions in future periods.

Implementation of our Clinical Quality Initiatives

The integral component of each of the challenge areas previously discussed is quality of care. We have implemented many of our expanded clinical quality initiatives and are in the process of implementing several others. These initiatives include monthly review of the 44 CMS quality indicators in place for federal fiscal year 2010, rapid response teams, mock Joint Commission surveys, hourly nursing rounds, our nurse leadership professional practice model, alignment of hospital management incentive compensation with quality performance indicators and the formation of Physician Advisory Councils at our hospitals to align the quality goals of our hospitals with those of the physicians who practice in our hospitals.

Sources of Revenues

Hospital revenues depend upon inpatient occupancy levels, the medical and ancillary services ordered by physicians and provided to patients, the volume of outpatient procedures and the charges or payment rates for such services. Reimbursement rates for inpatient services vary significantly depending on the type of payer, the type of service (e.g., acute care, intensive care or subacute) and the geographic location of the hospital. Inpatient occupancy levels fluctuate for various reasons, many of which are beyond our control.

We receive payment for patient services from:

- the federal government, primarily under the Medicare program;
- state Medicaid programs;
- health maintenance organizations, preferred provider organizations, managed Medicare providers, managed Medicaid providers and other private insurers, and
- individual patients

The following table sets forth the percentages of net patient revenues by payer for the years ended June 30, 2008, 2009 and 2010.

	Year ended June 30,		
	2008	2009	2010
Medicare	26.2%	25.3%	25.5%
Medicaid	7.6%	7.9%	7.4%
Managed Medicare	14.0%	14.1%	14.8%
Managed Medicaid	7.5%	8.8%	9.5%
Managed care	35.0%	34.7%	34.9%
Self pay	8.6%	8.3%	6.8%
Other	1.1%	0.9%	1.1%
Total	100.0%	100.0%	100.0%

See "Item 1 — Business — Sources of Revenues" included elsewhere in this report for a description of the types of payments we receive for services provided to patients enrolled in the traditional Medicare plan (both for inpatient and outpatient services), managed Medicare plans, Medicaid plans, managed Medicaid plans and managed care plans. In that section, we also discussed the unique reimbursement features of the traditional Medicare plan, including disproportionate share, outlier cases and direct graduate and indirect medical education including the annual Medicare regulatory updates published by CMS in August 2010 that impact reimbursement rates under the plan for services provided during the federal fiscal year beginning October 1, 2010. The future impact to reimbursement for certain of these payers under the Health Reform Law is also addressed.

Volumes by Payer

During the year ended June 30, 2010 compared to the year ended June 30, 2009, discharges increased 0.3% and total adjusted discharges increased 2.4%. The following table provides details of discharges by payer for the years ended June 30, 2008, 2009 and 2010.

	Year ended June 30,					
	2008		2009		2010	
Medicare	47,040	27.7%	45,516	27.1%	46,385	27.5%
Medicaid (a)	20,195	11.9%	17,068	10.2%	14,867	8.8%
Managed Medicare	26,040	15.3%	26,925	16.0%	27,393	16.3%
Managed Medicaid	19,893	11.7%	23,185	13.8%	25,717	15.3%
Managed care	50,040	29.5%	48,977	29.2%	45,152	26.8%
Self pay (a)	5,854	3.5%	5,650	3.4%	8,168	4.9%
Other	606	0.4%	559	0.3%	688	0.4%
Total	169,668	100.0%	167,880	100.0%	168,370	100.0%

(a) Medicaid and self pay discharges were impacted by the change in our Medicaid pending policy in our Illinois hospitals effective April 1, 2009 and in our other hospitals effective July 1, 2009. Absent the impact of the Medicaid pending policy changes, Medicaid discharges would have been 17,235 and 17,584 for the years ended June 30, 2009 and 2010, respectively, while self pay discharges would have been 5,483 and 5,451 for the years ended June 30, 2009 and 2010, respectively.

Payer Reimbursement Trends

In addition to the volume factors described above, patient mix, acuity factors and pricing trends affect our patient service revenues. Net patient revenue per adjusted discharge was $8,047, $8,503 and $8,408 for the years ended June 30, 2008, 2009 and 2010, respectively. The current year ratio was negatively impacted by the uninsured discount policy that we implemented in our Chicago hospitals on April 1, 2009 and in our Phoenix and San Antonio hospitals on July 1, 2009. Under this policy, we apply an uninsured discount (calculated as a standard percentage of gross charges) at the time of patient billing for those patients with no insurance coverage who do not qualify for charity care under our guidelines. We recorded $11.7 million and $215.7 million of uninsured discount revenue deductions during the years ended June 30, 2009 and 2010, respectively. Approximately $7.6 million of the $11.7 million of uninsured discounts for 2009 and $128.7 million of the $215.7 million of uninsured discounts for 2010 would have otherwise been included in net patient revenues and subjected to our allowance for doubtful accounts policy had we not implemented our uninsured discount policy at these hospitals.

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Accounts Receivable Collection Risks Leading to Increased Bad Debts

Similar to other companies in the hospital industry, we face continued pressures in collecting outstanding accounts receivable primarily due to volatility in the uninsured and underinsured populations in the markets we serve. The following table provides a summary of our accounts receivable payer class mix as of each respective period presented.

June 30, 2009	0-90 days	91-180 days	Over 180 days	Total
Medicare	15.6%	0.3%	0.3%	16.2%
Medicaid	6.7%	0.9%	1.0%	8.6%
Managed Medicare	10.0%	0.5%	0.3%	10.8%
Managed Medicaid	7.1%	0.5%	0.5%	8.1%
Managed care	25.1%	2.3%	1.5%	28.9%
Self pay(1)	9.7%	8.1%	0.8%	18.6%
Self pay after primary(2)	2.1%	2.9%	0.9%	5.9%
Other	1.8%	0.6%	0.5%	2.9%
Total	78.1%	16.1%	5.8%	100.0%

June 30, 2010	0-90 days	91-180 days	Over 180 days	Total
Medicare	17.7%	0.4%	0.3%	18.4%
Medicaid	5.6%	0.6%	0.9%	7.1%
Managed Medicare	11.3%	0.7%	0.6%	12.6%
Managed Medicaid	7.4%	0.4%	0.3%	8.1%
Managed care	27.1%	1.9%	1.1%	30.1%
Self pay(1)	10.2%	3.1%	0.7%	14.0%
Self pay after primary(2)	2.5%	3.3%	0.8%	6.6%
Other	2.1%	0.6%	0.4%	3.1%
Total	83.9%	11.0%	5.1%	100.0%

(1) Includes uninsured patient accounts only.

(2) Includes patient co-insurance and deductible amounts after payment has been received from the primary payer.

Our combined allowances for doubtful accounts, uninsured discounts and charity care covered 96.5% and 84.0% of combined self-pay and self-pay after primary accounts receivable as of June 30, 2009 and 2010, respectively. The period over period decrease is due to the implementation of our uninsured discount policy at our Phoenix and San Antonio hospitals effective July 1, 2009.

The volume of self-pay accounts receivable remains sensitive to a combination of factors including price increases, acuity of services, higher levels of patient deductibles and co-insurance under managed care plans, economic factors and the increased difficulties of uninsured patients who do not qualify for charity care programs to pay for escalating healthcare costs. We have implemented policies and procedures designed to expedite upfront cash collections and promote repayment plans from our patients. However, we believe bad debts will remain a significant risk for us and the rest of the hospital industry in the near term.

Governmental and Managed Care Payer Reimbursement

Healthcare spending comprises a significant portion of total spending in the United States and has been growing at annual rates that exceed inflation, wage growth and gross national product. There is considerable pressure on governmental payers, managed Medicare/Medicaid payers and commercial managed care payers to control costs by either reducing or limiting increases in reimbursement to healthcare providers or limiting benefits to enrollees. The current economic recession has magnified these pressures. Lower than expected tax collections due to higher unemployment and depressed consumer spending have resulted in budget shortfalls for most states, including those in which we operate. Additionally, the demand for Medicaid coverage has increased due to job losses that have left many individuals without health insurance. To balance their budgets, many states, either directly or through their managed Medicaid programs, may enact healthcare spending cuts or defer cash payments to healthcare providers, since raising taxes is not a popular option during recessionary cycles. Further, the tightened credit markets have complicated the states' efforts to issue additional bonds to raise cash. During the year ended June 30, 2010, Medicaid and managed Medicaid programs accounted for approximately 17% of our net patient revenues. Managed care payers also face economic pressures during periods of economic weakness due to lower enrollment resulting from higher unemployment rates and the inability of individuals to afford private insurance coverage. These payers may respond to these challenges by reducing or limiting increases to healthcare provider reimbursement rates or reducing benefits to enrollees. During the year ended June 30, 2010, we recognized approximately 35% of our net patient revenues from managed care payers. If we do not receive increased payer reimbursement rates from governmental or managed care payers that cover the increasing cost of providing healthcare services to our patients or if governmental payers defer payments to our hospitals, our financial position, results of operations and cash flows could be materially adversely impacted.

Premium Revenues

We recognize premium revenues from our three health plans, PHP, AAHP and MHP. Premium revenues from these three plans increased $161.7 million or 23.8% during the year ended June 30, 2010 compared to the year ended June 30, 2009. PHP's average membership increased to approximately 195,700 for fiscal 2010 compared to approximately 150,500 for fiscal 2011. PHP's increase in revenues and membership during fiscal year 2010 resulted from the increase in individuals eligible for AHCCCS coverage and the fact that the current fiscal year period includes a full year under the new AHCCCS contract (see discussion below) compared to only nine months during the previous fiscal year.

In May 2008, PHP was awarded a new contract with AHCCCS effective for the three-year period beginning October 1, 2008 and ending September 30, 2011. AHCCCS has the option to renew the new contract, in whole or in part, for two additional one-year periods commencing on October 1, 2011 and on October 1, 2012. The new contract covers the three counties covered under the previous contract (Gila, Maricopa and Pinal) plus an additional six Arizona counties (Apache, Coconino, Mohave, Navajo, Pima and Yavapai). The new contract utilizes a national episodic/diagnostic risk adjustment factor for non-reconciled enrollee risk groups, which AHCCCS applied retroactively to October 1, 2008, that was not part of PHP's previous AHCCCS contract. In response to the State of Arizona's budget crisis and continued concerns about economic indicators during its 2010 fiscal year, AHCCCS made certain changes to its current contract with PHP that negatively impact PHP's current and future revenues. AHCCCS could take further actions in the near term that could materially adversely impact our operating results and cash flows including reimbursement rate cuts, enrollment reductions, capitation payment deferrals, covered services reductions or limitations or other steps to reduce program expenditures including cancelling PHP's contract.

Critical Accounting Policies

Our consolidated financial statements have been prepared in accordance with accounting principles generally accepted in the United States. In preparing these financial statements, we make estimates and assumptions that affect the reported amounts of assets, liabilities, revenues and expenses included in the financial statements. Management bases its estimates on historical experience and other available information, the results of which form the basis of the estimates and assumptions. We consider the following accounting policies to be critical because they involve highly subjective and complex assumptions and assessments, are subject to a great degree of fluctuation period over period and are the most critical to our operating performance.

Revenues and Revenue Deductions

We recognize patient service revenues during the period the healthcare services are provided based upon estimated amounts due from payers. We record contractual adjustments to our gross charges to reflect expected reimbursement negotiated with or prescribed by third party payers. We estimate contractual adjustments and allowances based upon payment terms set forth in managed care health plan contracts and by federal and state regulations. For the majority of our patient service revenues, we apply contractual adjustments to patient accounts at the time of billing using specific payer contract terms entered into the accounts receivable systems, but in some cases we record an estimated allowance until payment is received. If our estimated contractual adjustments as a percentage of gross revenues were 1% higher for all insured accounts, our net revenues would have been reduced by approximately $79.0 million and $81.0 million for the years ended June 30, 2009 and 2010, respectively. We derive most of our patient service revenues from healthcare services provided to patients with Medicare (including managed Medicare plans) or managed care insurance coverage.

Services provided to Medicare patients are generally reimbursed at prospectively determined rates per diagnosis, while services provided to managed care patients are generally reimbursed based upon predetermined rates per diagnosis, per diem rates or discounted fee-for-service rates. Medicaid reimbursements vary by state. Other than Medicare, no individual payer represents more than 10% of our patient service revenues.

Medicare regulations and many of our managed care contracts are often complex and may include multiple reimbursement mechanisms for different types of services provided in our healthcare facilities. To obtain reimbursement for certain services under the Medicare program, we must submit annual cost reports and record estimates of amounts owed to or receivable from Medicare. These cost reports include complex calculations and estimates related to indirect medical education, disproportionate share payments, reimbursable Medicare bad debts and other items that are often subject to interpretation that could result in payments that differ from recorded estimates. We estimate amounts owed to or receivable from the Medicare program using the best information available and our interpretation of the applicable Medicare regulations. We include differences between original estimates and subsequent revisions to those estimates (including final cost report settlements) in our consolidated statements of operations in the period in which the revisions are made. Net adjustments for final third party settlements increased patient service revenues and income from continuing operations before income taxes by $7.9 million, $8.0 million and $6.6 million during the years ended June 30, 2008, 2009 and 2010, respectively. Additionally, updated regulations and contract negotiations with payers occur frequently, which necessitates continual review of revenue estimation processes by management. We believe that future adjustments to our current third party settlement estimates will not materially impact our results of operations, cash flows or financial position.

Effective for service dates on or after April 1, 2009, as a result of a state mandate, we implemented a new uninsured discount policy for those patients receiving services in our Illinois hospitals who had no insurance coverage and who did not otherwise qualify for charity care under our guidelines. Under this policy, we apply an uninsured discount (calculated as a standard percentage of gross charges) at the time of patient billing and include this discount as a reduction to patient service revenues. We implemented this same policy for our Phoenix and San Antonio hospitals effective for service dates on or after July 1, 2009. These discounts were approximately $11.7 million and $215.7 million for the years ended June 30, 2009 and 2010, respectively.

We do not pursue collection of amounts due from uninsured patients that qualify for charity care under our guidelines (currently those uninsured patients whose incomes are equal to or less than 200% of the current federal poverty guidelines set forth by the Department of Health and Human Services). We deduct charity care accounts from revenues when we determine that the account meets our charity care guidelines. We also provide discounts from billed charges and alternative payment structures for uninsured patients who do not qualify for charity care but meet certain other minimum income guidelines, primarily those uninsured patients with incomes between 200% and 500% of the federal poverty guidelines. During the past three fiscal years, a significant percentage of our charity care deductions represented services provided to undocumented aliens under the Section 1011 border funding reimbursement program. Border funding qualification ended in Texas during fiscal year 2009, ended in Illinois during fiscal year 2010, and we expect that qualification will end sometime during our fiscal 2011 in Arizona when funds appropriated to those states have been exhausted.

The following table provides a breakdown of our charity care deductions during the years ending June 30, 2008, 2009 and 2010, respectively (in millions).

	Year ended June 30,		
	2008	2009	2010
Total charity care deductions	$ 86.1	$ 91.8	$ 87.7
Border funding charity care deductions, net of payments received	$ 29.6	$ 34.9	$ 29.8
Payments received for border funding accounts	$ 3.8	$ 4.6	$ 3.5

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We record revenues related to the Illinois Provider Tax Assessment ("PTA") program when the receipt of payment from the state entity is assured. For the Texas Upper Payment Limit ("UPL") program we recognize revenues that offset the expenses associated with the provision of charity care when the services are provided. We recognize federal match revenues under the Texas UPL program when payments are assured.

We earned premium revenues of $450.2 million, $678.0 million and $839.7 million during the years ended June 30, 2008, 2009, 2010, respectively, from our health plans. Our health plans, PHP, AAHP and MHP, have agreements with AHCCCS, CMS and various health maintenance organizations ("HMOs"), respectively, to contract to provide medical services to subscribing participants. Under these agreements, our health plans receive monthly payments based on the number of HMO participants in MHP or the number and coverage type of members in PHP and AAHP. Our health plans recognize the payments as revenues in the month in which members are entitled to healthcare services with the exception of AAHP Medicare Part D reinsurance premiums and low income subsidy cost sharing premiums that are recorded as a liability to fund future healthcare costs or else repaid to CMS.

Allowance for Doubtful Accounts and Provision for Doubtful Accounts

Our ability to collect the self-pay portions of our receivables is critical to our operating performance and cash flows. Our allowance for doubtful accounts was approximately 30.6% and 21.8% of accounts receivable, net of contractual discounts, as of June 30, 2009 and 2010, respectively. The primary collection risk relates to uninsured patient accounts and patient accounts for which primary insurance has paid but patient deductibles or co-insurance portions remain outstanding.

We estimate our allowance for doubtful accounts using a standard policy that reserves all accounts aged greater than 365 days subsequent to discharge date plus percentages of uninsured accounts and self-pay after primary accounts less than 365 days old. We test our allowance for doubtful accounts policy quarterly using a hindsight calculation that utilizes write-off data for all payer classes during the previous twelve-month period to estimate the allowance for doubtful accounts at a point in time. We also supplement our analysis by comparing cash collections to net patient revenues and monitoring self-pay utilization. We adjust the standard percentages in our allowance for doubtful accounts reserve policy as necessary given changes in trends from these analyses. We most recently adjusted this reserve policy when we implemented our uninsured discount policy in Phoenix, San Antonio and Illinois. If our uninsured accounts receivable as of June 30, 2009 and 2010 were 1% higher, our provision for doubtful accounts would have increased by $1.0 million and $0.7 million, respectively. Significant changes in payer mix, business office operations, general economic conditions and healthcare coverage provided by federal or state governments or private insurers may have a significant impact on our estimates and significantly affect our liquidity, results of operations and cash flows.

Prior to the implementation of our new uninsured discount policy, we classified accounts pending Medicaid approval as Medicaid accounts in our accounts receivable aging report and recorded a contractual allowance for these accounts equal to the average Medicaid reimbursement rate for that specific state until qualification was confirmed at which time the account was netted in the aging. In the event an account did not successfully qualify for Medicaid coverage and did not meet our charity guidelines, the previously recorded Medicaid contractual adjustment remained a revenue deduction (similar to a self-pay discount), and the remaining net account balance was reclassified to uninsured status and subjected to our allowance for doubtful accounts policy. If accounts did not qualify for Medicaid coverage but did qualify as charity care, the contractual adjustments were reversed and the gross account balances was recorded as charity deductions.

Upon the implementation of our new uninsured discount policy, all uninsured accounts (including those pending Medicaid qualification) that do not qualify for charity care receive the standard uninsured discount. The balance of these accounts are subject to our allowance for doubtful accounts policy. For those accounts that subsequently qualify for Medicaid coverage, the uninsured discount is reversed and the account is reclassified to Medicaid accounts receivable with the appropriate contractual discount applied. Thus, the contractual allowance for Medicaid pending accounts is no longer necessary for those accounts subject to the uninsured discount policy. The following table provides the value of accounts pending Medicaid qualification, the balance successfully qualified for Medicaid coverage, the balance not qualified and transferred to uninsured status, the balance not qualified and transferred to charity and the percentage successfully qualified for Medicaid coverage during the respective fiscal years (dollars in millions).

	Year ended June 30,	
	2009	2010
Medicaid pending accounts receivable	$ 15.8	$ 23.5
Medicaid pending successfully qualified	$ 23.5	$ 44.3
Medicaid pending not qualified (uninsured)	$ 29.6	$ 63.5
Medicaid pending not qualified (charity)	$ 8.0	$ 17.1
Medicaid pending qualification success percentage	39%	36%

Because we require patient verification of coverage at the time of admission, reclassifications of Medicare or managed care accounts to self-pay, other than patient coinsurance or deductible amounts, occur infrequently and are not material to our financial statements. Additionally, the impact of these classification changes is further limited by our ability to identify any necessary classification changes prior to patient discharge or soon thereafter. Due to information system limitations, we are unable to quantify patient deductible and co-insurance receivables that are included in the primary payer classification in the accounts receivable aging report at any given point in time. When classification changes occur, the account balance remains aged from the patient discharge date.

Insurance Reserves

We have a self-insured medical plan for all of our employees. Claims are accrued under the self-insured plan as the incidents that gave rise to them occur. Unpaid claims accruals are based on the estimated ultimate cost of settlement, including claim settlement expenses, in accordance with an average lag time and historical experience.

Due to the nature of our operating environment, we are subject to professional and general liability and workers compensation claims and related lawsuits in the ordinary course of business. We maintain professional and general liability insurance with unrelated commercial insurance carriers to provide for losses up to $65.0 million in excess of our self-insured retention (such self-insured retention maintained through our captive insurance subsidiary and/or other of our subsidiaries) of $10.0 million through June 30, 2010 but increased to $15.0 million for the Illinois hospitals subsequent to June 30, 2010.

Through the period ended June 30, 2010, we insured our excess professional and general liability coverage under a retrospectively rated policy, and premiums under this policy were recorded at the minimum premium. We self-insure our workers compensation claims up to $1.0 million per claim and purchase excess insurance coverage for claims exceeding $1.0 million.

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The following tables summarize our employee health, professional and general liability and workers compensation reserve balances (including the current portions of such reserves) as of June 30, 2009 and 2010 and claims loss and claims payment information during the years ended June 30, 2008, 2009 and 2010.

	Employee Health	Professional and General Liability	Workers Compensation
Reserve balance:			
June 30, 2007	$ 1.2	$ 64.6	$ 18.5
June 30, 2008	$ 1.5	$ 74.3	$ 18.8
June 30, 2009	$ 13.4	$ 92.9	$ 18.2
June 30, 2010	$ 14.1	$ 91.8	$ 15.7
Current year provision for claims losses:			
Year ended June 30, 2008	$ 7.3	$ 22.4	$ 7.6
Year ended June 30, 2009	$ 93.2	$ 22.2	$ 7.8
Year ended June 30, 2010	$ 115.8	$ 26.4	$ 7.4
Adjustments to prior year claims losses:			
Year ended June 30, 2008	$ —	$ (0.6)	$ (2.3)
Year ended June 30, 2009	$ (0.6)	$ 13.4	$ (3.8)
Year ended June 30, 2010	$ (1.5)	$ 8.4	$ (5.1)
Claims paid related to current year:			
Year ended June 30, 2008	$ 5.8	$ 0.1	$ 1.0
Year ended June 30, 2009	$ 79.8	$ 0.3	$ 1.6
Year ended June 30, 2010	$ 101.7	$ 1.1	$ 1.1
Claims paid related to prior year:			
Year ended June 30, 2008	$ 1.2	$ 12.0	$ 4.0
Year ended June 30, 2009	$ 0.9	$ 16.7	$ 3.0
Year ended June 30, 2010	$ 11.9	$ 34.8	$ 3.7

In developing our estimates of our reserves for employee health, professional and general liability and workers compensation claims, we utilize actuarial and certain case-specific information. Each reserve is comprised of estimated indemnity and expense payments related to: (1) reported events ("case reserves") and (2) incurred but not reported ("IBNR") events as of the end of the period. Management uses information from its human resource and risk managers and its best judgment to estimate case reserves. Actuarial IBNR estimates are dependent on multiple variables including our risk exposures, our self-insurance limits, geographic locations in which we operate, the severity of our historical losses compared to industry averages and the reporting pattern of our historical losses compared to industry averages, among others. Most of these variables require judgment, and changes in these variables could result in significant period over period fluctuations in our estimates. We discount our workers compensation reserve using actuarial estimates of projected cash payments in future periods (approximately 5.0% for each of the past three fiscal years). We do not discount our professional and general liability reserve. We adjust these reserves from time to time as we receive updated information.

In April 2009, a jury awarded damages to the plaintiff in a professional liability case against one of our hospitals in the amount of approximately $14.9 million, which exceeded our captive subsidiary's $10.0 million self insured limit. Based upon this verdict, we increased our professional and general liability reserve by the excess of the verdict amount over our previously established case reserve estimate and recorded a reinsurance receivable for that portion exceeding $10.0 million. We settled this claim and paid the settlement amount in March 2010. We received cash payment for the reinsurance receivable in June 2010.

Our best estimate of professional and general liability and workers compensation IBNR utilizes statistical confidence levels that are below 75%. Using a higher statistical confidence level, while not permitted under United States generally accepted accounting principles, would increase the estimated reserve. The following table illustrates the sensitivity of the reserve estimates at 75% and 90% confidence levels (in millions).

	Professional and General Liability	Workers Compensation
Reserve at June 30, 2009		
As reported	$ 92.9	$ 18.2
With 75% confidence level	$ 104.9	$ 21.2
With 90% confidence level	$ 116.9	$ 23.8
Reserve at June 30, 2010		
As reported	$ 91.8	$ 15.7
With 75% confidence level	$ 105.7	$ 19.4
With 90% confidence level	$ 119.7	$ 22.8

Our best estimate of employee health claims IBNR relies primarily upon payment lag data. If our estimate of the number of unpaid days of employee health claims expense changed by 5 days, our employee health IBNR estimate would change by approximately $1.6 million.

Health Plan Claims Reserves

During the years ended June 30, 2008, 2009 and 2010, health plan claims expense was $328.2 million, $525.6 million and $665.8 million, respectively, primarily representing medical claims of PHP. Vanguard estimates PHP's reserve for medical claims using historical claims experience (including cost per member and payment lag time) and other actuarial data including number of members and certain member demographic information. The following table provides the health plan reserve balances as of June 30, 2009 and 2010 and health plan claims and payment information during the years ended June 30, 2008, 2009 and 2010, respectively (in millions).

	Year ended June 30,		
	2008	2009	2010
Health plan reserves and settlements, beginning of year	$ 61.4	$ 51.1	$ 117.6
Current year provision for health plan claims	329.7	525.5	670.7
Current year adjustments to prior year health plan claims	(1.5)	0.1	(4.9)
Program settlement, capitation and other activity	(24.2)	19.3	31.0
Claims paid related to current year	(268.4)	(424.6)	(571.7)
Claims paid related to prior years	(45.9)	(53.8)	(92.9)
Health plan reserves and settlements, end of year	$ 51.1	$ 117.6	$ 149.8

The increases in reserves, claims losses and claims payments from 2008 to 2009 and from 2009 to 2010 were primarily due to the significant increase in PHP members during the periods as a result of the new AHCCCS contract that went into effect on October 1, 2008, the increased number of individuals eligible for participation in the AHCCCS program during each year and an additional PHP risk group subject to a settlement reconciliation during 2010. While management believes that its estimation methodology effectively captures trends in medical claims costs, actual payments could differ significantly from its estimates given changes in the healthcare cost structure or adverse experience. During the years ended June 30, 2008, 2009 and 2010, approximately $31.2 million, $34.0 million and $42.8 million, respectively, of accrued and paid claims for services provided to our health plan members by our hospitals and our other healthcare facilities were eliminated in consolidation. Our operating results and cash flows could be materially affected by increased or decreased utilization of our healthcare facilities by members in our health plans.

Income Taxes

We believe that our income tax provisions are accurate and supportable, but certain tax matters require interpretations of tax law that may be subject to future challenge and may not be upheld under tax audit. To reflect the possibility that all of our tax positions may not be sustained, we maintain tax reserves that are subject to adjustment as updated information becomes available or as circumstances change. We record the impact of tax reserve changes to our income tax provision in the period in which the additional information, including the progress of tax audits, is obtained.

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We assess the realization of our deferred tax assets to determine whether an income tax valuation allowance is required. Based on all available evidence, both positive and negative, and the weight of that evidence to the extent such evidence can be objectively verified, we determine whether it is more likely than not that all or a portion of the deferred tax assets will be realized. The factors used in this determination include the following:

- Cumulative losses in recent years
- Income/losses expected in future years
- Availability, or lack thereof, of taxable income in prior carryback periods that would limit realization of tax benefits
- Carryforward period associated with the deferred tax assets and liabilities
- Prudent and feasible tax planning strategies

In addition, financial forecasts used in determining the need for or amount of federal and state valuation allowances are subject to changes in underlying assumptions and fluctuations in market conditions that could significantly alter our recoverability analysis and thus have a material adverse effect on our consolidated financial condition, results of operations or cash flows. Effective July 1, 2007, we adopted the relevant guidance for accounting for uncertainty in income taxes. The following table provides a detailed rollforward of our net liability for uncertain tax positions for the years ended June 30, 2008, 2009 and 2010 (in millions).

Balance at June 30, 2007	$	4.9
Additions based on tax positions reltaed to the current year		—
Additions for tax positions of prior years		0.4
Reductions for tax positions of prior years		—
Settlements		—
Balance at June 30, 2008	$	5.3
Additions based on tax positions reltaed to the current year		—
Additions for tax positions of prior years		—
Reductions for tax positions of prior years		(0.3)
Settlements		—
Balance at June 30, 2009	$	5.0
Additions based on tax positions reltaed to the current year		0.8
Additions for tax positions of prior years		6.1
Reductions for tax positions of prior years		—
Settlements		—
Balance at June 30, 2010	$	11.9

The provisions set forth in accounting for uncertain tax positions allow for the classification election of interest on an underpayment of income taxes, when the tax law requires interest to be paid, and penalties, when a tax position does not meet the minimum statutory threshold to avoid payment of penalties, in income taxes, interest expense or another appropriate expense classification based on the accounting policy election of the entity. We elected to continue our historical practice of classifying interest and penalties as a component of income tax expense. Of the $11.9 million total unrecognized tax benefits, $0.6 million of the balance as of June 30, 2010 would impact the effective tax rate if recognized.

Long-Lived Assets and Goodwill

Long-lived assets, including property, plant and equipment and amortizable intangible assets, comprise a significant portion of our total assets. We evaluate the carrying value of long-lived assets when impairment indicators are present or when circumstances indicate that impairment may exist. When management believes impairment indicators may exist, projections of the undiscounted future cash flows associated with the use of and eventual disposition of long-lived assets held for use are prepared. If the projections indicate that the carrying values of the long-lived assets are not recoverable, we reduce the carrying values to fair value. In May 2009, we recorded a $6.2 million ($3.8 million net of taxes) impairment charge to write-down the value of a building that we currently lease to other healthcare service providers to fair value. For long-lived assets held for sale, we compare the carrying values to an estimate of fair value less selling costs to determine potential impairment. We test for impairment of long-lived assets at the lowest level for which cash flows are measurable. These impairment tests are heavily influenced by assumptions and estimates that are subject to change as additional information becomes available. Given the relatively few number of hospitals we own and the significant amounts of long-lived assets attributable to those hospitals, an impairment of the long-lived assets for even a single hospital could materially adversely impact our operating results or financial position.

Goodwill also represents a significant portion of our total assets. We review goodwill for impairment annually during our fourth fiscal quarter or more frequently if certain impairment indicators arise. We review goodwill at the reporting level unit, which is one level below an operating segment. We compare the carrying value of the net assets of each reporting unit to the net present value of estimated discounted future cash flows of the reporting unit. If the carrying value exceeds the net present value of estimated discounted future cash flows, an impairment indicator exists and an estimate of the impairment loss is calculated. The fair value calculation includes multiple assumptions and estimates, including the projected cash flows and discount rates applied. Changes in these assumptions and estimates could result in goodwill impairment that could materially adversely impact our financial position or results of operations.

During the past three years, our two Illinois hospitals have experienced deteriorating economic factors that have negatively impacted their results of operations and cash flows. While various initiatives mitigated the impact of these economic factors during fiscal years 2008 and 2009, the operating results of the Illinois hospitals did not improve to the level anticipated during the first half of fiscal 2010. After having the opportunity to evaluate the operating results of the Illinois hospitals for the first six months of fiscal year 2010 and to reassess the market trends and economic factors, we concluded that it was unlikely that previously projected cash flows for these hospitals would be achieved. We performed an interim goodwill impairment test during the quarter ended December 31, 2009 and, based upon revised projected cash flows, market participant data and appraisal information, we determined that the $43.1 million remaining goodwill related to this reporting unit was impaired. The $43.1 million ($31.8 million, net of taxes) non-cash impairment loss is included in our consolidated statement of operations for the year ended June 30, 2010.

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Selected Operating Statistics

The following table sets forth certain operating statistics for each of the periods presented.

	Year ended June 30,		
	2008	2009	2010
Unaudited Operating Data - continuing operations:			
Number of hospitals, end of period	15	15	15
Number of licensed beds, end of period	4,181	4,135	4,135
Discharges (a)	169,668	167,880	168,370
Adjusted discharges-hospitals (b)	270,076	274,767	280,437
Adjusted discharges (c)	283,250	288,807	295,702
Net revenue per adjusted discharge-hospitals (d)	$ 8,110	$ 8,623	$ 8,516
Net revenue per adjusted discharge (e)	$ 8,047	$ 8,503	$ 8,408
Patient days (f)	734,838	709,952	701,265
Average length of stay (g)	4.33	4.23	4.17
Inpatient surgeries (h)	37,538	37,970	37,320
Outpatient surgeries (i)	73,339	76,378	75,969
Emergency room visits (j)	588,246	605,729	626,237
Occupancy rate (k)	48%	47%	46%
Member lives (l)	149,600	218,700	241,200
Health plan claims expense percentage (m)	72.9%	77.5%	79.3%

(a) Discharges represent the total number of patients discharged (in the facility for a period in excess of 23 hours) from our hospitals and is used by management and certain investors as a general measure of inpatient volumes.

(b) Adjusted discharges-hospitals is used by management and certain investors as a general measure of combined hospital inpatient and hospital outpatient volumes. Adjusted discharges-hospitals is computed by multiplying discharges by the sum of gross hospital inpatient revenues and gross hospital outpatient revenues and then dividing the result by gross hospital inpatient revenues.

(c) Adjusted discharges is used by management and certain investors as a general measure of consolidated inpatient and outpatient volumes. Adjusted discharges is computed by multiplying discharges by the sum of gross inpatient revenues and gross outpatient revenues and then dividing the result by gross inpatient revenues.

(d) Net revenue per adjusted discharge-hospitals is calculated by dividing net hospital patient revenues by adjusted discharge-hospitals and measures the average net payment expected to be received for a patient's stay in the hospital.

(e) Net revenue per adjusted discharge is calculated by dividing net patient revenues by adjusted discharges and measures the average net payment expected to be received for an episode of service provided to a patient.

(f) Patient days represent the number of days (calculated as overnight stays) our beds were occupied by patients during the periods.

(g) Average length of stay represents the average number of days an admitted patient stays in our hospitals.

(h) Inpatient surgeries represent the number of surgeries performed in our hospitals where overnight stays are necessary.

(i) Outpatient surgeries represent the number of surgeries performed at hospitals or ambulatory surgery centers on an outpatient basis (patient overnight stay not necessary).

(j) Emergency room visits represent the number of patient visits to a hospital emergency room where treatment is received, regardless of whether an overnight stay is subsequently required.

(k) Occupancy rate represents the percentage of hospital licensed beds occupied by patients. Occupancy rate provides a measure of the utilization of inpatient beds.

(l) Member lives represent the total number of members in PHP, AAHP and MHP as of the end of the respective period.

(m) Health plan claims expense percentage is calculated by dividing health plan claims expense by premium revenues.

Results of Operations

The following table presents summaries of our operating results for the years ended June 30, 2008, 2009 and 2010.

	Year ended June 30,					
	2008		2009		2010	
	(Dollars in millions)					
Patient service revenues	$ 2,325.4	83.8%	$ 2,507.4	78.7%	$ 2,537.2	75.1%
Premium revenues	450.2	16.2%	678.0	21.3%	839.7	24.9%
Total revenues	2,775.6	100.0%	3,185.4	100.0%	3,376.9	100.0%
Costs and expenses:						
Salaries and benefits (includes stock of $2.5, $4.4 and 4.2, respectively)	1,146.2	41.3%	1,233.8	38.7%	1,296.2	38.4%
Health plan claims expense	328.2	11.8%	525.6	16.5%	665.8	19.7%
Supplies	433.7	15.6%	455.5	14.3%	456.1	13.5%
Provision for doubtful accounts	205.5	7.4%	210.3	6.6%	152.5	4.5%
Other operating expenses	398.5	14.4%	461.9	14.5%	483.9	14.3%
Depreciation and amortization	129.3	4.7%	128.9	4.1%	139.6	4.1%
Interest, net	122.1	4.4%	111.6	3.5%	115.5	3.4%
Debt extinguishment costs	—	0.0%	—	0.0%	73.5	2.2%
Impairment loss	—	0.0%	6.2	0.2%	43.1	1.3%
Other	6.5	0.2%	2.7	0.1%	9.1	0.3%
Income (loss) from continuing operations before income taxes	5.6	0.2%	48.9	1.5%	(58.4)	(1.7)%
Income tax benefit (expense)	(2.2)	(0.1)%	(16.8)	(0.5)%	13.8	0.4%
Income (loss) from continuing operations	3.4	0.1%	32.1	1.0%	(44.6)	(1.2)%
Loss from discontinued operations net of taxes	(1.1)	(0.0)%	(0.3)	(0.0)%	(1.7)	(0.1)%
Net income (loss)	2.3	0.1%	31.8	1.0%	(46.3)	(1.4)%
Less: Net income attributable to non-controlling interests	(3.0)	(0.1)%	(3.2)	(0.1)%	(2.9)	(0.1)%
Net income (loss) attributable to Vanguard Health Systems, Inc stockholders	$ (0.7)	0.1%	$ 28.6	1.0%	$ (49.2)	(1.4)%

Year ended June 30, 2010 compared to Year ended June 30, 2009

Revenues. Total revenues increased 6.0% during the year ended June 30, 2010 compared to the prior year. Patient service revenues increased $29.8 million or 1.2% during the current year. This small increase relative to the prior year was primarily due to the implementation of our uninsured discount policy in our Illinois hospitals effective April 1, 2009 and in our Phoenix and San Antonio hospitals effective July 1, 2009 combined with the concurrent change to our Medicaid pending policy previously discussed. During the current year, we recognized $215.7 million of uninsured discount revenue deductions, $128.7 million of which would have otherwise been included in revenues and subjected to our allowance for doubtful accounts policy had the uninsured discount policy not been implemented at these hospitals. Health plan premium revenues increased $161.7 million during the current year as a result of increased PHP enrollment. Average enrollment at PHP was 195,671 during the year ended June 30, 2010, an increase of 30.0% compared to the prior year. More challenging economic conditions in Arizona since the prior year resulted in more individuals becoming eligible for AHCCCS coverage. Enrollment in our other two health plans decreased by 6.4% as of June 30, 2010 compared to June 30, 2009.

Discharges, adjusted discharges and emergency room visits increased 0.3%, 2.4% and 3.4%, respectively, during the year ended June 30, 2010 compared to the prior year, while total surgeries decreased by 0.9% during the current year. General economic weakness in the United States economy continues to impact demand for elective surgical procedures. Two new competitor hospitals in San Antonio opened in March 2009 and July 2009, which negatively impacted volumes in certain of our San Antonio hospitals during the current year. We continue to face volume and pricing pressures as a result of continuing economic weakness in the communities our hospitals serve, state efforts to reduce Medicaid program expenditures and intense competition for limited physician and nursing resources, among other factors. We expect the average population growth in the markets we serve to remain generally high in the long-term. As these populations increase and grow older, we believe that our clinical quality initiatives will improve our competitive position in those markets. However, these growth opportunities may not overcome the current industry and market challenges in the short-term.

We continue to implement multiple initiatives to transform our company's operations to prepare for the future changes we expect to occur in the healthcare industry. This transformation process is built upon providing ideal experiences for our patients and their families through clinical excellence, aligning nursing and physician interests to provide coordination of care and improving healthcare delivery efficiencies to provide quality outcomes without overutilization of resources. The success of these initiatives will determine our ability to increase revenues from our existing operations and to increase revenues through acquisitions of other hospitals.

Costs and expenses. Total costs and expenses from continuing operations, exclusive of income taxes, were $3,435.3 million or 101.7% of total revenues during the current year, compared to 98.5% during the prior year. The current year measure was negatively impacted by the goodwill impairment loss related to our Illinois hospitals recognized in December 2009 and by debt extinguishment costs incurred to complete our Refinancing finalized in January 2010 as further discussed in "Liquidity and Capital Resources" and presented elsewhere in this report. Many year over year comparisons of individual cost and expense items as a percentage of total revenues, particularly for health plan claims expense and the provision for doubtful accounts, were impacted by the significant growth in health plan premium revenues and the uninsured discount and Medicaid pending policy changes previously discussed. Salaries and benefits, health plan claims, supplies and provision for doubtful accounts represent the most significant of our normal costs and expenses and those typically subject to the greatest level of fluctuation year over year.

- **Salaries and benefits.** Salaries and benefits as a percentage of total revenues was not significantly different during the current year compared to the prior year. This ratio continued to be positively impacted by the significant increase in premium revenues, which utilize a much lower percentage of salaries and benefits than acute care services, during the current year compared to the prior year. For the acute care services operating segment, salaries and benefits as a percentage of patient service revenues was 48.9% during the current year compared to 47.3% during the prior year. This increase was negatively impacted by the adoption of our uninsured discount and Medicaid pending policies, as previously discussed. We continue to employ more physicians to support the communities our hospitals serve and have made significant investments in clinical quality initiatives that will require additional human resources in the short-term. As of June 30, 2010, we had approximately 20,100 full-time and part-time employees compared to approximately 19,200 as of June 30, 2009. We have been successful in limiting contract labor utilization as a result of our investments in clinical quality and nurse leadership initiatives. Our contract labor expense as a percentage of patient service revenues continued its downward trend to 1.2% for the year ended June 30, 2010 compared to 2.6% for the prior year.

- **Health plan claims**. Health plan claims expense as a percentage of premium revenues increased to 79.3% during the current year compared to 77.5% during the prior year. As enrollment increases, this ratio becomes especially sensitive to the mix of members, including covered groups based upon age and gender and county of residence. AHCCCS also implemented limits on profitability for certain member groups during the current contract year, which negatively impacted this ratio. In addition, the increased PHP revenues diluted the impact of the third party administrator revenues at MHP that have no corresponding health plan claims expense. Revenues and expenses between the health plans and our hospitals and related outpatient service providers of approximately $42.8 million, or 6.0% of gross health plan claims expense, were eliminated in consolidation during the current year.

- **Supplies**. Supplies as a percentage of acute care services segment revenues decreased to 17.7% during the current year compared to 17.9% during the prior year. This ratio would have reflected a greater improvement during the current year absent the impact to patient service revenues of the changes to our uninsured discount and Medicaid pending policies previously discussed. We continued our focus on supply chain efficiencies including reduction in physician commodity variation and improved pharmacy formulary management during the current year. Our ability to reduce this ratio in future years may be limited because our growth strategies include expansion of higher acuity services and due to inflationary pressures on medical supplies and pharmaceuticals.

- **Provision for doubtful accounts**. The provision for doubtful accounts as a percentage of patient service revenues decreased to 6.0% during the current year from 8.4% during the prior year. Most of this decrease related to the uninsured discount policy and Medicaid pending policy changes previously discussed. The net impact of these policy changes resulted in the recognition of a significant amount of uninsured revenue deductions that would have otherwise been reflected in the provision for doubtful accounts absent these changes. On a combined basis, the provision for doubtful accounts, charity care deductions and uninsured discounts as a percentage of acute care services segment revenues (prior to these revenue deductions) was 11.5%, 11.9% and 15.8% for the for the years ended June 30, 2008, 2009 and 2010, respectively. The uninsured discount and Medicaid pending policy changes resulted in an approximate 330 basis point increase in this ratio during the current year. The remainder of the increase related to price increases implemented during the current year.

Other operating expenses. Other operating expenses include, among others, purchased services, insurance, non-income taxes, rents and leases, repairs and maintenance and utilities. Other operating expenses as a percentage of total revenues decreased to 14.3% during the current year compared to 14.5% during the prior year. The improvement would have been greater absent the adoption of our uninsured discount and Medicaid pending policies, as previously discussed. In addition, the decrease was also the result of $11.9 million of additional insurance expense recognized during the prior year related to a significant professional liability verdict against one of our hospitals. We initially appealed this verdict, but during the current year we settled this case and paid the settlement amount.

Other. Depreciation and amortization increased by $10.7 million year over year as a result of our capital improvement and expansion initiatives. Net interest increased slightly year over year. We recorded a goodwill impairment loss of $43.1 million ($31.8 million, net of taxes) related to our Illinois hospitals during the current year based upon an interim impairment test completed in December 2009. In connection with the Refinancing, we recorded debt extinguishment costs of $73.5 million ($45.6 million, net of taxes) during the current year.

Income taxes. Our effective tax rate was approximately 23.6% during the year ended June 30, 2010 compared to 34.4% during the prior year. The effective rate was lower during the current year due to the fact that a considerable portion of the goodwill impairment loss related to our Illinois hospitals reporting unit, as previously discussed, was non-deductible for tax purposes.

Net income (loss) attributable to Vanguard Health Systems, Inc. stockholders. Net loss attributable to Vanguard stockholders was $49.2 million during the year ended June 30, 2010 compared to net income attributable to Vanguard Health Systems, Inc. stockholders of $28.6 million during the prior year. This change resulted primarily from the goodwill impairment loss and the debt extinguishment costs recognized during the current year.

Year ended June 30, 2009 compared to Year ended June 30, 2008

Revenues. Total revenues increased $409.8 million or 14.8% during the year ended June 30, 2009 compared to the prior year primarily due to a significant increase in health plan premium revenues as a result of increased PHP enrollment. Average enrollment at PHP was 150,468 during the year ended June 30, 2009, an increase of 48.3% compared to the prior year. The new AHCCCS contract that went into effect on October 1, 2008 included six new counties that PHP had not previously served. The new contract was in effect for nine months of the year ended June 30, 2009.

Patient service revenues increased 7.8% year over year primarily as a result of a 5.7% increase in patient revenues per adjusted discharge and a 1.9% increase in adjusted discharges. Total outpatient volumes increased year over year, including a 3.0% and 4.1% increase in emergency room visits and outpatient surgeries, respectively. Our volumes by payer remained relatively consistent during both years. However, our combined Medicaid and managed Medicaid net revenues as a percentage of total net revenues increased to 16.7% during 2009 compared to 15.1% during the prior year, primarily as a result of the increase in Texas UPL and Illinois PTA revenues. The acuity level of our patients also increased year over year. However, during the year ended June 30, 2009, we continued to generate most of our admissions from emergency room visits and experienced lower elective admissions.

Costs and Expenses. Total costs and expenses from continuing operations, exclusive of income taxes, were $3,136.5 million or 98.5% of total revenues during the year ended June 30, 2009, compared to 99.8% during the prior year. Salaries and benefits, supplies, health plan claims and provision for doubtful accounts represent the most significant of our normal costs and expenses and those typically subject to the greatest level of fluctuation year over year.

- **Salaries and benefits.** Salaries and benefits as a percentage of total revenues decreased to 38.7% during the year ended June 30, 2009 from 41.3% during the prior year. This ratio was positively impacted by the significant increase in premium revenues, which utilize a much lower rate of salaries and benefits than acute care services, during the year ended June 30, 2009 compared to the prior year and by the increase in Texas UPL and Illinois PTA revenues during the year ended June 30, 2009 compared to the prior year. Salaries and benefits as a percentage of acute care segment revenues were 47.3% during the year ended June 30, 2009 compared to 47.9% during the prior year, which improvement was primarily attributable to the Texas UPL and Illinois PTA revenues growth during the year ended June 30, 2009.

  These ratios were adversely impacted during the year ended June 30, 2009 by our investments in physician services and quality initiatives. We employed more physicians to support the communities our hospitals serve during 2009 and added significant corporate resources to manage and oversee the physician growth. Implementation of our quality initiatives also resulted in additional labor costs associated with training staff to utilize new clinical quality systems and additional hospital and corporate resources to monitor and manage quality indicators. As of June 30, 2009, we had approximately 19,200 full-time and part-time employees compared to 18,500 as of June 30, 2008. Our contract labor expense as a percentage of patient service revenues decreased to 2.6% for the year ended June 30, 2009 compared to 3.5% for the prior year.

- **Health plan claims.** Health plan claims expense as a percentage of premium revenues increased to 77.5% during 2009 compared to 72.9% during the prior year. The new PHP contract resulted in a significant change in the mix of our AHCCCS members with a significant increase in members in geographic areas not previously served by PHP. As a result of the bid process for these new areas, the rates paid to providers in those six new counties and capitated payment rates received from AHCCCS for those counties were not necessarily the same as those applicable to the three counties previously served by PHP. Also, the additional PHP revenues diluted the impact of the third party administrator revenues at MHP that have no corresponding health plan claims expense. During fiscal 2009, we accrued for the estimated amount payable to AHCCCS for the risk adjustment factor payment methodology that was retroactively applied to October 1, 2008, which also caused the health plan claims expense as a percentage of premium revenues to increase during the year ended June 30, 2009.

  Health plan claims expense represents the amounts paid by the health plans for healthcare services provided to their members, including an estimate of incurred but not yet reported claims that is determined based upon lag data and other actuarial assumptions. Revenues and expenses between the health plans and our hospitals and related outpatient service providers of approximately $34.0 million, or 6.1% of gross health plan claims expense, were eliminated in consolidation during the year ended June 30, 2009.

- **Supplies**. Supplies as a percentage of acute care services segment revenues decreased to 17.9% during the year ended June 30, 2009 compared to 18.4% during the prior year. The increase in Texas UPL and Illinois PTA revenues during 2009 accounted for approximately half of this improvement. Although the acuity of our services provided increased during 2009 compared to the prior year, we were successful in limiting the ratio of supplies to patient service revenues by further implementing certain supply chain initiatives such as increased use of our group purchasing contract and pharmacy formulary management.

- **Provision for doubtful accounts**. The provision for doubtful accounts as a percentage of patient service revenues decreased to 8.4% during the year ended June 30, 2009 from 8.8% during the prior year. On a combined basis, the provision for doubtful accounts, charity care deductions and uninsured discounts as a percentage of acute care services segment revenues (prior to these revenue deductions) was 11.9% for both the years ended June 30, 2008 and 2009.

Other operating expenses. Other operating expenses include, among others, purchased services, insurance, non-income taxes, rents and leases, repairs and maintenance and utilities. Other operating expenses as a percentage of total revenues increased to 14.5% during the year ended June 30, 2009 compared to 14.4% during the prior year. Other operating expenses as a percentage of patient service revenues increased to 18.4% during the year ended June 30, 2009 compared to 17.1% during the prior year. In April 2009, a jury awarded damages to the plaintiff in a professional liability case against one of our hospitals. Based upon this verdict, we recognized additional insurance expense of $11.9 million during the year ended June 30, 2009. Also, non-income taxes increased by $23.9 million during the year ended June 30, 2009 primarily as a result of $13.4 million of Illinois PTA program cash receipts that were subsequently paid to the state in the form of a provider tax and higher premiums taxes related to the significant enrollment growth at PHP.

Other. Depreciation and amortization was flat year over year. Net interest decreased by $10.5 million during the year ended June 30, 2009 primarily due to lower interest rates on the variable portion of our term debt. We incurred an impairment loss of $6.2 million ($3.8 million, net of taxes) during the year ended June 30, 2009 resulting from the write-down of a non-hospital building to fair value.

Income taxes. Our effective tax rate decreased to approximately 34.4% during the year ended June 30, 2009 compared to 39.3% during the prior year.

Net income (loss) attributable to Vanguard Health Systems, Inc. stockholders. Net income attributable to Vanguard Health Systems, Inc. stockholders was $28.6 million during the year ended June 30, 2009 compared to net loss attributable to Vanguard Health Systems, Inc. stockholders of $0.7 million during the prior year.

Liquidity and Capital Resources

Operating Activities

As of June 30, 2010 we had working capital of $105.0 million, including cash and cash equivalents of $257.6 million. Working capital at June 30, 2009 was $251.6 million. Cash provided by operating activities increased $2.1 million during the year ended June 30, 2010 compared to the prior year. Current year operating cash flows were negatively impacted by AHCCCS' deferral of the June 2010 capitation and supplemental payments to PHP of approximately $62.0 million until July 2010. Current year operating cash flows were positively impacted by the timing of payments of accounts payable during the current year compared to the prior year. Net days revenue in accounts receivable decreased 4 days to approximately 41 days at June 30, 2010 compared to approximately 45 days at June 30, 2009.

Investing Activities

Cash used in investing activities increased from $133.6 million during the year ended June 30, 2009 to $156.5 million during the year ended June 30, 2010, primarily as a result of a $23.9 million increase in capital expenditures from $132.0 million during the prior year to $155.9 million during the current year. A portion of this increase relates to expenditures made for our replacement hospital in San Antonio, as previously mentioned.

Financing Activities

Cash flows used in financing activities increased by $196.4 million during the year ended June 30, 2010 compared to the year ended June 30, 2009 primarily due to the $300.6 million share repurchase less the $100.3 million net debt proceeds from the refinancing transactions (debt borrowings less debt repayments and the payment of related fees and expenses) during the current year. As of June 30, 2010, we had outstanding $1,752.0 million in aggregate indebtedness. The "Refinancing" section below provides additional information related to our liquidity.

The Refinancing

In late January 2010, we completed a comprehensive refinancing plan (the "Refinancing"). As a result of the Refinancing, our liquidity requirements remain significant due to debt service requirements. Under the Refinancing, we entered into an $815.0 million senior secured term loan (the "2010 term loan facility") and a $260.0 million revolving credit facility (the "2010 revolving facility" and together with the 2010 term loan facility, the "2010 credit facilities"). The 2010 term loan facility matures in January 2016 and bears interest at a per annum rate equal to, at our option, LIBOR (subject to a floor of 1.50%) plus 3.50% or a base rate plus 2.50%. Upon the occurrence of certain events, we may request an incremental term loan facility to be added to the 2010 term loan facility to issue additional term loans in such amount as we determine, subject to the receipt of commitments by existing lenders or other financial institutions for such amount of term loans and the satisfaction of certain other conditions. The 2010 revolving facility matures in January 2015, and we may seek to increase the borrowing availability under the 2010 revolving facility to an amount larger than $260.0 million, subject to the receipt of commitments by existing lenders or other financial institutions for such increased revolving facility and the satisfaction of other conditions. Borrowings under the 2010 revolving facility bear interest at a per annum rate equal to, at our option, LIBOR plus 3.50% or a base rate plus 2.50%, both of which are subject to a 0.25% decrease dependent upon our consolidated leverage ratio. We may utilize the 2010 revolving facility to issue up to $100.0 million of letters of credit ($28.4 million of which are currently outstanding as of August 15, 2010).

Under the Refinancing, we also issued $950.0 million aggregate amount at maturity ($936.3 million cash proceeds) of 8.0% senior unsecured notes due February 2018 in a private placement offering (the "8.0% Notes"). The 8.0% Notes are redeemable, in whole or in part, at any time on or after February 1, 2014 at specified redemption prices. On or after February 1, 2014, we may redeem all or part of the 8.0% Notes at various redemption prices given the date of redemption as set forth in the indenture governing the 8.0% Notes. In addition, we may redeem up to 35% of the 8.0% Notes prior to February 1, 2013 with the net cash proceeds from certain equity offerings at a price equal to 108% of their principal amount, plus accrued and unpaid interest. We may also redeem some or all of the 8.0% Notes before February 1, 2014 at a redemption price equal to 100% of the principal amount thereof, plus a "make-whole" premium and accrued and unpaid interest.

The proceeds from the 2010 credit facilities, the issuance of the 8.0% Notes and available cash were used to repay the $764.2 million principal and interest outstanding related to our 2005 term loan facility; to fund $597.0 million and $232.5 million of cash tender offers and consent solicitations and accrued interest for those holders of the 9.0% Notes and 11.25% Notes, respectively, who accepted the tender offers; to pay $26.9 million to redeem those 9.0% Notes and 11.25% Notes not previously tendered including such principal, interest and call premiums; to pay fees expenses related to the Refinancing of approximately $93.6 million; to purchase 446 shares held by certain former employees for $0.6 million; and to fund a $300.0 million distribution to repurchase a portion of the shares owned by the remaining stockholders. Subsequent to the $300.0 million share repurchase, we completed a 1.4778 for one split that effectively returned the share ownership for each stockholder that participated in the distribution to the same level as that in effect immediately prior to the distribution.

On July 14, 2010, we issued an additional $225.0 million aggregate principal amount of 8.0% Notes (the "Add-on Notes"), which are guaranteed on a senior unsecured basis by Vanguard, Vanguard Health Holding Company I, LLC and certain restricted subsidiaries of VHS Holdco II. The additional notes were issued under the Indenture governing the 8.0% Notes that we issued on January 29, 2010 as part of the Refinancing. The Add-on Notes were issued at an offering price of 96.25% plus accrued interest, if any, from January 29, 2010. The proceeds from the Add-on Notes are intended to be used to finance, in part, our acquisition of substantially all the assets of DMC and to pay fees and expenses incurred in connection with the foregoing. Should the DMC acquisition not be approved by the Michigan Attorney General, we will use these proceeds for general corporate purposes, including other acquisitions.

Debt Covenants

Our 2010 credit facilities contain a number of covenants that, among other things, restrict, subject to certain exceptions, our ability, and the ability of our subsidiaries, to sell assets; incur additional indebtedness or issue preferred stock; repay other indebtedness (including the 8.0% Notes), pay dividends and distributions or repurchase our capital stock; create liens on assets; make investments, loans or advances; make certain acquisitions; engage in mergers or consolidations; create a healthcare joint venture; engage in certain transactions with affiliates; amend certain material agreements governing our indebtedness, including the 8.0% Notes; change the business conducted by our subsidiaries; enter into certain hedging agreements; and make capital expenditures above specified levels. In addition, the 2010 credit facilities include a maximum consolidated leverage ratio and a minimum consolidated interest coverage ratio. The following table sets forth the leverage and interest coverage covenant tests as of June 30, 2010.

	Debt Covenant Ratio	Actual Ratio
Interest coverage ratio requirement	2.00x	3.15x
Total leverage ratio limit	6.25x	4.39x

Factors outside our control may make it difficult for us to comply with these covenants during future periods. These factors include a prolonged economic recession, a higher number of uninsured or underinsured patients and decreased governmental or managed care payer reimbursement, among others, any or all of which could negatively impact our results of operations and cash flows and cause us to violate one or more of these covenants. Violation of one or more of the covenants could result in an immediate call of the outstanding principal amount under our 2010 term loan facility or the necessity of lender waivers with more onerous terms including adverse pricing or repayment provisions or more restrictive covenants. A default under our 2010 credit facilities would also result in a default under the Indenture governing our 8.0% Notes.

Credit Ratings

The table below summarizes our credit ratings as of the date of this filing.

	Standard & Poor's	Moody's
Corporate credit rating	B	B2
8.0% Notes	B-	B3
2010 credit facilities	BB	Ba2

Our credit ratings are subject to periodic reviews by the ratings agencies. If our results of operations deteriorate either as a result of weakness in the U.S. economy or the economies of the markets we serve or other factors, any or all of our corporate ratings may be downgraded. A credit rating downgrade could further impede our ability to refinance all or a portion of our outstanding debt or obtain additional debt.

Capital Resources

We anticipate spending a total of $200.0 million to $225.0 million in capital expenditures during fiscal 2011. We expect that cash on hand, cash generated from our operations and cash expected to be available to us under our 2010 credit facilities will be sufficient to meet our working capital needs, debt service requirements and planned capital expenditure programs during the next twelve months and into the foreseeable future. However, we cannot assure you that our operations will generate sufficient cash or that additional future borrowings under our senior credit facilities will be available to enable us to meet these requirements, especially given the current volatility in the credit markets and general economic weakness.

We had $257.6 million of cash and cash equivalents as of June 30, 2010. We rely on available cash, cash flows generated by operations and available borrowing capacity under our 2010 revolving facility to fund our operations and capital expenditures. We invest our cash in accounts in high-quality financial institutions. We continually explore various options to increase the return on our invested cash while preserving our principal cash balances. However, the significant majority of our cash and cash equivalents are not federally-insured and could be at risk in the event of a collapse of those financial institutions.

As of June 30, 2010, we held $19.8 million in total available for sale investments in auction rate securities ("ARS") backed by student loans, which are included in long-term investments in auction rate securities on our consolidated balance sheet due to inactivity in the primary ARS market during the past year. The par value of the ARS was $24.5 million as of June 30, 2010.

We also intend to continue to pursue acquisitions or partnering arrangements, either in existing markets or new markets, which fit our growth strategies. To finance such transactions, we expect to increase borrowings under our 2010 term loan facility and may draw upon cash on hand, utilize amounts available under our 2010 revolving facility or seek additional equity funding. We continually assess our capital needs and may seek additional financing, including debt or equity, as considered necessary to fund potential acquisitions, fund capital projects or for other corporate purposes. However, we may be unable to raise additional equity proceeds from Blackstone or other investors should we need to obtain cash for any of these purposes. Our future operating performance, ability to service our debt and ability to draw upon other sources of capital will be subject to future economic conditions and other business factors, many of which are beyond our control. Recent pending and completed acquisitions include the following:

- *Pending acquisition of DMC* — On June 10, 2010, we entered into a definitive agreement to purchase DMC, which owns and operates eight hospitals in and around Detroit, Michigan with 1,734 licensed beds for an expected cash purchase price of approximately $417.0 million, as previously discussed.

- *Completed acquisition of Westlake Hospital and West Suburban Medical Center* — On August 1, 2010, we acquired two acute care hospitals and associated outpatient facilities in Illinois from Resurrection Health Care. Located in the western suburbs of Chicago, the hospitals are 234-bed West Suburban Medical Center in Oak Park, Illinois and 225-bed Westlake Hospital in Melrose Park, Illinois for a cash purchase price of approximately $45.0 million.

- *Pending acquisition of Arizona Heart Institute and Arizona Heart Hospital* — On August 2, 2010, we signed a definitive agreement to acquire Arizona Heart Institute (AHI), a leading provider of cardiovascular care. The purchase of the AHI by Vanguard will occur through a section 363 sale, as part of a Chapter 11 reorganization plan since AHI filed in early August 2010 under the federal bankruptcy laws for a Chapter 11 reorganization of its business. A section 363 sale, so named because of the section of the Bankruptcy Code dealing with the procedure, allows the sale of all, or substantially all, of the filing company's assets to the purchaser free and clear of any liens or encumbrances. The sale is subject to the approval of the court. On August 6, 2010, we signed a definitive agreement to acquire Arizona Heart Hospital also located in Phoenix, Arizona.

Obligations and Commitments

The following table reflects a summary of obligations and commitments outstanding, including both the principal and interest portions of long-term debt, with payment dates as of June 30, 2010.

	Payments due by period				
	Within 1 year	During Years 2-3	During Years 4-5	After 5 Years	Total
			(In millions)		
Contractual Cash Obligations:					
Long-term debt (1)	$ 111.1	$ 296.3	$ 293.6	$ 2,041.7	$ 2,742.7
Operating leases (2)	30.1	47.4	33.4	30.7	141.6
Purchase obligations (2)	20.9	—	—	—	20.9
Health plan claims and settlements payable (3)	149.8	—	—	—	149.8
Estimated self-insurance liabilities (4)	38.1	35.3	23.0	25.2	121.6
Subtotal	$ 350.0	$ 379.0	$ 350.0	$ 2,097.6	$ 3,176.6

	Within 1 year	During Years 2-3	During Years 4-5	After 5 Years	Total
			(In millions)		
Other Commitments:					
Construction and capital improvements (5)	$ 75.1	$ 0.3	$ —	$ —	$ 75.4
Guarantees of surety bonds (6)	50.0	—	—	—	50.0
Letters of credit (7)	—	—	30.2	—	30.2
Physician commitments (8)	3.4	—	—	—	3.4
Estimated liability for uncertain tax positions (9)	11.9	—	—	—	11.9
Subtotal	$ 140.4	$ 0.3	$ 30.2	$ —	$ 170.9
Total obligations and commitments	$ 490.4	$ 379.3	$ 380.2	$ 2,097.6	$ 3,347.5

(1) Includes both principal and interest payments. The interest portion of our debt outstanding at June 30, 2010 assumes an average interest rate of 8.0%. The long-term debt obligations, adjusted to reflect the principal and interest related to the $225.0 million Add-on Notes (as previously discussed) would be increased by the following as of June 30, 2010: $18.0 million due within one year; $36.0 million due within two to three years; $36.0 million due within four to five years and $279.0 million due after five years.

(2) These obligations are not reflected in our consolidated balance sheets.

(3) Represents health claims incurred by members of PHP, AAHP and MHP, including incurred but not reported claims, and net amounts payable for program settlements to AHCCCS and CMS for certain programs for which profitability is limited. Accrued health plan claims and settlements is separately stated on our consolidated balance sheets.

(4) Includes the current and long-term portions of our professional and general liability, workers' compensation and employee health reserves.

(5) Represents our estimate of amounts we are committed to fund in future periods through executed agreements to complete projects included as construction in progress on our consolidated balance sheets. The construction and capital improvements obligations, adjusted to reflect capital commitments under the executed DMC Purchase Agreement (as previously discussed) would be increased by the following as of June 30, 2010: $150.0 million committed within one year; $300.0 million committed within two to three years and $400.0 million committed within four to five years.

(6) Represents performance bonds we have purchased related to health claims liabilities of PHP.

(7) Amounts relate primarily to instances in which we have letters of credit outstanding with the third party administrator of our self-insured workers' compensation program. The outstanding balance was reduced to $28.3 million subsequent to June 30, 2010.

(8) Includes physician guarantee liabilities recognized in our consolidated balance sheets under the guidance of accounting for guarantees and liabilities for other fixed expenses under physician relocation agreements not yet paid.

(9) Represents expected future tax liabilities recognized in our consolidated balance sheets determined under the guidance of accounting for income taxes.

Guarantees and Off Balance Sheet Arrangements

We are currently a party to a certain rent shortfall agreement with a certain unconsolidated entity. We also enter into physician income guarantees and service agreement guarantees and other guarantee arrangements, including parent-subsidiary guarantees, in the ordinary course of business. We have not engaged in any transaction or arrangement with an unconsolidated entity that is reasonably likely to materially affect liquidity.

Effects of Inflation and Changing Prices

Various federal, state and local laws have been enacted that, in certain cases, limit our ability to increase prices. Revenues for acute hospital services rendered to Medicare patients are established under the federal government's prospective payment system. We believe that hospital industry operating margins have been, and may continue to be, under significant pressure because of changes in payer mix and growth in operating expenses in excess of the increase in prospective payments under the Medicare program. In addition, as a result of increasing regulatory and competitive pressures, our ability to maintain operating margins through price increases to non-Medicare patients is limited.

Item 7A. Quantitative and Qualitative Disclosures About Market Risk.

We are subject to market risk from exposure to changes in interest rates based on our financing, investing and cash management activities. As of June 30, 2010, we had in place $1,075.0 million of senior credit facilities bearing interest at variable rates at specified margins above either the agent bank's alternate base rate or the LIBOR rate.

Our 2010 credit facilities consist of $815.0 million in term loans maturing in January 2016 and a $260.0 million revolving credit facility maturing in January 2015 (of which $30.2 million of capacity was utilized by outstanding letters of credit as of June 30, 2010). Although changes in the alternate base rate or the LIBOR rate would affect the cost of funds borrowed in the future, we believe the effect, if any, of reasonably possible near-term changes in interest rates would not be material to our results of operations or cash flows. An estimated 0.25% change in the variable interest rate under our 2010 term loan facility would result in a change in annual net interest of approximately $2.0 million.

Our $260.0 million revolving credit facility bears interest at the alternate base rate plus a margin ranging from 2.25%-2.50% per annum or the LIBOR rate plus a margin ranging from 3.25%-3.50% per annum, in each case dependent upon our consolidated leverage ratio. Our $815.0 million in outstanding term loans bear interest at the alternate base rate plus a margin of 2.50% per annum or the LIBOR rate (subject to a 1.50% floor) plus a margin of 3.50% per annum. We may request an incremental term loan facility to be added to our 2010 term loan facility in an unlimited amount, subject to receipt of commitments by existing lenders or other financing institutions and the satisfaction of certain other conditions. We may also seek to increase the borrowing availability under the 2010 revolving facility to an unlimited amount subject to the receipt of commitments by existing lenders or other financial institutions and the satisfaction of other conditions.

At June 30, 2010, we held $19.8 million in total available for sale investments in auction rate securities ("ARS") backed by student loans, which are included in long-term investments in auction rate securities on our consolidated balance sheets. The par value of the ARS was $24.5 million as of June 30, 2010. We recorded a realized loss on the ARS of $0.6 million and temporary impairments totaling $4.1 million ($2.5 million, net of taxes) related to all then outstanding par value ARS during our fiscal year ended June 30, 2009. The temporary impairments related to the ARS are included in accumulated other comprehensive loss on our consolidated balance sheet as of June 30, 2010.

Our ARS were rated "AAA" by one or more major credit rating agencies at June 30, 2010 based on their most recent ratings update. The ratings take into account insurance policies guaranteeing both the principal and accrued interest of the investments. The U.S. government guarantees approximately 96%-98% of the principal and accrued interest on each investment in student loans under the Federal Family Education Loan Program or similar programs.

We will continue to monitor market conditions for this type of ARS to ensure that our classification and fair value estimate remain appropriate. Should market conditions in future periods warrant a reclassification or other than temporary impairment of our ARS, we do not believe our financial position, results of operations, cash flows or compliance with debt covenants would be materially impacted. We believe that we currently have adequate working capital to fund operations during the near future based on access to cash and cash equivalents, expected operating cash flows and availability under our revolving credit facility. We do not expect that our holding of the ARS until market conditions improve will significantly adversely impact our operating cash flows.

Item 8. Financial Statements and Supplementary Data.

INDEX TO AUDITED CONSOLIDATED FINANCIAL STATEMENTS

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

Board of Directors
Vanguard Health Systems, Inc.

We have audited the accompanying consolidated balance sheets of Vanguard Health Systems, Inc. as of June 30, 2010 and 2009, and the related consolidated statements of operations, equity and cash flows for each of the three years in the period ended June 30, 2010. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. We were not engaged to perform an audit of the Company's internal control over financial reporting. Our audits included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Vanguard Health Systems, Inc. at June 30, 2010 and 2009, and the consolidated results of its operations and its cash flows for each of the three years in the period ended June 30, 2010, in conformity with U.S. generally accepted accounting principles.

/s/ Ernst & Young LLP

Nashville, Tennessee
August 26, 2010

PART I
FINANCIAL INFORMATION

Item 1. Financial Statements.

VANGUARD HEALTH SYSTEMS, INC.
CONSOLIDATED BALANCE SHEETS

	June 30, 2009	June 30, 2010
	(In millions, except share and per share amounts)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 308.2	$ 257.6
Restricted cash	1.9	2.3
Accounts receivable, net of allowance for doubtful accounts of approximately $121.5 and $75.6, respectively	275.3	270.4
Inventories	48.3	49.6
Deferred tax assets	29.6	21.9
Prepaid expenses and other current assets	68.4	119.2
Total current assets	731.7	721.0
Property, plant and equipment, net of accumulated depreciation	1,174.1	1,203.8
Goodwill	692.1	649.1
Intangible assets, net of accumulated amortization	54.6	66.0
Deferred tax assets, noncurrent	38.0	50.0
Investments in auction rate securities	21.6	19.8
Other assets	19.0	19.9
Total assets	$ 2,731.1	$ 2,729.6
LIABILITIES AND EQUITY		
Current liabilities:		
Accounts payable	$ 127.9	$ 194.8
Accrued salaries and benefits	133.9	144.9
Accrued health plan claims and settlements	117.6	149.8
Accrued interest	13.2	41.4
Other accrued expenses and current liabilities	79.5	76.9
Current maturities of long-term debt	8.0	8.2
Total current liabilities	480.1	616.0
Professional and general liability and workers compensation reserves	76.7	83.6
Other liabilities	34.9	31.6
Long-term debt, less current maturities	1,543.6	1,743.8
Commitments and contingencies		
Equity:		
Vanguard Health Systems, Inc. stockholders' equity:		
Common Stock of $.01 par value; 1,000,000 shares authorized; 749,550 and 749,104 issued and outstanding, respectively	—	—
Additional paid-in capital	651.3	354.9
Accumulated other comprehensive loss	(6.8)	(2.5)
Retained deficit	(56.7)	(105.9)
Total Vanguard Health Systems, Inc. stockholders' equity	587.8	246.5
Non-controlling interests	8.0	8.1
Total equity	595.8	254.6
Total liabilities and equity	$ 2,731.1	$ 2,729.6

See accompanying notes.

VANGUARD HEALTH SYSTEMS, INC.
CONSOLIDATED STATEMENTS OF OPERATIONS

	Year ended June 30,		
	2008	2009	2010
		(In millions)	
Patient service revenues	$ 2,325.4	$ 2,507.4	$ 2,537.2
Premium revenues	450.2	678.0	839.7
Total revenues	2,775.6	3,185.4	3,376.9
Costs and Expenses:			
Salaries and benefits (includes stock compensation of $2.5, $4.4 and $4.2, respectively)	1,146.2	1,233.8	1,296.2
Health plan claims expense	328.2	525.6	665.8
Supplies	433.7	455.5	456.1
Provision for doubtful accounts	205.5	210.3	152.5
Purchased services	145.6	163.8	179.5
Non-income taxes	28.2	52.2	52.9
Rents and leases	41.0	42.6	43.8
Other operating expenses	183.7	203.3	207.7
Depreciation and amortization	129.3	128.9	139.6
Interest, net	122.1	111.6	115.5
Impairment loss	—	6.2	43.1
Debt extinguishment costs	—	—	73.5
Other	6.5	2.7	9.1
Income (loss) from continuing operations before income taxes	5.6	48.9	(58.4)
Income tax benefit (expense)	(2.2)	(16.8)	13.8
Income (loss) from continuing operations	3.4	32.1	(44.6)
Loss from discontinued operations, net of taxes	(1.1)	(0.3)	(1.7)
Net income (loss)	2.3	31.8	(46.3)
Less: Net income attributable to non-controlling interests	(3.0)	(3.2)	(2.9)
Net income (loss) attributable to Vanguard Health Systems, Inc stockholders	$ (0.7)	$ 28.6	$ (49.2)
Amounts attributable to Vanguard Health Systems, Inc. stockholders:			
Income (loss) from continuing operations, net of taxes	$ 0.4	$ 28.9	$ (47.5)
Loss from discontinued operations, net of taxes	(1.1)	(0.3)	(1.7)
Net income (loss) attributable to Vanguard Health Systems, Inc stockholders	$ (0.7)	$ 28.6	$ (49.2)

See accompanying notes.

VANGUARD HEALTH SYSTEMS, INC.
CONSOLIDATED STATEMENTS OF EQUITY

	Vanguard Health Systems, Inc. Stockholders						
	Common Stock		Additional Paid-In Capital	Accumulated Other Comprehensive Loss	Retained Deficit	Non-Controlling Interests	Total Equity
	Shares	Amount					
	(In millions, except share amounts)						
Balance at June 30, 2007	749,550	$ —	$ 644.6	$ —	$ (87.2)	$ 9.3	$ 566.7
Stock compensation (non-cash)	—	—	2.5	—	—	—	2.5
Distributions paid to non-controlling interests	—	—	—	—	—	(3.2)	(3.2)
Issuance of common stock	168	—	0.2	—	—	—	0.2
Repurchase of common stock	(168)	—	(0.2)	—	—	—	(0.2)
Cumulative effect of adoption of accounting for uncertain tax positions	—	—	—	—	2.6	—	2.6
Comprehensive income (loss):							
Change in fair value of interest rate swap (net of tax effect)	—	—	—	2.8	—	—	2.8
Net income (loss)	—	—	—	—	(0.7)	3.0	2.3
Total comprehensive income				2.8	(0.7)	3.0	5.1
Balance at June 30, 2008	749,550	—	647.1	2.8	(85.3)	9.1	573.7
Stock compensation (non-cash)	—	—	4.4	—	—	—	4.4
Distributions paid to non-controlling interests	—	—	—	—	—	(4.3)	(4.3)
Repurchase of equity incentive units	—	—	(0.2)	—	—	—	(0.2)
Comprehensive income (loss):							
Change in fair value of interest rate swap (net of tax effect)	—	—	—	(7.1)	—	—	(7.1)
Change in fair value of auction rate securities (net of tax effect)	—	—	—	(2.5)	—	—	(2.5)
Net income	—	—	—	—	28.6	3.2	31.8
Total comprehensive income				(9.6)	28.6	3.2	22.2
Balance at June 30, 2009	749,550	—	651.3	(6.8)	(56.7)	8.0	595.8
Stock compensation (non-cash)	—	—	4.2	—	—	—	4.2
Repurchase of stock	(242,659)	—	(300.6)	—	—	—	(300.6)
Stock split ($.01 par value)	242,213	—	—	—	—	—	—
Distributions paid to non-controlling interests	—	—	—	—	—	(2.8)	(2.8)
Comprehensive income (loss):							
Change in fair value of interest rate swap (net of tax effect)	—	—	—	2.6	—	—	2.6
Termination of interest rate swap	—	—	—	1.7	—	—	1.7
Net income (loss)	—	—	—	—	(49.2)	2.9	(46.3)
Total comprehenive income (loss)				4.3	(49.2)	2.9	(42.0)
Balance at June 30, 2010	749,104	$ —	$ 354.9	$ (2.5)	$ (105.9)	$ 8.1	$ 254.6

See accompanying notes.

VANGUARD HEALTH SYSTEMS, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS

	Year ended June 30,		
	2008	2009	2010
		(In millions)	
Operating activities:			
Net income (loss)	$ 23	$ 31.8	$ (46.3)
Adjustments to reconcile net income (loss) to net cash provided by operating activities:			
Loss from discontinued operations	1.1	0.3	1.7
Depreciation and amortization	129.3	128.9	139.6
Provision for doubtful accounts	205.5	210.3	152.5
Amortization of loan costs	4.9	5.4	5.2
Accretion of principal on notes	19.5	21.8	6.5
Loss (gain) on disposal of assets	0.8	(2.3)	1.8
Acquisition related expenses	—	—	3.1
Stock compensation	2.5	4.4	4.2
Deferred income taxes	(1.7)	6.4	(8.5)
Impairment loss	—	6.2	43.1
Realized holding loss on investments	—	0.6	—
Debt extinguishment costs	—	—	73.5
Changes in operating assets and liabilities:			
Accounts receivable	(222.6)	(185.6)	(148.3)
Inventories	(4.1)	1.0	(1.3)
Prepaid expenses and other current assets	(19.6)	(12.7)	(80.5)
Accounts payable	12.4	(27.5)	67.1
Accrued expenses and other liabilities	45.3	122.7	102.8
Net cash provided by operating activities — continuing operations	175.6	311.7	316.2
Net cash provided by (used in) operating activities — discontinued operations	0.7	1.4	(1.0)
Net cash provided by operating activities	176.3	313.1	315.2
Investing activities:			
Acquisitions and related expenses	(0.2)	(4.4)	(4.6)
Capital expenditures	(119.8)	(132.0)	(155.9)
Proceeds from asset dispositions	0.4	4.9	2.0
Purchases of auction rate securities	(90.0)	—	—
Sales of auction rate securities	63.7	—	1.8
Other	1.1	(2.0)	0.3
Net cash used in investing activities — continuing operations	(144.8)	(133.5)	(156.4)
Net cash provided by (used in) investing activities — discontinued operations	1.0	(0.1)	(0.1)
Net cash used in investing activities	(143.8)	(133.6)	(156.5)
Financing activities:			
Payments of long-term debt	(7.8)	(7.8)	(1,557.4)
Proceeds from debt borrowings	—	—	1,751.3
Payments of refinancing costs and fees	—	—	(93.6)
Repurchases of stock, equity incentive units and stock options	(0.2)	(0.2)	(300.6)
Payments related to derivative instrument with financing element	—	—	(6.2)
Distributions paid to non-controlling interests and other	(3.0)	(4.9)	(2.8)
Net cash used in financing activities	(11.0)	(12.9)	(209.3)
Net increase (decrease) in cash and cash equivalents	21.5	166.6	(50.6)
Cash and cash equivalents, beginning of year	120.1	141.6	308.2
Cash and cash equivalents, end of year	$ 141.6	$ 308.2	$ 257.6

See accompanying notes.

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VANGUARD HEALTH SYSTEMS, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS

	Year ended June 30,		
	2008	2009	2010
		(In millions)	
Supplemental cash flow information:			
Net cash paid for interest	$ 99.1	$ 86.4	$ 71.7
Net cash paid (received) for income taxes	$ 1.3	$ 17.3	$ (11.1)
Supplemental noncash activities:			
Capitalized interest	$ 1.4	$ 2.0	$ 2.4
Change in fair value of interest rate swap, net of taxes	$ 2.8	$ (7.1)	$ 2.6
Change in fair value of auction rate securities, net of taxes	$ —	$ (2.5)	$ —

See accompanying notes.

VANGUARD HEALTH SYSTEMS, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
June 30, 2010

1. BUSINESS AND BASIS OF PRESENTATION

Business

Vanguard Health Systems, Inc. ("Vanguard") is an investor-owned healthcare company whose affiliates own and operate hospitals and related healthcare businesses in urban and suburban areas. As of June 30, 2010, Vanguard's affiliates owned and managed 15 acute care hospitals with 4,135 licensed beds and related outpatient service locations complementary to the hospitals providing healthcare services in San Antonio, Texas; metropolitan Phoenix, Arizona; metropolitan Chicago, Illinois; and Massachusetts. Vanguard also owns managed health plans in Chicago, Illinois and Phoenix, Arizona and two surgery centers in Orange County, California.

Basis of Presentation

The accompanying consolidated financial statements include the accounts of subsidiaries and affiliates controlled by Vanguard. Vanguard generally defines control as the ownership of the majority of an entity's voting interests. Vanguard also consolidates any entities for which it receives the majority of the entity's expected returns or is at risk for the majority of the entity's expected losses based upon its investment or financial interest in the entity. All material intercompany accounts and transactions have been eliminated. Since none of Vanguard's common shares are publicly held, no earnings per share information is presented in the accompanying consolidated financial statements. Certain prior year amounts from the accompanying consolidated financial statements have been reclassified to conform to current year presentation. The majority of Vanguard's expenses are "cost of revenue" items. Costs that could be classified as general and administrative include certain Vanguard corporate office costs, which approximated $44.3 million, $54.5 million and $65.8 million for the years ended June 30, 2008, 2009 and 2010, respectively.

Use of Estimates

In preparing Vanguard's financial statements in conformity with accounting principles generally accepted in the United States, management makes estimates and assumptions that affect the amounts recorded or classification of items in the consolidated financial statements and accompanying notes. Actual results could differ from those estimates.

Probable Acquisition

On June 10, 2010, Vanguard entered into a definitive agreement to purchase the Detroit Medical Center ("DMC"), which owns and operates eight hospitals in and around Detroit, Michigan with 1,734 licensed beds, including Children's Hospital of Michigan, Detroit Receiving Hospital, Harper University Hospital, Huron Valley-Sinai Hospital, Hutzel Women's Hospital, Rehabilitation Institute of Michigan, Sinai-Grace Hospital and DMC Surgery Hospital.

Under the purchase agreement, Vanguard will acquire all of DMC's assets (other than donor restricted assets and certain other assets) and assume all of its liabilities (other than its outstanding bonds and notes and certain other liabilities) for $417.0 million in cash, which will be used to repay all of such non-assumed debt. The $417.0 million cash payment represents Vanguard's full cash funding obligations to DMC in order to close the transaction, except for its assumption or payment of DMC's usual and customary transaction expenses. The assumed liabilities include a pension liability under a "frozen" defined benefit pension plan of DMC estimated at $184 million as of December 31, 2009 that Vanguard anticipates will be funded over seven years based upon actuarial assumptions and estimates, as adjusted periodically by actuaries. Vanguard will also commit to spend $500.0 million in capital expenditures in the DMC facilities during the five years subsequent to closing of the transaction, which amount relates to a specific project list agreed to between the DMC board of representatives and Vanguard. In addition, Vanguard will commit to spend $350.0 million during this five-year period relating to the routine capital needs of the DMC facilities. The acquisition is pending review and approval by the Michigan Attorney General. Assuming such approval is obtained, Vanguard expects to close the transaction during its second quarter of fiscal year 2011.

VANGUARD HEALTH SYSTEMS, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (continued)

Refinancing Transactions

In January 2010, Vanguard completed a comprehensive refinancing plan (the "Refinancing"). Under the Refinancing, certain of Vanguard's subsidiaries issued $950.0 million of new 8.0% Senior Unsecured Notes due 2018 (the "8.0% Notes"), entered into an $815.0 million senior secured term loan maturing in 2016 (the "2010 term loan facility") and entered into a new $260.0 million revolving credit facility that expires in 2015 (the "2010 revolving facility"). The proceeds from these new debt instruments were used to repay the outstanding principal and interest related to Vanguard's previous term loan facility; to retire its previously outstanding 9.0% senior subordinated notes (the "9.0% Notes") and its 11.25% senior discount notes (the "11.25% Notes") through redemption or tender offers/consent solicitations and pay accrued interest for such notes; to purchase 446 shares of common stock from certain former employees; to fund a $300.0 million distribution to repurchase a portion of the shares owned by the remaining stockholders; and to pay fees and expenses relating to the Refinancing of approximately $93.6 million.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Revenues and Revenue Deductions

Vanguard recognizes patient service revenues during the period the healthcare services are provided based upon estimated amounts due from payers. Vanguard estimates contractual adjustments and allowances based upon payment terms set forth in managed care health plan contracts and by federal and state regulations. For the majority of its patient service revenues, Vanguard applies contractual adjustments to patient accounts at the time of billing using specific payer contract terms entered into the accounts receivable systems, but in some cases Vanguard records an estimated allowance until payment is received. Vanguard derives most of its patient service revenues from healthcare services provided to patients with Medicare and related managed Medicare plans or managed care insurance coverage. Medicare, which represented approximately 26%, 25% and 25% of Vanguard's net patient revenues during its fiscal years ended June 30, 2008, 2009 and 2010, respectively, was the only individual payer for which Vanguard derived more than 10% of net patient revenues during those periods.

Services provided to Medicare and related managed Medicare patients are generally reimbursed at prospectively determined rates per diagnosis ("PPS"), while services provided to managed care patients are generally reimbursed based upon predetermined rates per diagnosis, per diem rates or discounted fee-for-service rates. Medicaid reimbursements vary by state.

Medicare regulations and Vanguard's principal managed care contracts are often complex and may include multiple reimbursement mechanisms for different types of services provided in its healthcare facilities. To obtain reimbursement for certain services under the Medicare program, Vanguard must submit annual cost reports and record estimates of amounts owed to or receivable from Medicare. These cost reports include complex calculations and estimates related to indirect medical education, disproportionate share payments, reimbursable Medicare bad debts and other items that are often subject to interpretation that could result in payments that differ from recorded estimates. Vanguard estimates amounts owed to or receivable from the Medicare program using the best information available and its interpretation of the applicable Medicare regulations. Vanguard includes differences between original estimates and subsequent revisions to those estimates (including final cost report settlements) in the consolidated statements of operations in the period in which the revisions are made. Net adjustments for final third party settlements increased patient service revenues and income from continuing operations by $7.9 million ($4.9 million net of taxes), $8.0 million ($5.0 million net of taxes) and $6.6 million ($4.1 million net of taxes) during the years ended June 30, 2008, 2009 and 2010, respectively. Additionally, updated regulations and contract negotiations occur frequently, which necessitates continual review of estimation processes by management. Management believes that future adjustments to its current third party settlement estimates will not significantly impact Vanguard's results of operations or financial position.

VANGUARD HEALTH SYSTEMS, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (continued)

Vanguard does not pursue collection of amounts due from uninsured patients that qualify for charity care under its guidelines (currently those uninsured patients whose incomes are equal to or less than 200% of the current federal poverty guidelines set forth by the Department of Health and Human Services). Vanguard deducts charity care accounts from revenues when it determines that the account meets its charity care guidelines. Vanguard also provides discounts from billed charges and alternative payment structures for uninsured patients who do not qualify for charity care but meet certain other minimum income guidelines, primarily those uninsured patients with incomes between 200% and 500% of the federal poverty guidelines. During the years ended June 30, 2008, 2009 and 2010, Vanguard deducted $86.1 million, $91.8 million and $87.7 million of charity care from revenues, respectively.

Vanguard receives periodic payments under the Bexar County, Texas upper payment limit ("UPL") Medicaid payment program. UPL programs allow private hospitals to enter into indigent care affiliation agreements with governmental entities. Within the parameters of these programs, private hospitals expand charity care services to indigent patients and alleviate expenses for the governmental entity. The governmental entity is then able to utilize its tax revenue to fund the Medicaid program for private hospitals. Vanguard recognizes revenues from the UPL program when Vanguard becomes entitled to the expected reimbursements, including a federal match portion, and such reimbursements are assured.

During the third quarter of fiscal 2009, the federal government approved federal matching funds for the Illinois Provider Tax Assessment ("PTA") program. The PTA program enables the state of Illinois to increase funding for its state Medicaid plan. Hospitals providing services to Medicaid enrollees receive funds directly from the state. Hospital providers, with certain exceptions, are then assessed a provider tax, which is payable to the state, and may or may not exceed funds received from the state. Vanguard recognizes revenues equal to the gross payments to be received when such payments are assured. Vanguard recognized expenses for the taxes due back to the state under the PTA program when the related revenues are recognized.

Effective for service dates on or after April 1, 2009, as a result of a state mandate, Vanguard implemented a new uninsured discount policy for those patients receiving services in its Illinois hospitals who had no insurance coverage and who did not otherwise qualify for charity care under its guidelines. Vanguard implemented this same policy in its Phoenix and San Antonio hospitals effective for service dates on or after July 1, 2009. Under this policy, Vanguard applies an uninsured discount (calculated as a standard percentage of gross charges) at the time of patient billing and includes this discount as a reduction to patient service revenues. These discounts were approximately $11.7 million and $215.7 million for the years ended June 30, 2009 and 2010, respectively.

Vanguard had premium revenues from its health plans of $450.2 million, $678.0 million and $839.7 million during the years ended June 30, 2008, 2009 and 2010, respectively. Vanguard's health plans, Phoenix Health Plan ("PHP"), Abrazo Advantage Health Plan ("AAHP") and MacNeal Health Providers ("MHP"), have agreements with the Arizona Health Care Cost Containment System ("AHCCCS"), Centers for Medicare and Medicaid Services ("CMS") and various health maintenance organizations ("HMOs"), respectively, to contract to provide medical services to subscribing participants. Under these agreements, Vanguard's health plans receive monthly payments based on the number of HMO participants in MHP or the number and coverage type of members in PHP and AAHP. Vanguard's health plans recognize the payments as revenues in the month in which members are entitled to healthcare services with the exception of AAHP Medicare Part D reinsurance premiums and low income subsidy cost sharing premiums that are recorded as a liability to fund future healthcare costs or else repaid to the government.

Cash and Cash Equivalents

Vanguard considers all highly liquid investments with maturity of 90 days or less when purchased to be cash equivalents. Vanguard manages its credit exposure by placing its investments in high quality securities and by periodically evaluating the relative credit standing of the financial institutions holding its cash and investments.

Restricted Cash

As of June 30, 2009 and 2010, Vanguard had restricted cash balances of $1.9 million and $2.3 million, respectively. These balances primarily represent restricted cash accounts related to liquidity requirements of AAHP and certain other arrangements.

VANGUARD HEALTH SYSTEMS, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (continued)

Accounts Receivable

Vanguard's primary concentration of credit risk is patient accounts receivable, which consists of amounts owed by various governmental agencies, insurance companies and private patients. Vanguard manages the receivables by regularly reviewing its accounts and contracts and by providing appropriate allowances for contractual discounts and uncollectible amounts. Vanguard typically writes off uncollected accounts receivable 120 days subsequent to discharge date. Medicare program net receivables, including managed Medicare receivables, comprised approximately 33% and 31% of net patient receivables as of June 30, 2009 and 2010, respectively. Medicare revenues are included in the acute care services operating segment. Receivables from various state Medicaid programs and managed Medicaid programs comprised approximately 21% and 15% of net patient receivables as of June 30, 2009 and 2010, respectively. Remaining receivables relate primarily to various HMO and Preferred Provider Organization ("PPO") payers, commercial insurers and private patients. Concentration of credit risk for these payers is limited by the number of patients and payers.

Effective July 1, 2007, Vanguard began estimating the allowance for doubtful accounts using a standard policy that reserves 100% of all accounts aged greater than 365 days subsequent to discharge date plus a standard percentage of uninsured accounts less than 365 days old plus a standard percentage of self-pay after insurance/Medicare less than 365 days old. Effective June 30, 2008, Vanguard adjusted its policy to increase the standard percentages applied to uninsured accounts and self-pay after insurance/Medicare accounts. Vanguard adjusted its standard percentages again in April 2009 and July 2009 to consider the impact of its new uninsured discount policy, as previously described. Vanguard tests its allowance for doubtful accounts policy quarterly using a hindsight calculation that utilizes write-off data for all payer classes during the previous twelve-month period to estimate the allowance for doubtful accounts at a point in time. Vanguard also supplements its analysis by comparing cash collections to net patient revenues and monitoring self-pay utilization. Significant changes in payer mix, business office operations, general economic conditions and healthcare coverage provided by federal or state governments or private insurers may have a significant impact on Vanguard's estimates and significantly affect its results of operations and cash flows.

Vanguard classifies accounts pending Medicaid approval as self-pay accounts in its accounts receivable aging report and applies the standard uninsured discount. The net account balance is further subject to the allowance for doubtful accounts reserve policy. Should the account qualify for Medicaid coverage, the previously recorded uninsured discount is reversed and the account is reclassified to Medicaid accounts receivable with the appropriate contractual discount applied. Should the account not qualify for Medicaid coverage but qualify as charity care under Vanguard's charity policy, the previously recorded uninsured discount is reversed and the entire account balance is recorded as a charity deduction.

A summary of Vanguard's allowance for doubtful accounts activity, including those for discontinued operations, during the three most recent fiscal years follows (in millions):

	Balance at Beginning of Period	Additions Charged to Costs and Expenses	Accounts Written off, Net of Recoveries	Balance at End of Period
Allowance for doubtful accounts:				
Year ended June 30, 2008	$ 113.2	$ 201.0	$ 196.5	$ 117.7
Year ended June 30, 2009	$ 117.7	$ 210.8	$ 207.0	$ 121.5
Year ended June 30, 2010	$ 121.5	$ 152.5	$ 198.4	$ 75.6

Inventories

Inventories, consisting of medical supplies and pharmaceuticals, are stated at the lower of cost (first-in, first-out) or market.

Property, Plant and Equipment

Purchases of property, plant and equipment are stated at cost. Routine maintenance and repairs are charged to expense as incurred. Expenditures that increase values, change capacities or extend useful lives are capitalized. For assets other than leasehold improvements depreciation is computed using the straight-line method over the estimated useful lives of the assets, which approximate 3 to 40 years. Leasehold improvements are depreciated over the lesser of the estimated useful life or term of the lease. Depreciation expense was approximately $126.1 million, $125.2 million and $135.6 million for the years ended June 30, 2008, 2009 and 2010, respectively. Vanguard tests its property, plant and equipment and other long-lived assets for impairment as management becomes aware of impairment indicators.

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During fiscal 2008, 2009 and 2010, Vanguard capitalized $1.4 million, $2.0 million and $2.4 million of interest, respectively, associated with certain of its hospital construction and expansion projects. Vanguard estimates that it is contractually obligated to expend approximately $75.4 million related to projects classified as construction in progress as of June 30, 2010. Vanguard also capitalizes costs associated with developing computer software for internal use. Vanguard capitalizes both internal and external direct costs, excluding training, during the application development stage primarily for the purpose of customizing vendor software to integrate with Vanguard's hospital information systems. The estimated net book value of capitalized internal use software included in net property, plant and equipment, was approximately $52.0 million and $55.8 million as of June 30, 2009 and 2010, respectively. The amortization expense for internal use software, included in depreciation expense, was approximately $9.9 million, $9.5 million and $11.8 million for the years ended June 30, 2008, 2009 and 2010, respectively.

The following table provides the gross asset balances for each major class of asset and total accumulated depreciation as of June 30, 2009 and 2010 (in millions).

	June 30, 2009	June 30, 2010
Class of asset:		
Land and improvements	$ 148.7	$ 161.8
Buildings and improvements	842.4	864.0
Equipment	641.5	740.5
Construction in progress	60.0	88.5
	1,692.6	1,854.8
Less: accumulated depreciation	(518.5)	(651.0)
Net property, plant and equipment	$ 1,174.1	$ 1,203.8

Investments in Auction Rate Securities

As of June 30, 2010, Vanguard held $19.8 million in total available for sale investments in auction rate securities ("ARS") backed by student loans, which are included in long-term investments in auction rate securities on its consolidated balance sheet due to inactivity in the primary ARS market during the past years. The par value of the ARS was $24.5 million as of June 30, 2010. A summary of activity for Vanguard's ARS during the three most recent fiscal years follows (in millions).

Balance at June 30, 2008	$ 26.3
Realized holding loss	(0.6)
Temporary impairment recognized in Accumulated Other Comprehensive Loss ($2.5 million, net of taxes)	(4.1)
Balance at June 30, 2009	21.6
Proceeds from redemptions at par value	(1.8)
Balance at June 30, 2010	$ 19.8

Vanguard's ARS were rated "AAA" by one or more major credit rating agencies at June 30, 2010. The ratings take into account insurance policies guaranteeing both the principal and accrued interest of the investments. The U.S. government guarantees approximately 96%-98% of the principal and accrued interest on each investment in student loans under the Federal Family Education Loan Program or other similar programs.

VANGUARD HEALTH SYSTEMS, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (continued)

Vanguard does not currently intend to sell and does not believe it is more likely than not it will be required to sell its ARS prior to liquidity returning to the market and their fair value recovering to par value. Vanguard will continue to monitor market conditions for this type of ARS to ensure that its classification and fair value estimate for the ARS remain appropriate in future periods. If Vanguard intends to sell any of the ARS, prior to maturity, at an amount below carrying value, or if it becomes more likely than not that Vanguard will be required to sell its ARS, Vanguard will be required to recognize an other-than-temporary impairment.

Long-Lived Assets and Goodwill

Long-lived assets, including property, plant and equipment and amortizable intangible assets, comprise a significant portion of Vanguard's total assets. Vanguard evaluates the carrying value of long-lived assets when impairment indicators are present or when circumstances indicate that impairment may exist. When management believes impairment indicators may exist, projections of the undiscounted future cash flows associated with the use of and eventual disposition of long-lived assets held for use are prepared. Vanguard uses Level 3 inputs, generally defined as unobservable inputs representing Vanguard's own assumptions, when impairment indicators may exist. If the projections indicate that the carrying values of the long-lived assets are not expected to be recoverable, Vanguard reduces the carrying values to fair value. For long-lived assets held for sale, Vanguard compares the carrying values to an estimate of fair value less selling costs to determine potential impairment. Vanguard tests for impairment of long-lived assets at the lowest level for which cash flows are measurable. These impairment tests are heavily influenced by assumptions and estimates that are subject to change as additional information becomes available. Given the relatively few number of hospitals Vanguard owns and the significant amounts of long-lived assets attributable to those hospitals, an impairment of the long-lived assets for even a single hospital could have a material adverse impact on its operating results or financial position.

Goodwill also represents a significant portion of Vanguard's total assets. Vanguard reviews goodwill for impairment annually during its fourth fiscal quarter or more frequently if certain impairment indicators arise. Vanguard reviews goodwill at the reporting unit level, which is one level below an operating segment. Vanguard compares the carrying value of the net assets of each reporting unit to the net present value of estimated discounted future cash flows of the reporting unit. If the carrying value exceeds the net present value of estimated discounted future cash flows, an impairment indicator exists and an estimate of the impairment loss is calculated. The fair value calculation includes multiple assumptions and estimates, including the projected cash flows and discount rates applied. Changes in these assumptions and estimates could result in goodwill impairment that could have a material adverse impact on Vanguard's results of operations or statement of position.

Amortization of Intangible Assets

Amounts allocated to contract-based intangible assets, which represent PHP's contract with AHCCCS and PHP's various contracts with network providers, are amortized over their useful lives, which equal 10 years. No amortization is recorded for indefinite-lived intangible assets. Deferred loan costs and syndication costs are amortized over the life of the applicable credit facility or notes using the effective interest method. Physician income and service agreement guarantee intangible assets are recorded based upon the estimated future payments under the contracts and are amortized over the applicable contract service periods. The useful lives over which intangible assets are amortized range from two years to ten years.

Income Taxes

Vanguard accounts for income taxes using the asset and liability method. This guidance requires the recognition of deferred tax assets and liabilities for the expected future tax consequences of temporary differences between the carrying amounts and the tax bases of assets and liabilities.

Vanguard believes that its tax return provisions are accurate and supportable, but certain tax matters require interpretations of tax law that may be subject to future challenge and may not be upheld under tax audit. To reflect the possibility that all of its tax positions may not be sustained, Vanguard maintains tax reserves that are subject to adjustment as updated information becomes available or as circumstances change. Vanguard records the impact of tax reserve changes to its income tax provision in the period in which the additional information, including the progress of tax audits, is obtained.

VANGUARD HEALTH SYSTEMS, INC.
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Vanguard assesses the realization of its deferred tax assets to determine whether an income tax valuation allowance is required. Based on all available evidence, both positive and negative, and the weight of that evidence to the extent such evidence can be objectively verified, Vanguard determines whether it is more likely than not that all or a portion of the deferred tax assets will be realized. The factors used in this determination include the following:

- Cumulative losses in recent years
- Income/losses expected in future years
- Unsettled circumstances that, if favorably resolved, would adversely affect future operations
- Availability, or lack thereof, of taxable income in prior carryback periods that would limit realization of tax benefits
- Carryforward period associated with the deferred tax assets and liabilities
- Prudent and feasible tax planning strategies

In addition, financial forecasts used in determining the need for or amount of federal and state valuation allowances are subject to changes in underlying assumptions and fluctuations in market conditions that could significantly alter Vanguard's recoverability analysis and thus have a material adverse impact on Vanguard's consolidated financial condition, results of operations or cash flows.

Accrued Health Plan Claims and Settlements

During the years ended June 30, 2008, 2009 and 2010, health plan claims expense was $328.2 million, $525.6 million and $665.8 million, respectively, primarily representing health claims incurred by members in PHP. Vanguard estimates PHP's reserve for health claims using historical claims experience (including cost per member and payment lag time) and other actuarial data including number of members and certain member demographic information. Accrued health plan claims and settlements, including incurred but not reported claims and net amounts payable to AHCCCS and CMS for certain programs for which profitability is limited, for all Vanguard health plans combined was approximately $117.6 million and $149.8 million as of June 30, 2009 and 2010, respectively. While management believes that its estimation methodology effectively captures trends in medical claims costs, actual payments could differ significantly from its estimates given changes in the healthcare cost structure or adverse experience. Due to changes in historical claims trends, during its fiscal year ended June 30, 2008, Vanguard decreased its health plan claims and settlements reserve related to prior fiscal year health claims experience by $1.5 million ($0.9 million net of taxes). During its fiscal year ended June 30, 2009, Vanguard increased its health plan claims and settlements reserve related to prior fiscal year health claims experience by $0.1 million ($0.1 million net of taxes). During its fiscal year ended June 30, 2010, Vanguard decreased its health plan claims and settlements reserve related to prior fiscal year health claims experience by $4.9 million ($3.0 million net of taxes). Additional adjustments to prior year estimates may be necessary in future periods as more information becomes available.

During the years ended June 30, 2008, 2009 and 2010, approximately $31.2 million, $34.0 million and $42.8 million, respectively, of accrued and paid claims for services provided to Vanguard's health plan members by its hospitals and its other healthcare facilities were eliminated in consolidation. Vanguard's operating results and cash flows could be materially affected by increased or decreased utilization of its healthcare facilities by members in its health plans.

Employee Health Insurance Reserve

Effective July 1, 2008, Vanguard began covering all of its employees under its self-insured medical plan. Prior to that, only a portion of Vanguard's employees were covered under this self-insured plan. Claims are accrued under the self-insured medical plan as the incidents that give rise to them occur. Unpaid claims accruals are based on the estimated ultimate cost of settlement, including claim settlement expenses, in accordance with an average lag time and historical experience. The reserve for self-insured medical plan was approximately $13.4 million and $14.1 million as of June 30, 2009 and 2010, respectively, and is included in accrued salaries and benefits in the accompanying consolidated balance sheets. Vanguard mitigated its self-insured risk by purchasing stop-loss coverage for catastrophic claims at a $500,000 per enrollee annual limit. During the years ended June 30, 2009 and 2010, approximately $23.1 million and $30.2 million were eliminated in consolidation related to self-insured medical claims expense incurred and revenues earned due to employee utilization of Vanguard's healthcare facilities.

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Professional and General Liability and Workers Compensation Reserves

Given the nature of its operating environment, Vanguard is subject to professional and general liability and workers compensation claims and related lawsuits in the ordinary course of business. Vanguard maintains professional and general liability insurance with unrelated commercial insurance carriers to provide for losses up to $65.0 million in excess of its self-insured retention (such self-insured retention maintained through Vanguard's wholly owned captive insurance subsidiary and/or another of its wholly owned subsidiaries) of $10.0 million through June 30, 2010 but increased to $15.0 million for its Illinois hospitals subsequent to June 30, 2010.

Through the year ended June 30, 2010, Vanguard insured its excess coverage under a retrospectively rated policy, and premiums under this policy were recorded based on Vanguard's historical claims experience. Vanguard self-insures its workers compensation claims up to $1.0 million per claim and purchases excess insurance coverage for claims exceeding $1.0 million.

Vanguard's reserves for professional and general liability as of June 30, 2009 and 2010 were $92.9 million and $91.8 million, respectively. As of June 30, 2009 and 2010 the reserves for workers' compensation were $18.2 million and $15.7 million, respectively. Vanguard utilizes actuarial information to estimate its reserves for professional and general liability and workers compensation claims. Each reserve is comprised of estimated indemnity and expense payments related to: (1) reported events ("case reserves") and (2) incurred but not reported ("IBNR") events as of the end of the period. Management uses information from its risk managers and its best judgment to estimate case reserves. Actuarial IBNR estimates are dependent on multiple variables including Vanguard's risk exposures, its self-insurance limits, geographic locations in which it operates, the severity of its historical losses compared to industry averages and the reporting pattern of its historical losses compared to industry averages, among others. Most of these variables require judgment, and changes in these variables could result in significant period over period fluctuations in Vanguard's estimates. Vanguard discounts its workers compensation reserve using a 5% factor, an actuarial estimate of projected cash payments in future periods. Vanguard does not discount the reserve for estimated professional and general liability claims. Vanguard adjusts these reserves from time to time as it receives updated information. Due to changes in historical loss trends, during its fiscal year ended June 30, 2008, Vanguard decreased its professional and general liability reserve related to prior fiscal years by $0.6 million ($0.4 million net of taxes). During its fiscal years ended June 30, 2009 and 2010, Vanguard increased its professional and general liability reserve related to prior fiscal years by $13.4 million ($8.3 million net of taxes) and $8.4 million ($5.2 million net of taxes), respectively. Similarly, Vanguard decreased its workers compensation reserve related to prior fiscal years by $2.3 million ($1.4 million net of taxes), $3.8 million ($2.4 million net of taxes) and $5.1 million ($3.2 million net of taxes), respectively, during its fiscal years ended June 30, 2008, 2009 and 2010. Additional adjustments to prior year estimates may be necessary in future periods as Vanguard's reporting history and loss portfolio matures.

Market and Labor Risks

Vanguard operates primarily in four geographic markets. If economic or other factors limit its ability to provide healthcare services in one or more of these markets, Vanguard's cash flows and results of operations could be materially adversely impacted. Approximately 1,600 full-time employees in Vanguard's Massachusetts hospitals are subject to collective organizing agreements. This group represents approximately 8% of Vanguard's workforce. During fiscal 2007, Vanguard entered into a new three-year contract with the union representing the majority of this group that ended on December 31, 2009. Vanguard is negotiating a new contract with the union and does not expect a new agreement to be finalized until the end of calendar 2010. If Vanguard experiences significant future labor disruptions related to these unionized employees, its cash flows and results of operations could be materially adversely impacted.

Stock-Based Compensation

Vanguard records stock-based employee compensation granted prior to July 1, 2006 using a minimum value method. For grants dated July 1, 2006 and subsequent, Vanguard records stock-based employee compensation using a Black-Scholes-Merton model.

VANGUARD HEALTH SYSTEMS, INC.
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The following table sets forth the weighted average assumptions utilized in the minimum value pricing model for stock option grants under the 2004 Option Plan prior to July 1, 2006 and those utilized in the Black-Scholes-Merton valuation model for grants under the 2004 Option Plan subsequent to July 1, 2006.

	Minimum Value	Black-Scholes Merton
Risk-free interest rate	4.11%-4.95%	3.61%-5.13%
Dividend yield	0.00%	0.00%
Volatility (wtd avg)	N/A	31.12%
Volatility (annual)	N/A	26.39%-37.73%
Expected option life	10 years	6.5 years

For stock options included in the Black-Scholes-Merton valuation model, Vanguard used historical stock price information of certain peer group companies for a period of time equal to the expected option life period to determine estimated volatility. Vanguard determined the expected life of the stock options by averaging the contractual life of the options and the vesting period of the options. The estimated fair value of options is amortized to expense on a straight-line basis over the options' vesting period.

Recently Issued Accounting Pronouncements

In January 2010, the FASB issued Accounting Standard Update ("ASU") 2010-06, an amendment to ASC 820-10, "Fair Value Measurements and Disclosures — Overall," that requires additional disclosures about the different classes of assets and liabilities measured at fair value, the valuation techniques and inputs used, the activity in Level 3 fair value measurements and the transfers between Levels 1, 2 and 3. The new disclosures and clarifications of existing disclosures were effective for Vanguard's quarter ended March 31, 2010, except for the disclosures about the rollforward of activity in Level 3 fair value measurements, which will be required to be adopted by Vanguard for the quarter ended September 30, 2011. Vanguard does not expect the adoption of this standard to have a significant impact on its financial position, results of operations or cash flows.

In September 2009, the FASB issued additional guidance concerning the manner in which fair value of liabilities should be determined. Previous guidance defined the fair value of a liability as the price that would be paid to transfer the liability in an orderly transaction between market participants at the measurement date. The new guidance amends these criteria by specifically addressing valuation techniques, liabilities traded as assets and quoted prices in an active market. The new guidance was effective for Vanguard's quarter ended March 31, 2010. The adoption of this new guidance did not significantly impact Vanguard's financial position, results of operations or cash flows.

3. FAIR VALUE MEASUREMENTS

Fair value is determined using assumptions that market participants would use to determine the price of the asset or liability as opposed to measurements determined based upon information specific to the entity holding those assets and liabilities. To determine those market participant assumptions, Vanguard considered the guidance for fair value measurements and disclosures, the hierarchy of inputs that the entity must consider including both independent market data inputs and the entity's own assumptions about the market participant assumptions. This hierarchy is summarized as follows.

Level 1 Unadjusted quoted prices in active markets for identical assets and liabilities.

Level 2 Directly or indirectly observable inputs, other than quoted prices included in Level 1. Level 2 inputs may include, among others, interest rates and yield curves observable at commonly quoted intervals, volatilities, loss severities, credit risks and other inputs that are derived principally from or corroborated by observable market data by correlation or other means.

Level 3 Unobservable inputs used when there is little, if any, market activity for the asset or liability at the measurement date. These inputs represent the entity's own assumptions about the assumptions that market participants would use to price the asset or liability developed using the best information available.

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Vanguard's policy is to recognize transfers between levels as of the actual date of the event, or change in circumstances, that caused the transfer.

The following table summarizes Vanguard's assets measured at fair value on a recurring basis as of June 30, 2010, aggregated by the fair value hierarchy level within which those measurements were made (in millions).

	Fair Value	Level 1 Inputs	Level 2 Inputs	Level 3 Inputs
Assets:				
Investments in auction rate securities	$ 19.8	$ —	$ —	$ 19.8

The following table provides a reconciliation of the beginning and ending balances for the year ended June 30, 2010 for those fair value measurements using significant Level 3 unobservable inputs (in millions).

	Balance at June 30, 2009	Redemptions	Balance at June 30, 2010
Investments in auction rate securities	$ 21.6	$ 1.8	$ 19.8

There was no significant change in the fair value measurements using significant Level 3 unobservable inputs from June 30, 2009 to June 30, 2010.

Auction Rate Securities

As of June 30, 2010, Vanguard held $19.8 million in total available for sale investments in auction rate securities ("ARS") backed by student loans, which are included in investments in auction rate securities on the accompanying consolidated balance sheets. These ARS are accounted for as long-term available for sale securities. The par value of the ARS was $24.5 million at June 30, 2010. The ARS have maturity dates ranging from 2039 to 2043 and are guaranteed by the U.S. government at approximately 96%-98% of the principal and accrued interest under the Federal Family Education Loan Program or other similar programs. Due to the lack of market liquidity and other observable market inputs for these ARS, Vanguard utilized Level 3 inputs to estimate the $19.8 million fair value of these ARS. Valuations from forced liquidations or distressed sales are inconsistent with the definition of fair value set forth in the pertinent accounting guidance, which assumes an orderly market. For its valuation estimate, management utilized a discounted cash flow analysis that included estimates of the timing of liquidation of these ARS and the impact of market risks on exit value. Vanguard does not currently intend to sell and does not believe it is more likely than not it will be required to sell these ARS prior to liquidity returning to the market and their fair value recovering to par value.

In September 2008, Vanguard received a tender offer for $10.0 million par value of ARS at 94% of par value. As a result of Vanguard's acceptance of the tender offer and the other-than-temporary decline in fair value, Vanguard recorded a $0.6 million realized holding loss on these ARS during the quarter ended September 30, 2008, which is included in other expenses on the accompanying consolidated statement of operations for the year ended June 30, 2009. However, the tender offer contained certain conditions that were not met as of the December 2008 deadline, and the tender failed. As a result of the failed tender and continued lack of immediate marketability, all ARS are presented as long-term assets on the accompanying consolidated balance sheets. Vanguard recorded temporary impairments of $4.1 million ($2.5 million, net of taxes) related to the ARS during the fiscal year ended June 30, 2009, which are included in accumulated other comprehensive loss ("AOCL") on the consolidated balance sheets. In addition, approximately $1.8 million of the ARS were redeemed at par during the fourth quarter of Vanguard's fiscal year ended June 30, 2010.

VANGUARD HEALTH SYSTEMS, INC.
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Interest Rate Swap Agreement

Vanguard enters into derivative instruments from time to time to manage the cash flow risk associated with the variable interest component of its outstanding term debt or to manage the fair value risk of its other debt instruments with fixed interest rates. Vanguard does not hold or issue derivative instruments for trading purposes and is not a party to any instrument with leverage features.

During April 2008, Vanguard entered into an interest rate swap agreement with Bank of America, N.A. (the "counterparty") that went into effect on June 30, 2008 for a notional $450.0 million of its outstanding term debt. Under this agreement and through March 31, 2009, Vanguard made or received net interest payments based upon the difference between the 90-day LIBOR rate and the swap fixed interest rate of 2.785%. Vanguard accounted for this swap as a highly effective cash flow hedge with critical terms that substantially match the underlying term debt and measured any ineffectiveness using the hypothetical derivative method.

In March 2009, Vanguard and the counterparty executed an amended swap agreement with the same terms and provisions as the original agreement except that after March 31, 2009, Vanguard made or received net interest payments based upon the difference between the 30-day LIBOR rate and the swap fixed interest rate of 2.5775%. As a result of this amended swap agreement, Vanguard de-designated its existing cash flow hedge and re-designated the amended swap agreement as a hedge of the remaining interest payments associated with $450.0 million of Vanguard's outstanding term debt. As the forecasted transactions (i.e. the future interest payments under Vanguard's outstanding term debt) were still probable of occurring, Vanguard did not immediately recognize the accumulated other comprehensive loss balance related to the de-designated swap in earnings. Based on its assessment, Vanguard determined that this re-designated swap was highly effective in offsetting the changes in cash flows related to the hedged risk. Vanguard terminated the amended interest rate swap agreement in February 2010 in connection with the Refinancing.

Cash and Cash Equivalents and Restricted Cash

The carrying amounts reported for cash and cash equivalents and restricted cash approximate fair value because of the short-term maturity of these instruments.

Accounts Receivable and Accounts Payable

The carrying amounts reported for accounts receivable and accounts payable approximate fair value because of the short-term maturity of these instruments.

Long-Term Debt

The fair values of the 8.0% Notes and the 2010 term loan facility as of June 30, 2010 were approximately $916.8 million and $797.7 million, respectively, based upon stated market prices. The fair values are subject to change as market conditions change.

4. PREPAID EXPENSES AND OTHER CURRENT ASSETS

Prepaid expenses and other current assets in the accompanying consolidated balance sheets consist of the following at June 30, 2009 and 2010 (in millions):

	2009	2010
Prepaid insurance	$ 6.1	$ 0.4
Prepaid maintenance contracts	7.9	6.4
Other prepaid expenses	8.9	8.8
Third party settlements	2.1	6.6
Reinsurance receivables	1.5	—
Health plan receivables	26.0	81.4
Other receivables	15.9	15.6
	$ 68.4	$ 119.2

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The increase in health plan receivables at June 30, 2010 was primarily the result of AHCCCS' deferral of June capitation and other payments to PHP. Substantially all of these deferred payments were received subsequent to June 30, 2010.

5. IMPAIRMENT OF GOODWILL AND LONG-LIVED ASSETS

Vanguard completed its annual goodwill impairment test during the fourth quarter of fiscal 2010 noting no impairment. However, Vanguard did recognize an impairment loss earlier in fiscal 2010 based upon an interim impairment analysis. During the past three years, Vanguard's two Illinois hospitals have experienced deteriorating economic factors that have negatively impacted their results of operations and cash flows. While various initiatives mitigated the impact of these economic factors during fiscal years 2008 and 2009, the operating results of the Illinois hospitals did not improve to the level anticipated during the first half of fiscal 2010. After having the opportunity to evaluate the operating results of the Illinois hospitals for the first six months of fiscal year 2010 and reassess the market trends and economic factors, Vanguard concluded that it was unlikely that previously projected cash flows for these hospitals would be achieved. Vanguard performed an interim goodwill impairment test during the quarter ended December 31, 2009 and, based upon revised projected cash flows, market participant data and appraisal information, Vanguard determined that the $43.1 million remaining goodwill related to this reporting unit of Vanguard's acute care services segment was impaired. Vanguard recorded the $43.1 million ($31.8 million, net of taxes) non-cash impairment loss during its quarter ended December 31, 2009.

6. GOODWILL AND INTANGIBLE ASSETS

The following table provides information regarding the intangible assets, including deferred loan costs, included on the accompanying consolidated balance sheets as of June 30, 2009 and 2010 (in millions).

	Gross Carrying Amount		Accumulated Amortization	
Class of Intangible Asset	2009	2010	2009	2010
Amortized intangible assets:				
Deferred loan costs	$ 43.9	$ 39.1	$ 21.5	$ 1.9
Contracts	31.4	31.4	14.9	18.0
Physician income and other guarantees	27.3	31.1	18.3	25.0
Other	4.5	8.8	1.0	2.7
Subtotal	107.1	110.4	55.7	47.6
Indefinite-lived intangible assets:				
License and accreditation	3.2	3.2	—	—
Total	$ 110.3	$ 113.6	$ 55.7	$ 47.6

Amortization expense for contract-based intangibles and other intangible assets during the fiscal years ended June 30, 2008, 2009 and 2010 was approximately $3.2 million and $3.6 million and $4.8 million, respectively. Total estimated amortization expense for these intangible assets during the next five years and thereafter is as follows: 2011 — $4.2 million; 2012 — $4.2 million; 2013 — $4.2 million; 2014 — $4.2 million; 2015 - $1.7 million and $1.0 million thereafter.

Amortization of deferred loan costs of $4.9 million, $5.4 million and $5.2 million during the years ended June 30, 2008, 2009 and 2010, respectively, is included in net interest. In connection with the Refinancing, approximately $18.5 million of the previously capitalized deferred loan costs were expensed as debt extinguishment costs and approximately $0.6 million will continue to be amortized under carryover lender provisions. In addition, Vanguard capitalized approximately $38.5 million of deferred loan costs during fiscal 2010 associated with its new debt instruments. Amortization of physician income and other guarantees of $6.7 million, $6.2 million and $6.7 million during the years ended June 30, 2008, 2009 and 2010, respectively, is included in purchased services or other operating expenses.

VANGUARD HEALTH SYSTEMS, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (continued)

During 2010, goodwill increased by $0.1 million related to acquisitions of healthcare entities and decreased by $43.1 million related to the Illinois market impairment recognized. During 2009, goodwill increased by $2.9 million related to acquisitions of healthcare entities. As of June 30, 2010 Vanguard has recognized goodwill impairments of $166.9 million in the aggregate, all of which relate to Vanguard's acute care services segment.

7. OTHER ACCRUED EXPENSES AND CURRENT LIABILITIES

The following table presents summaries of items comprising other accrued expenses and current liabilities in the accompanying consolidated balance sheets as of June 30, 2009 and 2010 (in millions).

	2009	2010
Property taxes	$ 17.0	$ 13.2
Current portion of professional and general liability and workers compensation insurance	34.4	24.0
Accrued income guarantees	3.0	2.6
Interest rate swap payable	6.9	—
Accrued capital expenditures	10.7	21.0
Other	7.5	16.1
	$ 79.5	$ 76.9

8. FINANCING ARRANGEMENTS

A summary of Vanguard's long-term debt as of June 30, 2009 and 2010 follows (in millions).

	2009	2010
9.0% Senior Subordinated Notes	$ 575.0	$ —
11.25% Senior Discount Notes	210.2	—
Term loans payable under credit facility due 2011	766.4	—
8.0% Senior Unsecured Notes	—	937.0
Term loans payable under credit facility due 2016	—	815.0
	1,551.6	1,752.0
Less: current maturities	(8.0)	(8.2)
	$ 1,543.6	$ 1,743.8

8.0% Notes

In connection with the Refinancing on January 29, 2010, two of Vanguard's wholly owned subsidiaries, Vanguard Health Holding Company II, LLC and Vanguard Holding Company II, Inc. (collectively, the "Issuers"), completed a private placement of $950.0 million ($936.3 million cash proceeds) 8% Senior Unsecured Notes due February 1, 2018 ("8.0% Notes"). Interest on the 8.0% Notes is payable semi-annually on August 1 and February 1 of each year. The 8.0% Notes are unsecured general obligations of the Issuers and rank *pari passu* in right of payment to all existing and future senior unsecured indebtedness of the Issuers. The $13.7 million discount is accreted to par over the term of the 8.0% Notes. All payments on the 8.0% Notes are guaranteed jointly and severally on a senior unsecured basis by Vanguard and its domestic subsidiaries, other than those subsidiaries that do not guarantee the obligations of the borrowers under the senior credit facilities.

VANGUARD HEALTH SYSTEMS, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (continued)

On or after February 1, 2014, the Issuers may redeem all or part of the 8.0% Notes at various redemption prices given the date of redemption as set forth in the indenture governing the 8.0% Notes. In addition, the Issuers may redeem up to 35% of the 8.0% Notes prior to February 1, 2013 with the net cash proceeds from certain equity offerings at a price equal to 108% of their principal amount, plus accrued and unpaid interest. The Issuers may also redeem some or all of the 8.0% Notes before February 1, 2014 at a redemption price equal to 100% of the principal amount thereof, plus a "make-whole" premium and accrued and unpaid interest.

On May 7, 2010, the Issuers exchanged substantially all of its outstanding 8.0% Notes for new 8.0% senior unsecured notes with identical terms and conditions, except that the exchange notes were registered under the Securities Act of 1933. Terms and conditions of the exchange offer were set forth in the registration statement on Form S-4 filed with the Securities and Exchange Commission on March 3, 2010, that became effective on April 1, 2010. See Note 19, Subsequent Events, for details related to Vanguard's issuance of an additional $225.0 million of 8.0% Notes subsequent to June 30, 2010.

Credit Facility Debt

In connection with the Refinancing on January 29, 2010, two of Vanguard's wholly owned subsidiaries, Vanguard Health Holding Company II, LLC and Vanguard Holding Company II, Inc. (collectively, the "Co-borrowers"), entered into new senior secured credit facilities (the "2010 credit facilities") with various lenders and Bank of America, N.A. and Barclays Capital as joint book runners, and repaid all amounts outstanding under the previous credit facility. The 2010 credit facilities include a six-year term loan facility (the "2010 term loan facility") in the aggregate principal amount of $815.0 million and a five-year $260.0 million revolving credit facility (the "2010 revolving facility").

In addition, subject to the receipt of commitments by existing lenders or other financial institutions and the satisfaction of certain other conditions, the Co-borrowers may request an incremental term loan facility to be added to the 2010 term loan facility. The Co-borrowers may seek to increase the borrowing availability under the 2010 revolving facility to an amount larger than $260.0 million, subject to the receipt of commitments by existing lenders or other financial institutions for such increased revolving capacity and the satisfaction of other conditions. Vanguard's remaining borrowing capacity under the 2010 revolving facility, net of letters of credit outstanding, was $229.8 million as of June 30, 2010.

The 2010 term loan facility bears interest at a rate equal to, at Vanguard's option, LIBOR (subject to a 1.50% floor) plus 3.50% per annum or a base rate plus 2.50% per annum. The interest rate applicable to the 2010 term loan facility was approximately 5.0% as of June 30, 2010. Vanguard also makes quarterly principal payments equal to one-fourth of one percent of the outstanding principal balance of the 2010 term loan facility and will continue to make such payments until maturity of the term debt.

Any future borrowings under the 2010 revolving facility will bear interest at a rate equal to, at Vanguard's option, LIBOR plus 3.50% per annum or a base rate plus 2.50% per annum, both of which are subject to a decrease of up to 0.25% dependent upon Vanguard's consolidated leverage ratio. Vanguard may utilize the 2010 revolving facility to issue up to $100.0 million of letters of credit ($30.2 million of which were outstanding at June 30, 2010). Vanguard also pays a commitment fee to the lenders under the 2010 revolving facility in respect of unutilized commitments thereunder at a rate equal to 0.50% per annum. Vanguard also pays customary letter of credit fees under this facility. The 2010 credit facilities contain numerous covenants that restrict Vanguard or its subsidiaries from completing certain transactions and also include limitations on capital expenditures, a minimum interest coverage ratio requirement and a maximum leverage ratio requirement. Vanguard was in compliance with each of these debt covenants as of June 30, 2010. Obligations under the credit agreement are unconditionally guaranteed by Vanguard and Vanguard Health Holding Company I, LLC ("VHS Holdco I") and, subject to certain exceptions, each of VHS Holdco I's wholly-owned domestic subsidiaries (the "U.S. Guarantors"). Obligations under the credit agreement are also secured by substantially all of the assets of Vanguard Health Holding Company II, LLC ("VHS Holdco II") and the U.S. Guarantors including a pledge of 100% of the membership interests of VHS Holdco II, 100% of the capital stock of substantially all U.S. Guarantors (other than VHS Holdco I) and 65% of the capital stock of each of VHS Holdco II's non-U.S. subsidiaries that are directly owned by VHS Holdco II or one of the U.S. Guarantors and a security interest in substantially all tangible and intangible assets of VHS Holdco II and each U.S. Guarantor.

VANGUARD HEALTH SYSTEMS, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (continued)

Future Maturities

The aggregate annual principal payments of long-term debt for each of the next five fiscal years and thereafter are as follows: 2011 — $8.2 million; 2012 — $8.1 million; 2013 — $8.1 million, 2014 — $8.1 million; 2015 — $8.1 million and $1,724.4 million thereafter.

Debt Extinguishment Costs

In connection with the Refinancing, Vanguard recorded debt extinguishment costs of $73.5 million ($45.6 million net of taxes). The debt extinguishment costs include $40.2 million of tender/consent fees and call premiums to extinguish the 9.0% Notes and 11.25% Notes, $18.5 million of previously capitalized loan costs, $11.9 million of loan costs incurred related to the new debt instruments that Vanguard expensed in accordance with accounting guidance related to modifications or exchanges of debt instruments for which carryover lenders' cash flows changed by more than 10%, $1.7 million for the interest rate swap settlement payment and $1.2 million of third party costs, all related to the Refinancing.

Other Information

Vanguard conducts substantially all of its business through its subsidiaries. Most of Vanguard's subsidiaries had previously jointly and severally guaranteed the 9.0% Notes on a subordinated basis and currently jointly and severally guarantee the 8.0% Notes. Certain of Vanguard's other consolidated wholly-owned and non wholly-owned entities did not previously guarantee the 9.0% Notes and currently do not guarantee the 8.0% Notes in conformity with the provisions of the indentures governing those notes and do not guarantee the 2010 credit facilities in conformity with the provisions thereof. The condensed consolidating financial information for the parent company, the issuers of the senior notes (both the previous 9.0% Notes and the new 8.0% Notes), the issuers of the senior discount notes (the 11.25% Notes), the subsidiary guarantors, the non-guarantor subsidiaries, certain eliminations and consolidated Vanguard as of June 30, 2009 and 2010 and for the years ended June 30, 2008, 2009 and 2010 follows:

VANGUARD HEALTH SYSTEMS, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (continued)

VANGUARD HEALTH SYSTEMS, INC.
Condensed Consolidating Balance Sheets
June 30, 2009

	Parent	Issuers of Senior Notes and Term Debt	Issuers of Senior Discount Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
ASSETS							
Current assets:							
Cash and cash equivalents	$ —	$ —	$ —	$ 168.3	$ 139.9	$ —	$ 308.2
Restricted cash	—	—	—	0.2	1.7	—	1.9
Accounts receivable, net	—	—	—	257.0	18.3	—	275.3
Inventories	—	—	—	44.5	3.8	—	48.3
Prepaid expenses and other current assets	2.5	—	—	94.9	34.6	(34.0)	98.0
Total current assets	2.5	—	—	564.9	198.3	(34.0)	731.7
Propery, plant and equipment, net	—	—	—	1,114.7	59.4	—	1,174.1
Goodwill	—	—	—	608.5	83.6	—	692.1
Intangible assets, net	—	19.4	2.9	13.5	18.8	—	54.6
Investments in consolidated subsidiaries	608.8	—	—	—	24.5	(633.3)	—
Investments in auction rate securities	—	—	—	—	21.6	—	21.6
Other assets	—	—	—	56.8	0.2	—	57.0
Total assets	$ 611.3	$ 19.4	$ 2.9	$ 2,358.4	$ 406.4	$ (667.3)	$ 2,731.1
LIABILITIES AND EQUITY							
Current liabilities:							
Accounts payable	$ —	$ —	$ —	$ 112.7	$ 15.2	$ —	$ 127.9
Accrued expenses and other current liabilities	—	20.0	—	201.9	122.3	—	344.2
Current maturities of long-term debt	—	8.0	—	(0.2)	0.2	—	8.0
Total current liabilities	—	28.0	—	314.4	137.7	—	480.1
Other liabilities	—	—	—	71.9	73.7	(34.0)	111.6
Long-term debt, less current maturities	—	1,333.4	210.2	—	—	—	1,543.6
Intercompany	15.5	(810.4)	(120.9)	1,314.8	(60.1)	(338.9)	—
Equity	595.8	(531.6)	(86.4)	657.3	255.1	(294.4)	595.8
Total liabilities and equity	$ 611.3	$ 19.4	$ 2.9	$ 2,358.4	$ 406.4	$ (667.3)	$ 2,731.1

VANGUARD HEALTH SYSTEMS, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (continued)

VANGUARD HEALTH SYSTEMS, INC.
Condensed Consolidating Balance Sheets
June 30, 2010

	Parent	Issuers of Senior Notes and Term Debt	Issuers of Senior Discount Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
ASSETS							
Current assets:							
Cash and cash equivalents	$ —	$ —	$ —	$ 198.6	$ 59.0	$ —	$ 257.6
Restricted cash	—	—	—	0.6	1.7	—	2.3
Accounts receivable, net	—	—	—	249.4	21.0	—	270.4
Inventories	—	—	—	46.0	3.6	—	49.6
Prepaid expenses and other current assets	—	—	—	62.5	85.9	(7.3)	141.1
Total current assets	—	—	—	557.1	171.2	(7.3)	721.0
Propery, plant and equipment, net	—	—	—	1,147.3	56.5	—	1,203.8
Goodwill	—	—	—	564.3	84.8	—	649.1
Intangible assets, net	—	37.2	—	14.8	14.0	—	66.0
Investments in consolidated subsidiaries	608.8	—	—	—	—	(608.8)	—
Investments in auction rate securities	—	—	—	—	19.8	—	19.8
Other assets	—	—	—	69.7	0.2	—	69.9
Total assets	$ 608.8	$ 37.2	$ —	$ 2,353.2	$ 346.5	$ (616.1)	$ 2,729.6
LIABILITIES AND EQUITY							
Current liabilities:							
Accounts payable	$ —	$ —	$ —	$ 158.2	$ 36.6	$ —	$ 194.8
Accrued expenses and other current liabilities	—	41.4	—	212.9	158.7	—	413.0
Current maturities of long-term debt	—	8.2	—	(0.2)	0.2	—	8.2
Total current liabilities	—	49.6	—	370.9	195.5	—	616.0
Other liabilities	—	—	—	70.3	52.2	(7.3)	115.2
Long-term debt, less current maturities	—	1,743.8	—	—	—	—	1,743.8
Intercompany	354.2	(1,052.4)	—	1,177.0	(182.0)	(296.8)	—
Total equity (deficit)	254.6	(703.8)	—	735.0	280.8	(312.0)	254.6
Total liabilities and equity	$ 608.8	$ 37.2	$ —	$ 2,353.2	$ 346.5	$ (616.1)	$ 2,729.6

VANGUARD HEALTH SYSTEMS, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (continued)

VANGUARD HEALTH SYSTEMS, INC.
Condensed Consolidating Statements of Operations
For the year ended June 30, 2008

	Parent	Issuers of Senior Notes and Term Debt	Issuers of Senior Discount Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Patient service revenues	$ —	$ —	$ —	$ 2,197.1	$ 150.8	$ (22.5)	$ 2,325.4
Premium revenues	—	—	—	57.7	392.7	(0.2)	450.2
Total revenues	—	—	—	2,254.8	543.5	(22.7)	2,775.6
Salaries and benefits	2.5	—	—	1,062.2	81.5	—	1,146.2
Health plan claims expense	—	—	—	35.8	314.9	(22.5)	328.2
Supplies	—	—	—	405.0	28.7	—	433.7
Provision for doubtful accounts	—	—	—	196.8	8.7	—	205.5
Purchased services	—	—	—	132.6	13.0	—	145.6
Other operating expenses	0.2	—	—	179.8	32.1	(0.2)	211.9
Rents and leases	—	—	—	34.0	7.0	—	41.0
Depreciation and amortization	—	—	—	115.1	14.2	—	129.3
Interest, net	—	109.9	19.8	(9.3)	1.7	—	122.1
Management fees	—	—	—	(8.2)	8.2	—	—
Other	—	—	—	60.5	(54.0)	—	6.5
Total costs and expenses	2.7	109.9	19.8	2,204.3	456.0	(22.7)	2,770.0
Income (loss) from continuing operations before income taxes	(2.7)	(109.9)	(19.8)	50.5	87.5	—	5.6
Income tax benefit (expense)	(2.2)	—	—	—	(13.4)	13.4	(2.2)
Equity in earnings of subsidiaries	4.2	—	—	—	—	(4.2)	—
Income (loss) from continuing operations	(0.7)	(109.9)	(19.8)	50.5	74.1	9.2	3.4
Income (loss) from discontinued operations, net of taxes	—	—	—	2.1	(3.2)	—	(1.1)
Net income (loss)	(0.7)	(109.9)	(19.8)	52.6	70.9	9.2	2.3
Less: Net income attributable to non-controlling interests	—	—	—	(3.0)	—	—	(3.0)
Net income (loss) attributable to Vanguard Health Systems, Inc. stockholders	$ (0.7)	$ (109.9)	$ (19.8)	$ 49.6	$ 70.9	$ 9.2	$ (0.7)

VANGUARD HEALTH SYSTEMS, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (continued)

VANGUARD HEALTH SYSTEMS, INC.
Condensed Consolidating Statements of Operations
For the year ended June 30, 2009

	Parent	Issuers of Senior Notes and Term Debt	Issuers of Senior Discount Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Patient service revenues	$ —	$ —	$ —	$ 2,359.5	$ 171.2	$ (23.3)	$ 2,507.4
Premium revenues	—	—	—	60.2	618.0	(0.2)	678.0
Total revenues	—	—	—	2,419.7	789.2	(23.5)	3,185.4
Salaries and benefits	4.4	—	—	1,138.4	91.0	—	1,233.8
Health plan claims expense	—	—	—	34.8	514.1	(23.3)	525.6
Supplies	—	—	—	422.9	32.6	—	455.5
Provision for doubtful accounts	—	—	—	200.2	10.1	—	210.3
Purchased services	—	—	—	149.1	14.7	—	163.8
Other operating expenses	0.2	—	—	198.8	56.7	(0.2)	255.5
Rents and leases	—	—	—	35.6	7.0	—	42.6
Depreciation and amortization	—	—	—	114.7	14.2	—	128.9
Interest, net	—	93.8	22.1	(6.7)	2.4	—	111.6
Management fees	—	—	—	(14.1)	14.1	—	—
Impairment loss	—	—	—	6.2	—		6.2
Other	—	—	—	2.7	—	—	2.7
Total costs and expenses	4.6	93.8	22.1	2,282.6	756.9	(23.5)	3,136.5
Income (loss) from continuing operations before income taxes	(4.6)	(93.8)	(22.1)	137.1	32.3	—	48.9
Income tax benefit (expense)	(16.8)	—	—	—	(9.4)	9.4	(16.8)
Equity in earnings of subsidiaries	50.0	—	—	—	—	(50.0)	—
Income (loss) from continuing operations	28.6	(93.8)	(22.1)	137.1	22.9	(40.6)	32.1
Income (loss) from discontinued operations, net of taxes	—	—	—	(0.6)	0.3	—	(0.3)
Net income (loss)	28.6	(93.8)	(22.1)	136.5	23.2	(40.6)	31.8
Less: Net income attributable to non-controlling interests	—	—	—	(3.2)	—	—	(3.2)
Net income (loss) attributable to Vanguard Health Systems, Inc. stockholders	$ 28.6	$ (93.8)	$ (22.1)	$ 133.3	$ 23.2	$ (40.6)	$ 28.6

VANGUARD HEALTH SYSTEMS, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (continued)

VANGUARD HEALTH SYSTEMS, INC.
Condensed Consolidating Statements of Operations
For the year ended June 30, 2010

	Parent	Issuers of Senior Notes and Term Debt	Issuers of Senior Discount Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Patient service revenues	$ —	$ —	$ —	$ 2,396.9	$ 183.1	$ (42.8)	$ 2,537.2
Premium revenues	—	—	—	59.5	810.4	(30.2)	839.7
Total revenues	—	—	—	2,456.4	993.5	(73.0)	3,376.9
Salaries and benefits	4.2	—	—	1,194.9	97.1	—	1,296.2
Health plan claims expense	—	—	—	46.3	662.3	(42.8)	665.8
Supplies	—	—	—	421.9	34.2	—	456.1
Provision for doubtful accounts	—	—	—	144.9	7.6	—	152.5
Purchased services	—	—	—	155.4	24.1	—	179.5
Other operating expenses	0.2	—	—	219.0	71.6	(30.2)	260.6
Rents and leases	—	—	—	36.5	7.3	—	43.8
Depreciation and amortization	—	—	—	127.1	12.5	—	139.6
Interest, net	—	104.4	14.7	(7.2)	3.6	—	115.5
Impairment loss	—	—	—	43.1	—		43.1
Debt extinguishment costs	—	67.8	5.7	—	—		73.5
Management fees	—	—	—	(16.9)	16.9	—	—
Other	—	—	—	9.1	—	—	9.1
Total costs and expenses	4.4	172.2	20.4	2,374.1	937.2	(73.0)	3,435.3
Income (loss) from continuing operations before income taxes	(4.4)	(172.2)	(20.4)	82.3	56.3	—	(58.4)
Income tax benefit (expense)	13.8	—	—	—	(20.0)	20.0	13.8
Equity in earnings of subsidiaries	(58.6)	—	—	—	—	58.6	—
Income (loss) from continuing operations	(49.2)	(172.2)	(20.4)	82.3	36.3	78.6	(44.6)
Income (loss) from discontined operations, net of taxes	—	—	—	(1.7)	—	—	(1.7)
Net income (loss)	(49.2)	(172.2)	(20.4)	80.6	36.3	78.6	(46.3)
Less: Net income attributable to non-controlling interests	—	—	—	(2.9)	—	—	(2.9)
Net income (loss) attributable to Vanguard Health Systems, Inc. stockholders	$ (49.2)	$ (172.2)	$ (20.4)	$ 77.7	$ 36.3	$ 78.6	$ (49.2)

VANGUARD HEALTH SYSTEMS, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (continued)

VANGUARD HEALTH SYSTEMS, INC.
Condensed Consolidating Statements of Cash Flows
For the year ended June 30, 2008

	Parent	Issuers of Senior Notes and Term Debt	Issuers of Senior Discount Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Operating activities:							
Net income (loss)	$ (0.7)	$ (109.9)	$ (19.8)	$ 52.1	$ 70.9	$ 9.7	$ 2.3
Adjustments to reconcile net income (loss) to net cash provided by (used in) operating activities							
Loss (income) from discontinued operations, net of taxes	—	—	—	(2.1)	3.2	—	1.1
Depreciation and amortization	—	—	—	115.1	14.2	—	129.3
Provision for doubtful accounts	—	—	—	196.8	8.7	—	205.5
Deferred income taxes	(1.7)	—	—	—	—	—	(1.7)
Amortization of loan costs	—	4.6	0.3	—	—	—	4.9
Accretion of principal on senior discount notes	—	—	19.5	—	—	—	19.5
Loss on disposal of assets	—	—	—	0.9	—	—	0.9
Stock compensation	2.5	—	—	—	—	—	2.5
Changes in operating assets and liabilities, net of effects of acquisitions:							
Equity in earnings of subsidiaries	(3.7)	—	—	—	—	3.7	—
Accounts receivable	—	—	—	(216.5)	(6.1)	—	(222.6)
Inventories	—	—	—	(4.3)	0.2	—	(4.1)
Prepaid expenses and other current assets	(4.5)	—	—	(17.5)	2.4	—	(19.6)
Accounts payable	—	—	—	5.8	6.6	—	12.4
Accrued expenses and other liabilities	4.4	(0.2)	—	76.0	(21.6)	(13.4)	45.2
Net cash provided by (used in) operating activities — continuing operations	(3.7)	(105.5)	—	206.3	78.5	—	175.6
Net cash provided by operating activities — discontinued operations	—	—	—	(0.6)	1.3	—	0.7
Net cash provided by (used in) operating activities	(3.7)	(105.5)	—	205.7	79.8	—	176.3

VANGUARD HEALTH SYSTEMS, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (continued)

VANGUARD HEALTH SYSTEMS, INC.
Condensed Consolidating Statements of Cash Flows
For the year ended June 30, 2008
(continued)

	Parent	Issuers of Senior Notes and Term Debt	Issuers of Senior Discount Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Investing activities:							
Capital expenditures	—	—	—	(116.3)	(3.5)	—	(119.8)
Acquisitions and related expenses	—	—	—	(0.2)	—	—	(0.2)
Proceeds from asset dispositions	—	—	—	—	0.4	—	0.4
Purchases of auction rate securities	—	—	—	—	(90.0)	—	(90.0)
Sales of auction rate securities	—	—	—	—	63.7	—	63.7
Other	—	—	—	—	1.1	—	1.1
Net cash used in investing activities — continuing operations	—	—	—	(116.5)	(28.3)	—	(144.8)
Net cash provided by (used in) investing activities — discontinued operations	—	—	—	1.3	(0.3)	—	1.0
Net cash used in investing activities	—	—	—	(115.2)	(28.6)	—	(143.8)
Financing activities:							
Payments of long-term debt	$ —	$ (7.8)	$ —	$ —	$ —	$ —	$ (7.8)
Repurchases of stock, equity incentive units and stock options	—	—	—	(0.2)	—	—	(0.2)
Cash provided by (used in) intercompany activity	3.7	113.3		(17.0)	(100.0)	—	—
Distributions paid to non-controlling interests and other	—	—	—	(3.0)	—	—	(3.0)
Net cash provided by (used in) financing activities	3.7	105.5	—	(20.2)	(100.0)	—	(11.0)
Net increase (decrease) in cash and cash equivalents	—	—	—	70.3	(48.8)	—	21.5
Cash and cash equivalents, beginning of period	—	—	--	11.7	108.4	—	120.1
Cash and cash equivalents, end of period	$ —	$ —	$ —	$ 82.0	$ 59.6	$ —	$ 141.6

VANGUARD HEALTH SYSTEMS, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (continued)

VANGUARD HEALTH SYSTEMS, INC.
Condensed Consolidating Statements of Cash Flows
For the year ended June 30, 2009

	Parent	Issuers of Senior Notes and Term Debt	Issuers of Senior Discount Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Operating activities:							
Net income (loss)	$ 28.6	$ (93.8)	$ (22.1)	$ 135.7	$ 23.2	$ (39.8)	$ 31.8
Adjustments to reconcile net income (loss) to net cash provided by (used in) operating activities							
Loss (income) from discontinued operations, net of taxes	—	—	—	0.6	(0.3)	—	0.3
Depreciation and amortization	—	—	—	114.7	14.2	—	128.9
Provision for doubtful accounts	—	—	—	200.2	10.1	—	210.3
Deferred income taxes	6.4	—	—	—	—	—	6.4
Amortization of loan costs	—	5.1	0.3	—	—	—	5.4
Accretion of principal on senior discount notes	—	—	21.8	—	—	—	21.8
Gain on disposal of assets	—	—	—	(2.3)	—	—	(2.3)
Stock compensation	4.4	—	—	—	—	—	4.4
Impairment loss	—	—	—	6.2	—	—	6.2
Realized holding loss on investments	—	—	—	—	0.6	—	0.6
Changes in operating assets and liabilities, net of effects of acquisitions:							
Equity in earnings of subsidiaries	(49.2)	—	—	—	—	49.2	—
Accounts receivable	—	—	—	(182.6)	(3.0)	—	(185.6)
Inventories	—	—	—	0.8	0.2	—	1.0
Prepaid expenses and other current assets	—	—	—	7.9	(20.6)	—	(12.7)
Accounts payable	—	—	—	(24.8)	(2.7)	—	(27.5)
Accrued expenses and other liabilities	9.8	6.8	—	32.1	83.4	(9.4)	122.7
Net cash provided by (used in) operating activities — continuing operations	—	(81.9)	—	288.5	105.1	—	311.7
Net cash provided by operating activities — discontinued operations	—	—	—	1.1	0.3	—	1.4
Net cash provided by (used in) operating activities	—	(81.9)	—	289.6	105.4	—	313.1

VANGUARD HEALTH SYSTEMS, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (continued)

VANGUARD HEALTH SYSTEMS, INC.
Condensed Consolidating Statements of Cash Flows
For the year ended June 30, 2009
(Continued)

	Parent	Issuers of Senior Notes and Term Debt	Issuers of Senior Discount Notes	Guarantor Subsidiaries	Combined Non-Gurantors	Eliminations	Total Consolidated
				(In millions)			
Investing activities:							
Capital expenditures	—	—	—	(122.2)	(9.8)	—	(132.0)
Acquisitions and related expenses	—	—		(4.4)	—	—	(4.4)
Proceeds from asset dispositions	—	—	—	4.9	—	—	4.9
Other	—	—	—	(1.7)	(0.3)	—	(2.0)
Net cash used in investing activities — continuing operations	—	—	—	(123.4)	(10.1)	—	(133.5)
Net cash used in investing activities — discontinued operations	—	—	—	(0.1)	—	—	(0.1)
Net cash used in investing activities	—	—	—	(123.5)	(10.1)	—	(133.6)
Financing activities:							
Payments of long-term debt	$ —	$ (7.8)	$ —	$ —	$ —	$ —	$ (7.8)
Repurchases of stock, equity incentive units and stock options		—	—	(0.2)			(0.2)
Cash provided by (used in) intercompany activity	—	89.7	—	(74.7)	(15.0)		—
Distributions paid to non-controlling interests and other	—	—	—	(4.9)	—	—	(4.9)
Net cash provided by (used in) financing activities	—	81.9	—	(79.8)	(15.0)	—	(12.9)
Net decrease in cash and cash equivalents	—	—	—	86.3	80.3	—	166.6
Cash and cash equivalents, beginning of period	—	—	—	82.0	59.6	—	141.6
Cash and cash equivalents, end of period	$ —	$ —	$ —	$ 168.3	$ 139.9	$ —	$ 308.2

VANGUARD HEALTH SYSTEMS, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (continued)

VANGUARD HEALTH SYSTEMS, INC.
Condensed Consolidating Statements of Cash Flows
For the year ended June 30, 2010

	Parent	Issuers of Senior Notes and Term Debt	Issuers of Senior Discount Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Operating activities:							
Net income (loss)	$ (49.2)	$ (172.2)	$ (20.4)	$ 80.6	$ 36.3	$ 78.6	$ (46.3)
Adjustments to reconcile net income (loss) to net cash provided by (used in) operating activities:							
Loss from discontinued operations, net of taxes	—	—	—	1.7	—	—	1.7
Depreciation and amortization	—	—	—	127.1	12.5	—	139.6
Provision for doubtful accounts	—	—	—	144.9	7.6	—	152.5
Deferred income taxes	(8.5)	—	—	—	—	—	(8.5)
Amortization of loan costs	—	4.9	0.3	—	—	—	5.2
Accretion of principal on senior discount notes	—	0.7	5.8	—	—	—	6.5
Debt extinguishment costs	—	67.8	5.7	—	—	—	73.5
Loss on disposal of assets	—	—	—	1.8	—	—	1.8
Stock compensation	4.2	—	—	—	—	—	4.2
Impairment loss	—	—	—	43.1	—	—	43.1
Acquisition related expenses	—	—	—	3.1	—	—	3.1
Changes in operating assets and liabilities, net of effects of acquisitions:							
Equity in earnings of subsidiaries	58.6	—	—	—	—	(58.6)	—
Accounts receivable	—	—	—	(138.0)	(10.3)	—	(148.3)
Inventories	—	—	—	(1.5)	0.2	—	(1.3)
Prepaid expenses and other current assets	—	—	—	(53.7)	(26.8)	—	(80.5)
Accounts payable	—	—	—	45.7	21.4	—	67.1
Accrued expenses and other liabilities	(5.1)	(2.1)	—	115.0	15.0	(20.0)	102.8
Net cash provided by (used in) operating activities — continuing operations	—	(100.9)	(8.6)	369.8	55.9	—	316.2
Net cash used in operating activities — discontinued operations	—	—	—	(1.0)	—	—	(1.0)
Net cash provided by (used in) operating activities	—	(100.9)	(8.6)	368.8	55.9	—	315.2

VANGUARD HEALTH SYSTEMS, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (continued)

VANGUARD HEALTH SYSTEMS, INC.
Condensed Consolidating Statements of Cash Flows
For the year ended June 30, 2010
(Continued)

	Parent	Issuers of Senior Notes and Term Debt	Issuers of Senior Discount Notes	Guarantor Subsidiaries	Combined Non-Gurantors	Eliminations	Total Consolidated
				(In millions)			
Investing activities:							
Capital expenditures	—	—	—	(149.8)	(6.1)	—	(155.9)
Acquisitions and related expenses	—	—		(4.6)	—	—	(4.6)
Proceeds from asset dispositions	—	—	—	2.0	—	—	2.0
Sales of auction rate securities	—	—	—	—	1.8	—	1.8
Other	—	—	—	0.3	—	—	0.3
Net cash used in investing activities — continuing operations	—	—	—	(152.1)	(4.3)	—	(156.4)
Net cash used in investing activities — discontinued operations	—	—	—	(0.1)	—	—	(0.1)
Net cash used in investing activities	—	—	—	(152.2)	(4.3)	—	(156.5)
Financing activities:							
Payments of long-term debt	$ —	$ (1,341.4)	$ (216.0)	$ —	$ —	$ —	$ (1,557.4)
Proceeds from debt borrowings	—	1,751.3	—	—	—	—	1,751.3
Payments of refinancing costs and fees	—	(80.3)	(13.3)	—	—	—	(93.6)
Repurchases of stock, equity incentive units and stock options	(300.6)	—	—	—	—	—	(300.6)
Payments related to derivative instrument with financing element	(6.2)	—	—	—	—	—	(6.2)
Distributions	—	—	—	—	(10.7)	7.9	(2.8)
Cash provided by (used in) intercompany activity	306.8	(228.7)	237.9	(186.3)	(121.8)	(7.9)	—
Net cash provided by (used in) financing activities	—	100.9	8.6	(186.3)	(132.5)	—	(209.3)
Net increase (decrease) in cash and cash equivalents	—	—	—	30.3	(80.9)	—	(50.6)
Cash and cash equivalents, beginning of period	—	—	—	168.3	139.9	—	308.2
Cash and cash equivalents, end of period	$ —	$ —	$ —	$ 198.6	$ 59.0	$ —	$ 257.6

VANGUARD HEALTH SYSTEMS, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (continued)

9. INCOME TAXES

Significant components of the provision for income taxes from continuing operations are as follows (in millions).

	Year ended June 30,		
	2008	2009	2010
Current:			
Federal	$ 1.5	$ 8.2	$ (7.3)
State	2.3	2.2	2.0
Total current	3.8	10.4	(5.3)
Deferred:			
Federal	(0.8)	8.6	(10.0)
State	(8.6)	(0.9)	(2.3)
Total deferred	(9.4)	7.7	(12.3)
Change in valuation allowance	7.8	(1.3)	3.8
Total income tax expense (benefit)	$ 2.2	$ 16.8	$ (13.8)

The following table presents the income taxes associated with continuing operations and discontinued operations as reflected in the accompanying consolidated statements of operations (in millions).

	Year ended June 30,		
	2008	2009	2010
Continuing operations	$ 2.2	$ 16.8	$ (13.8)
Discontinued operations	(0.7)	(0.2)	(1.0)
Total	$ 1.5	$ 16.6	$ (14.8)

The increases in the valuation allowance during all three years presented result from state net operating loss carryforwards that may not ultimately be utilized because of the uncertainty regarding Vanguard's ability to generate taxable income in certain states. The effective income tax rate differed from the federal statutory rate for the periods presented as follows:

	Year ended June 30,		
	2008	2009	2010
Income tax at federal statutory rate	35.0%	35.0%	35.0%
Income tax at state statutory rate	(125.2)	1.0	1.6
Nondeductible expenses and other	10.2	3.3	(1.0)
Book income of consolidated partnerships attributable to non-controlling interests	(18.6)	(2.3)	1.6
Nondeductible impairment loss			(7.2)
Change in valuation allowance	137.9	(2.6)	(6.4)
Effective income tax rate	39.3%	34.4%	23.6%

VANGUARD HEALTH SYSTEMS, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (continued)

Deferred income taxes reflect the net tax effects of temporary differences between the carrying amounts of assets and liabilities for financial reporting purposes and the amounts used for income tax purposes. Significant components of Vanguard's deferred tax assets and liabilities as of June 30, 2009 and 2010, were as follows (in millions):

	2009	2010
Deferred tax assets:		
Net operating loss carryover	$ 33.7	$ 82.6
Excess tax basis over book basis of accounts receivable	10.2	3.8
Accrued expenses and other	42.2	47.1
Deferred loan costs	1.4	5.6
Professional and general liability reserves	21.6	30.6
Health plan claims, workers compensation and employee health reserves	13.7	14.1
Alternative minimum tax credit and other credits	—	4.1
Deferred interest expense	30.9	—
Total deferred tax assets	153.7	187.9
Valuation allowance	(28.6)	(32.4)
Total deferred tax assets, net of valuation allowance	125.1	155.5
Deferred tax liabilities:		
Depreciation, amortization and fixed assets basis differences	33.1	59.7
Exces book basis over tax basis of prepaid assets and other	24.4	23.9
Total deferred tax liabilities	57.5	83.6
Net deferred tax assets	$ 67.6	$ 71.9

As of June 30, 2010, Vanguard had generated net operating loss ("NOL") carryforwards for federal income tax and state income tax purposes of approximately $139.0 million and $658.0 million, respectively. The significant increase in the federal income tax NOL carryforward from $9.0 million as of June 30, 2009 to $139.0 million as of June 30, 2010 resulted from a tax method accounting change that was filed for the year ended June 30, 2009, as well as costs associated with the Refinancing during fiscal year 2010. The federal and state NOL carryforwards expire from 2020 to 2030 and 2011 to 2030, respectively. Approximately $2.2 million of these NOLs are subject to annual limitations for federal purposes. These limitations are not expected to significantly affect Vanguard's ability to ultimately recognize the benefit of these NOLs in future years.

Accounting for Uncertainty in Income Taxes

Effective July 1, 2007, Vanguard adopted the provisions of guidance for uncertain tax positions. As required by this guidance, Vanguard recorded a $4.9 million gross liability for unrecognized tax benefits, accrued interest and penalties. The table below summarizes the total changes in unrecognized tax benefits during the years ended June 30, 2008, 2009 and 2010 (in millions).

Balance at July 1, 2007	$ 4.9
Additions based on tax positions related to the current year	—
Additions for tax positions of prior years	0.4
Reductions for tax positions of prior years	—
Settlements	—
Balance at June 30, 2008	5.3
Additions based on tax positions related to the current year	—
Additions for tax positions of prior years	—
Reductions for tax positions of prior years	(0.3)
Settlements	—
Balance at June 30, 2009	5.0
Additions based on tax positions related to the current year	0.8
Additions for tax positions of prior years	6.1
Reductions for tax positions of prior years	—
Settlements	—
Balance at June 30, 2010	$ 11.9

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VANGUARD HEALTH SYSTEMS, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (continued)

Of the $11.9 million total unrecognized tax benefits, $0.6 million of the balance as of June 30, 2010 of unrecognized tax benefits would impact the effective tax rate if recognized.

The provisions of the guidance for uncertain tax positions allow for the classification of interest on an underpayment of income taxes, when the tax law required interest to be paid, and penalties, when a tax position does not meet the minimum statutory threshold to avoid payment of penalties, in income taxes, interest expense or another appropriate expense classification based on the accounting policy election of the company. Vanguard has elected to classify interest and penalties related to the unrecognized tax benefits as a component of income tax expense. During the years ended June 30, 2008, 2009 and 2010, Vanguard recognized approximately $20,000, $40,000 and $60,000, respectively, of such interest and penalties.

Vanguard's U.S. federal income tax returns for tax years 2005 and beyond remain subject to examination by the Internal Revenue Service.

10. STOCKHOLDERS' EQUITY

Vanguard has the authority to issue 1,000,000 shares of common stock, par value $.01 per share.

Common Stock of Vanguard and Class A Membership Units of Holdings

In connection with the Blackstone merger, Blackstone, Morgan Stanley Capital Partners and its affiliates (collectively, "MSCP"), management and other investors purchased $624.0 million of Class A Membership Units of Holdings. Holdings then invested the $624.0 million in the common stock of Vanguard, and in addition Blackstone invested $125.0 million directly in the common stock of Vanguard. In February 2005, other investors purchased approximately $0.6 million of Class A membership units of Holdings. Holdings then invested the $0.6 million in the common stock of Vanguard.

Equity Incentive Membership Units of Holdings

In connection with the Blackstone merger, certain members of senior management purchased Class B, Class C and Class D membership units in Holdings (collectively the "equity incentive units") for approximately $5.7 million pursuant to the Amended and Restated Limited Liability Company Operating Agreement of Holdings dated September 23, 2004 ("LLC Agreement"). Vanguard determined the value of the equity incentive units by utilizing appraisal information. The Class B and D units vest 20% on each of the first five anniversaries of the purchase date, while the Class C units vest on the eighth anniversary of the purchase date subject to accelerated vesting upon the occurrence of a sale by Blackstone of at least 25% of its Class A units at a price per unit exceeding 2.5 times the per unit price paid on September 23, 2004. Upon a change of control (as defined in the LLC Agreement), all Class B and D units fully vest, and Class C units fully vest if the change in control constitutes a liquidity event (as defined in the LLC Agreement). In exchange for a cash payment of $5.7 million, Vanguard issued to Holdings 83,890 warrants with an exercise price of $1,000 per share and 35,952 warrants with an exercise price of $3,000 per share to purchase Vanguard's common stock. The exercise prices of the warrants were reduced by $400.47 in connection with the Refinancing transactions discussed below. The warrants may be exercised at any time. Vanguard reserved 119,842 shares of its common stock to be issued upon exercise of the warrants.

During previous fiscal years, Vanguard and Holdings repurchased a total of 7,491 outstanding equity incentive units from former executive officers for approximately $0.4 million. The purchase price for unvested units was based upon the lower of cost or fair market value (determined by an independent appraisal) or the lower of cost or fair market value less a 25% discount, as set forth in the LLC Agreement. The purchase price for vested units was fair market value or fair market value less a 25% discount.

VANGUARD HEALTH SYSTEMS, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (continued)

Put and Call Features of Acquisition Subsidiary Stock

For a period of 30 days commencing June 1, 2007 and each June 1 thereafter, University of Chicago Hospitals ("UCH") has the right to require Vanguard to purchase its shares in the subsidiary that acquired Louis A. Weiss Memorial Hospital for a purchase price equal to four times the acquisition subsidiary's Adjusted EBITDA (as defined in the shareholders agreement between the parties) for the most recent 12 months of operations less all indebtedness of the acquisition subsidiary (including capital leases) at such time, multiplied by UCH's percentage interest in the acquisition subsidiary on the date of purchase. Similarly, during the same 30-day periods, Vanguard has the right to require UCH to sell to it UCH's shares in the acquisition subsidiary for a purchase price equal to the greater of (i) six times the acquisition subsidiary's Adjusted EBITDA (as defined in the shareholders agreement among the parties) for the most recent 12 months of operations less all indebtedness of the acquisition subsidiary (including capital leases) at such time, times UCH's percentage interest in the acquisition subsidiary on the date of purchase, and (ii) the price paid by UCH for its interest in the acquisition subsidiary minus dividends or other distributions to UCH in respect of that interest.

Refinancing Transactions

In January 2010, Vanguard's Board of Directors authorized and Vanguard completed the repurchase of 446 shares held by certain former employees and 242,213 shares of outstanding common stock held by the remaining shareholders through privately negotiated transactions for $300 6 million as part of the Refinancing. Subsequent to the $300 6 million share repurchase, Vanguard completed a 1.4778 for one split that effectively returned the share ownership for each stockholder that participated in the repurchase (other than the holders of the 446 shares) to the same level as that in effect immediately prior to the repurchase. As required by the 2004 Option Plan, Vanguard reduced the exercise price for each class of outstanding options by $400.47, the per share equivalent of the 242,213 share repurchase discussed above, in order to keep the potential ownership position of the option holders equitable subsequent to such share repurchases and common share stock split. The exercise price modification for option holders did not result in the recognition of additional compensation expense to Vanguard.

11. COMPREHENSIVE INCOME (LOSS)

Comprehensive income (loss) consists of two components: net income (loss) attributable to Vanguard Health Systems, Inc. stockholders and other comprehensive income (loss). Other comprehensive income (loss) refers to revenues, expenses, gains and losses that under the guidance related to accounting for comprehensive income are recorded as elements of equity but are excluded from net income (loss) attributable to Vanguard Health Systems, Inc. stockholders. The following table presents the components of comprehensive income (loss), net of taxes, for the years ended June 30, 2008, 2009 and 2010 (in millions).

	Year ended June 30,		
	2008	2009	2010
Net income (loss) attributable to Vanguard Health Systems, Inc. stockholders	$ (0.7)	$ 28.6	$ (49.2)
Change in fair value of interest rate swap	4.6	(11.5)	5.2
Change in unrealized holding losses on ARS	—	(4.1)	—
Change in income tax (expense) benefit	(1.8)	6.0	(2.6)
Termination of interest rate swap reclassification adjustment, net of taxes			1.7
Net income attributabe to non-controlling interests	3.0	3.2	2.9
Comprehensive income (loss)	$ 5.1	$ 22.2	$ (42.0)

VANGUARD HEALTH SYSTEMS, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (continued)

The components of accumulated other comprehensive loss, net of taxes, as of June 30, 2009 and 2010 are as follows (in millions):

	June 30, 2009	June 30, 2010
Fair value of interest rate swap	$ (6.9)	$ —
Unrealized holding loss on investments in auction rate securities	(4.1)	(4.1)
Income tax benefit	4.2	1.6
Accumulated other comprehensive loss	$ (6.8)	$ (2.5)

12. STOCK BASED COMPENSATION

As previously discussed, Vanguard used the minimum value pricing model to determine stock compensation costs related to stock option grants prior to July 1, 2006. On July 1, 2006, Vanguard recorded stock compensation using the Black-Scholes-Merton model. During fiscal years 2008, 2009 and 2010, Vanguard incurred stock compensation of $2.5 million and $4.4 million and $4.2 million, respectively, related to grants under its 2004 Stock Incentive Plan.

2004 Stock Incentive Plan

After the Blackstone merger, Vanguard adopted the 2004 Stock Incentive Plan ("the 2004 Option Plan"). As of June 30, 2010, the 2004 Option Plan, as amended, allows for the issuance of up to 145,611 options to purchase common stock of Vanguard to its employees, members of its Board of Directors or other service providers of Vanguard or any of its affiliates. The stock options may be granted as Liquidity Event Options, Time Options or Performance Options at the discretion of the Board. The Liquidity Event Options vest 100% at the eighth anniversary of the date of grant and have an exercise price per share as determined by the Board or a committee thereof. The Time Options vest 20% at each of the first five anniversaries of the date of grant and have an exercise price per share as determined by the Board or a committee thereof. The Performance Options vest 20% at each of the first five anniversaries of the date of grant and have an exercise price equal to $2,599.53 per share or as determined by the Board. The Time Options and Performance Options immediately vest upon a change of control, while the Liquidity Event Options immediately vest only upon a qualifying Liquidity Event, as defined in the Plan Document. As of June 30, 2010, 113,133 options were outstanding under the 2004 Option Plan, as amended.

The following tables summarize options transactions during the year ended June 30, 2010.

	2004 Stock Incentive Plan	
	# of Options	Wtd Avg Exercise Price
Options outstanding at June 30, 2009	102,455	$ 1,242.57
Options granted	14,296	1,240.42
Options exercised	—	—
Options cancelled	(3,618)	1,266.38
Options outstanding at June 30, 2010	113,133	$ 1,241.53
Options available for grant at June 30, 2010	31,974	$ 1,334.61
Options exercisable at June 30, 2010	39,732	$ 1,557.55

VANGUARD HEALTH SYSTEMS, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (continued)

The following table provides information relating to the 2004 Option Plan during each period presented.

	Year ended June 30,		
	2008	2009	2010
Weighted average fair value of options granted during each year	$ 408.6	$ 315.2	$ 342.3
Intrinsic value of options exercised during each year (in millions)	$ 0.1	$ —	$ —
Fair value of outstanding options that vested during each year (in millions)	$ 1.2	$ 1.6	$ 2.6

The following table sets forth certain information regarding vested options at June 30, 2010, options expected to vest subsequent to June 30, 2010 and total options expected to vest over the life of all options granted.

	Currently Vested	Additional Expected to Vest	Total Expected to Vest
Number of options at June 30, 2010	39,732	54,697	94,429
Weighted average exercise price	$ 1,557.55	$ 1,052.36	$ 1,264.92
Aggregate compensation cost at June 30, 2010 (in millions)	$ 8.5	$ 18.8	$ 27.3
Weighted average remaining contractual term	5.7 years	7.2 years	6.7 years

13. DEFINED CONTRIBUTION PLAN

Effective June 1, 1998, Vanguard adopted its defined contribution employee benefit plan, the Vanguard 401(k) Retirement Savings Plan (the "401(k) Plan"). The 401(k) Plan is a multiple employer defined contribution plan whereby employees who are age 21 or older are eligible to participate.

The 401(k) Plan allows eligible employees to make contributions of 2% to 20% of their annual compensation. Employer matching contributions, which vary by employer, vest 20% after two years of service and continue vesting at 20% per year until fully vested. For purposes of determining vesting percentages in the 401(k) Plan, many employees received credit for years of service with their respective predecessor companies. Vanguard's matching expense, including matching expense for discontinued operations, for the years ended June 30, 2008, 2009 and 2010 was approximately $14.5 million, $15.7 million and $17.7 million, respectively.

14. LEASES

Vanguard leases certain real estate properties and equipment under operating leases having various expiration dates. Future minimum operating lease payments under non-cancelable leases for each fiscal year presented below are approximately as follows (in millions).

	Operating Leases
2011	$ 30.1
2012	25.6
2013	21.8
2014	18.7
2015	14.7
Thereafter	30.7
	$ 141.6

During the years ended June 30, 2008, 2009 and 2010, rent expense was approximately $41.0 million, $42.6 million and $43.8 million, respectively.

VANGUARD HEALTH SYSTEMS, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (continued)

15. CONTINGENCIES AND HEALTHCARE REGULATION

Contingencies

Vanguard is presently, and from time to time, subject to various claims and lawsuits arising in the normal course of business. In the opinion of management, the ultimate resolution of these matters is not expected to have a material adverse effect on Vanguard's financial position or results of operations.

Professional and General Liability Insurance

Given the nature of its operating environment, Vanguard is subject to professional and general liability claims and related lawsuits in the ordinary course of business. Vanguard maintains professional and general liability insurance with unrelated commercial insurance carriers to provide for losses up to $65.0 million in excess of its self-insured retention (such self-insured retention maintained through Vanguard's captive insurance subsidiary and/or another of its subsidiaries) of $10.0 million through June 30, 2010 but increased to $15.0 million for its Illinois hospitals subsequent to June 30, 2010. In April 2009, a jury awarded damages to the plaintiff in a professional liability case against one of Vanguard's hospitals in the amount of approximately $14.9 million, which exceeded Vanguard's captive subsidiary's $10.0 million self insured limit. Based upon this verdict, Vanguard increased its professional and general liability reserve for the year ended June 30, 2009, by the excess of the verdict amount over its previously established case reserve estimate and recorded a reinsurance receivable for that portion exceeding $10.0 million. Vanguard settled this claim and paid the settlement amount in March 2010 and received payment for its reinsurance receivable in June 2010.

Governmental Regulation

Laws and regulations governing the Medicare, Medicaid and other federal healthcare programs are complex and subject to interpretation. Vanguard's management believes that it is in compliance with all applicable laws and regulations in all material respects. However, compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties, and exclusion from the Medicare, Medicaid and other federal healthcare programs. Vanguard is not aware of any material regulatory proceeding or investigation underway or threatened involving allegations of potential wrongdoing.

Reimbursement

Final determination of amounts earned under prospective payment and cost-reimbursement activities is subject to review by appropriate governmental authorities or their agents. In the opinion of Vanguard's management, adequate provision has been made for any adjustments that may result from such reviews.

Laws and regulations governing the Medicare and Medicaid and other federal healthcare programs are complex and subject to interpretation. Vanguard's management believes that it is in compliance with all applicable laws and regulations in all material respects and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing related to Medicare and Medicaid programs. While no such regulatory inquiries have been made, Vanguard's compliance with such laws and regulations is subject to future government review and interpretation. Non-compliance with such laws and regulations could result in significant regulatory action including fines, penalties, and exclusion from the Medicare, Medicaid and other federal healthcare programs.

Acquisitions

Vanguard has acquired and expects to continue to acquire businesses with prior operating histories. Acquired companies may have unknown or contingent liabilities, including liabilities for failure to comply with healthcare laws and regulations, such as billing and reimbursement, fraud and abuse and similar anti-referral laws. Although Vanguard institutes policies designed to conform practices to its standards following the completion of its acquisitions, there can be no assurance that it will not become liable for past activities of prior owners that may later be asserted to be improper by private plaintiffs or government agencies. Although Vanguard generally seeks to obtain indemnification from prospective sellers covering such matters, there can be no assurance that any such matter will be covered by indemnification, or if covered, that such indemnification will be adequate to cover potential losses and fines.

VANGUARD HEALTH SYSTEMS, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (continued)

Employment-Related Agreements

Effective June 1, 1998, Vanguard executed employment agreements with three of its current senior executive officers. Vanguard executed an employment agreement with a fourth current senior executive officer on September 1, 1999. The employment agreements were amended on September 23, 2004 to extend the term of each employment agreement another 5 years and to provide that the Blackstone merger did not constitute a change of control, as defined in the agreements. From November 15, 2007 to December 31, 2008, Vanguard entered into written employment agreements with four other executive officers for terms expiring five years from the agreement date. The employment agreements will renew automatically for additional one-year periods, unless terminated by Vanguard or the executive officer. The employment agreements provide, among other things, for minimum salary levels, for participation in bonus plans, and for amounts to be paid as liquidated damages in the event of a change in control or termination by Vanguard without cause.

Vanguard has executed severance protection agreements ("severance agreements") between Vanguard and each of its other officers who do not have employment agreements. The severance agreements are automatically extended for successive one year terms at the discretion of Vanguard unless a change in control occurs, as defined in the severance agreement, at which time the severance agreement continues in effect for a period of not less than three years beyond the date of such event. Vanguard may be obligated to pay severance payments as set forth in the severance agreements in the event of a change in control and the termination of the executive's employment of Vanguard.

Guarantees

Physician Guarantees

In the normal course of its business, Vanguard enters into physician relocation agreements under which it guarantees minimum monthly income, revenues or collections or guarantees reimbursement of expenses up to maximum limits to physicians during a specified period of time (typically, 12 months to 24 months). In return for the guarantee payments, the physicians are required to practice in the community for a stated period of time (typically, 3 to 4 years) or else return the guarantee payments to Vanguard. Vanguard records a liability at fair value for all guarantees entered into on or after January 1, 2006. Vanguard determines this liability and an offsetting intangible asset by calculating an estimate of expected payments to be made over the guarantee period. Vanguard reduces the liability as it makes guarantee payments and amortizes the intangible asset over the term of the physicians' relocation agreements. Vanguard also estimates the fair value of liabilities and offsetting intangible assets related to payment guarantees for physician service agreements for which no repayment provisions exist. As of June 30, 2010, Vanguard had a net intangible asset of $5.5 million and a remaining liability of $2.6 million related to these physician income and service guarantees. The maximum amount of Vanguard's unpaid physician income and service guarantees as of June 30, 2010 was approximately $2.6 million.

Other Guarantees

As part of its contract with the AHCCCS, one of Vanguard's health plans, PHP, is required to maintain a performance guarantee, the amount of which is based upon PHP's membership and capitation premiums received. As of June 30, 2010, Vanguard maintained this performance guarantee in the form of $50.0 million of surety bonds with independent third party insurers collateralized by letters of credit of approximately $5.0 million. These surety bonds expire on September 30, 2010.

VANGUARD HEALTH SYSTEMS, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (continued)

16. RELATED PARTY TRANSACTIONS

Pursuant to the Blackstone merger agreement, Vanguard entered into a transaction and monitoring fee agreement with Blackstone and Metalmark Subadvisor LLC ("Metalmark SA"), which is an affiliate of Metalmark Capital LLC, which has shared voting or investment power in Holdings' units owned by the MSCP Funds. Under the terms of the agreement, Vanguard agreed to pay Blackstone an annual monitoring fee of $4.0 million and to pay Metalmark SA an annual monitoring fee of $1.2 million for the first five years and $0.6 million annually thereafter plus out of pocket expenses. The monitoring fee represents compensation to Blackstone and Metalmark SA for their advisory and consulting services with respect to financing transactions, strategic decisions, dispositions or acquisitions of assets and other Vanguard affairs from time to time. Blackstone also has the option under the agreement to elect at any time in anticipation of a change in control or initial public offering to require Vanguard to pay both Blackstone and Metalmark SA a lump sum monitoring fee, calculated as the net present value of future annual monitoring fees assuming a remaining ten-year payment period, in lieu of the remaining annual monitoring fee payments. If Blackstone chooses a lump sum payment, Metalmark SA is entitled to receive not less than 15% of the sum of the initial $20.0 million Blackstone transaction fee and the cumulative monitoring fees and lump sum monitoring fee paid to Blackstone less the cumulative aggregate monitoring fees paid to Metalmark SA to date. During fiscal 2008, Vanguard paid approximately $5.2 million and $1.2 million in monitoring fees and expenses to Blackstone and Metalmark SA, respectively. During the year ended 2009, Vanguard paid $4.0 million and $1.2 million in monitoring fees and expenses to Blackstone and Metalmark SA, respectively. During fiscal year 2010, Vanguard paid $4.4 million and $0.7 million in monitoring fees and expenses to Blackstone and Metalmark SA, respectively.

Blackstone and Metalmark SA have the ability to control Vanguard's policies and operations, and their interests may not in all cases be aligned with Vanguard's interests. Vanguard also conducts business with other entities controlled by Blackstone or Metalmark SA. Vanguard's results of operations could be materially different as a result of Blackstone and Metalmark SA's control than such results would be if Vanguard were autonomous.

Effective July 1, 2008, Vanguard entered into an Employer Health Program Agreement with Equity Healthcare LLC ("Equity Healthcare"), which is an affiliate of Blackstone. Equity Healthcare negotiates with providers of standard administrative services for health benefit plans as well as other related services for cost discounts and quality of service monitoring capability by Equity Healthcare. Equity Healthcare receives from Vanguard a fee of $2 per employee per month ("PEPM Fee"). As of June 30, 2010, Vanguard has approximately 12,350 employees enrolled in these health and welfare benefit plans.

17. SEGMENT INFORMATION

Vanguard's acute care hospitals and related healthcare businesses are similar in their activities and the economic environments in which they operate (i.e. urban markets). Accordingly, Vanguard's reportable operating segments consist of 1) acute care hospitals and related healthcare businesses, collectively, and 2) health plans consisting of MHP, a contracting entity for outpatient services provided by MacNeal Hospital and Weiss Memorial Hospital and participating physicians in the Chicago area, PHP, a Medicaid managed health plan operating in Arizona, and AAHP, a Medicare and Medicaid dual eligible managed health plan operating in Arizona. The following tables provide unaudited condensed financial information by operating segment for the years ended June 30, 2008, 2009 and 2010, including a reconciliation of Segment EBITDA to income (loss) from continuing operations before income taxes (in millions):

VANGUARD HEALTH SYSTEMS, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (continued)

	Year ended June 30, 2008			
	Acute Care Services	Health Plans	Eliminations	Consolidated
Patient service revenues (1)	$ 2,325.4	$ —	$ —	$ 2,325.4
Premium revenues	—	450.2	—	450.2
Inter-segment revenues	31.2	—	(31.2)	—
Total revenues	2,356.6	450.2	(31.2)	2,775.6
Salaries and benefits (excludes stock compensation)	1,127.7	16.0	—	1,143.7
Health plan claims expense (1)	—	328.2	—	328.2
Supplies	433.5	0.2	—	433.7
Provision for doubtful accounts	205.5	—	—	205.5
Other operating expenses-external	368.6	29.9	—	398.5
Operating expenses-intersegment	—	31.2	(31.2)	—
Total operating expenses	2,135.3	405.5	(31.2)	2,509.6
Segment EBITDA (2)	221.3	44.7	—	266.0
Less:				
Interest, net	126.6	(4.5)	—	122.1
Depreciation and amortization	125.1	4.2	—	129.3
Equity method income	(0.7)	—	—	(0.7)
Stock compensation	2.5	—	—	2.5
Loss on disposal of assets	0.8	—	—	0.8
Monitoring fees and expenses	6.4	—	—	6.4
Income from continuing operations before income taxes	$ (39.4)	$ 45.0	$ —	$ 5.6
Segment assets	$ 2,400.8	$ 181.5	$ —	$ 2,582.3
Capital expenditures	$ 119.2	$ 0.6	$ —	$ 119.8

(1) Vanguard eliminates in consolidation those patient service revenues earned by its healthcare facilities attributable to services provided to members in its owned health plans and eliminates the corresponding medical claims expenses incurred by the health plans for those services.

(2) Segment EBITDA is defined as income (loss) from continuing operations before income taxes less interest expense (net of interest income), depreciation and amortization, equity method income, stock compensation, gain or loss on disposal of assets, realized holding losses on investments, monitoring fees and expenses, acquisition related expenses, debt extinguishment costs, and impairment losses. Management uses Segment EBITDA to measure performance for Vanguard's segments and to develop strategic objectives and operating plans for those segments. Segment EBITDA eliminates the uneven effect of non-cash depreciation of tangible assets and amortization of intangible assets, much of which results from acquisitions accounted for under the purchase method of accounting. Segment EBITDA also eliminates the effects of changes in interest rates which management believes relate to general trends in global capital markets, but are not necessarily indicative of the operating performance of Vanguard's segments. Management believes that Segment EBITDA provides useful information about the financial performance of Vanguard's segments to investors, lenders, financial analysts and rating agencies. Additionally, management believes that investors and lenders view Segment EBITDA as an important factor in making investment decisions and assessing the value of Vanguard. Segment EBITDA is not a substitute for net income (loss), operating cash flows or other cash flow statement data determined in accordance with accounting principles generally accepted in the United States. Segment EBITDA, as presented, may not be comparable to similar measures of other companies.

VANGUARD HEALTH SYSTEMS, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (continued)

	Year ended June 30, 2009			
	Acute Care Services	Health Plans	Eliminations	Consolidated
Patient service revenues (1)	$ 2,507.4	$ —	$ —	$ 2,507.4
Premium revenues	—	678.0	—	678.0
Inter-segment revenues	34.0	—	(34.0)	—
Total revenues	2,541.4	678.0	(34.0)	3,185.4
Salaries and benefits (excludes stock compensation)	1,198.8	30.6	—	1,229.4
Health plan claims expense (1)	—	525.6	—	525.6
Supplies	455.2	0.3	—	455.5
Provision for doubtful accounts	210.3	—	—	210.3
Other operating expenses-external	425.5	36.4	—	461.9
Operating expenses-intersegment	—	34.0	(34.0)	—
Total operating expenses	2,289.8	626.9	(34.0)	2,882.7
Segment EBITDA (2)	251.6	51.1	—	302.7
Less:				
Interest, net	112.2	(0.6)	—	111.6
Depreciation and amortization	124.8	4.1	—	128.9
Equity method income	(0.8)	—	—	(0.8)
Stock compensation	4.4	—	—	4.4
Gain on disposal of assets	(2.3)	—	—	(2.3)
Monitoring fees and expenses	5.2	—	—	5.2
Realized loss on investments	0.6	—	—	0.6
Impairment loss	6.2	—	—	6.2
Income from continuing operations before income taxes	$ 1.3	$ 47.6	$ —	$ 48.9
Segment assets	$ 2,480.8	$ 250.3	$ —	$ 2,731.1
Capital expenditures	$ 130.3	$ 1.7	$ —	$ 132.0

(1) Vanguard eliminates in consolidation those patient service revenues earned by its healthcare facilities attributable to services provided to members in its owned health plans and eliminates the corresponding medical claims expenses incurred by the health plans for those services.

(2) Segment EBITDA is defined as income (loss) from continuing operations before income taxes less interest expense (net of interest income), depreciation and amortization, equity method income, stock compensation, gain or loss on disposal of assets, realized holding losses on investments, monitoring fees and expenses, acquisition related expenses, debt extinguishment costs and impairment losses. Management uses Segment EBITDA to measure performance for Vanguard's segments and to develop strategic objectives and operating plans for those segments. Segment EBITDA eliminates the uneven effect of non-cash depreciation of tangible assets and amortization of intangible assets, much of which results from acquisitions accounted for under the purchase method of accounting. Segment EBITDA also eliminates the effects of changes in interest rates which management believes relate to general trends in global capital markets, but are not necessarily indicative of the operating performance of Vanguard's segments. Management believes that Segment EBITDA provides useful information about the financial performance of Vanguard's segments to investors, lenders, financial analysts and rating agencies. Additionally, management believes that investors and lenders view Segment EBITDA as an important factor in making investment decisions and assessing the value of Vanguard. Segment EBITDA is not a substitute for net income (loss), operating cash flows or other cash flow statement data determined in accordance with accounting principles generally accepted in the United States. Segment EBITDA, as presented, may not be comparable to similar measures of other companies.

VANGUARD HEALTH SYSTEMS, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (continued)

	Year ended June 30, 2010			
	Acute Care Services	Health Plans	Eliminations	Consolidated
Patient service revenues (1)	$ 2,537.2	$ —	$ —	$ 2,537.2
Premium revenues	—	839.7	—	839.7
Inter-segment revenues	42.8	—	(42.8)	—
Total revenues	2,580.0	839.7	(42.8)	3,376.9
Salaries and benefits (excludes stock compensation)	1,257.9	34.1	—	1,292.0
Health plan claims expense (1)	—	665.8	—	665.8
Supplies	456.0	0.1	—	456.1
Provision for doubtful accounts	152.5	—	—	152.5
Other operating expenses-external	447.0	36.9	—	483.9
Operating expenses-intersegment	—	42.8	(42.8)	—
Total operating expenses	2,313.4	779.7	(42.8)	3,050.3
Segment EBITDA (2)	266.6	60.0	—	326.6
Less:				
Interest, net	116.5	(1.0)	—	115.5
Depreciation and amortization	135.2	4.4	—	139.6
Equity method income	(0.9)	—	—	(0.9)
Stock compensation	4.2	—	—	4.2
Loss on disposal of assets	1.8	—	—	1.8
Monitoring fees and expenses	5.1	—	—	5.1
Acquisition related expenses	3.1	—	—	3.1
Debt extinguishment costs	73.5	—	—	73.5
Impairment loss	43.1	—	—	43.1
Income (loss) from continuing operations before income taxes	$ (115.0)	$ 56.6	$ —	$ (58.4)
Segment assets	$ 2,503.6	$ 226.0	$ —	$ 2,729.6
Capital expenditures	$ 154.8	$ 1.1	$ —	$ 155.9

(1) Vanguard eliminates in consolidation those patient service revenues earned by its healthcare facilities attributable to services provided to members in its owned health plans and eliminates the corresponding medical claims expenses incurred by the health plans for those services.

(2) Segment EBITDA is defined as income (loss) from continuing operations before income taxes less interest expense (net of interest income), depreciation and amortization, equity method income, stock compensation, gain or loss on disposal of assets, realized holding losses on investments, monitoring fees and expenses, acquisition related expenses, debt extinguishment costs and impairment losses. Management uses Segment EBITDA to measure performance for Vanguard's segments and to develop strategic objectives and operating plans for those segments. Segment EBITDA eliminates the uneven effect of non-cash depreciation of tangible assets and amortization of intangible assets, much of which results from acquisitions accounted for under the purchase method of accounting. Segment EBITDA also eliminates the effects of changes in interest rates which management believes relate to general trends in global capital markets, but are not necessarily indicative of the operating performance of Vanguard's segments. Management believes that Segment EBITDA provides useful information about the financial performance of Vanguard's segments to investors, lenders, financial analysts and rating agencies. Additionally, management believes that investors and lenders view Segment EBITDA as an important factor in making investment decisions and assessing the value of Vanguard. Segment EBITDA is not a substitute for net income (loss), operating cash flows or other cash flow statement data determined in accordance with accounting principles generally accepted in the United States. Segment EBITDA, as presented, may not be comparable to similar measures of other companies.

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VANGUARD HEALTH SYSTEMS, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (continued)

18. UNAUDITED QUARTERLY OPERATING RESULTS

The following table presents summarized unaudited quarterly results of operations for the fiscal years ended June 30, 2009 and 2010. Management believes that all necessary adjustments have been included in the amounts stated below for a fair presentation of the results of operations for the periods presented when read in conjunction with Vanguard's consolidated financial statements for the fiscal years ended June 30, 2009 and 2010. Results of operations for a particular quarter are not necessarily indicative of results of operations for an annual period and are not predictive of future periods (in millions).

	September 30, 2008	December 31, 2008	March 31, 2009	June 30, 2009
Total revenues	$ 715.4	$ 789.2	$ 854.3	$ 826.5
Net income	$ 1.9	$ 10.8	$ 16.4	$ 2.7
Net income attributable to Vanguard Health Systems, Inc. stockholders	$ 1.0	$ 10.1	$ 15.7	$ 1.8

	September 30, 2009	December 31, 2009	March 31, 2010	June 30, 2010
Total revenues	$ 819.9	$ 840.5	$ 858.1	$ 858.4
Net income (loss)	$ 2.4	$ (19.9)	$ (32.4)	$ 3.6
Net income (loss) attributable to Vanguard Health Systems, Inc. stockholders	$ 1.5	$ (20.7)	$ (32.8)	$ 2.8

19. SUBSEQUENT EVENTS

On July 14, 2010, Vanguard Health Holding Company II, LLC ("VHS Holdco II") and Vanguard Holding Company II, Inc. ("VHS Holdco II Inc." and, together with VHS Holdco II, the "Issuers"), subsidiaries of Vanguard, entered into a Second Supplemental Indenture among the Issuers, Vanguard, the other guarantors named therein and U.S. Bank National Association, as trustee (the "Supplemental Indenture"), under which the Issuers co-issued (the "New Senior Notes Offering") $225.0 million aggregate principal amount of 8.0% Senior Notes due 2018 (the "New Senior Notes"), which are guaranteed on a senior unsecured basis by Vanguard, Vanguard Health Holding Company I, LLC and certain restricted subsidiaries of VHS Holdco II. The New Senior Notes Offering was made under the Indenture governing the 8.0% Notes that were issued on January 29, 2010 as part of the Refinancing. The New Senior Notes were issued at an offering price of 96.25% plus accrued interest, if any, from January 29, 2010. The proceeds from the New Senior Notes are intended to be used to finance, in part, Vanguard's acquisition of substantially all the assets of DMC and to pay fees and expenses incurred in connection with the foregoing. Should the DMC acquisition not be approved by the Michigan Attorney General, Vanguard will use these proceeds for general corporate purposes, including other acquisitions.

On August 1, 2010, Vanguard completed the purchase of Westlake Hospital and West Suburban Medical Center in the western suburbs of Chicago, Illinois from Resurrection Health Care. Westlake Hospital is a 225-bed acute care facility located in Melrose Park, Illinois, and West Suburban Medical Center is a 234-bed acute care facility located in Oak Park, Illinois. Both of these facilities are located less than 10 miles from Vanguard's MacNeal Hospital. As part of the purchase, Vanguard acquired substantially all of the assets and assumed certain liabilities of these hospitals for a total cash purchase price of approximately $45.0 million.

In early August 2010, Vanguard signed a definitive agreement to acquire Arizona Heart Institute (AHI), a leading provider of cardiovascular care and Arizona Heart Hospital (AHH), a 59-bed hospital located in Phoenix, Arizona. Through these agreements, Abrazo Health Care, a Phoenix-based subsidiary of Vanguard, will create a distributive cardiovascular network of community-based physicians with a flagship cardiovascular inpatient facility that will provide future opportunities to greatly expand cardiovascular services and patient base throughout the region. The purchase of AHI by Vanguard will occur through a section 363 sale, as part of a Chapter 11 reorganization plan since AHI filed in early August 2010 under the federal bankruptcy laws for a Chapter 11 reorganization of its business. A section 363 sale, so named because of the section of the Bankruptcy Code dealing with the procedure, allows the sale of all, or substantially all, of the filing company's assets to the purchaser free and clear of any liens or encumbrances. Vanguard expects the AHI and AHH transactions to close during the second quarter of fiscal 2011. However, the closing of the AHI transaction could be delayed or not approved at all by the bankruptcy court.

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Item 9. Changes in and Disagreements With Accountants on Accounting and Financial Disclosure.

None.

Item 9A. Controls and Procedures.

Evaluation of Disclosure Control and Procedures

As of the end of the period covered by this report, our management conducted an evaluation, with the participation of our chief executive officer and chief financial officer, of the effectiveness of our disclosure controls and procedures (as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934 (the "Exchange Act")). Based on this evaluation, our chief executive officer and chief financial officer have concluded that our disclosure controls and procedures are effective to ensure that information required to be disclosed by us in the reports that we file or submit under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in Securities and Exchange Commission's rules and forms and that such information is accumulated and communicated to management, including our chief executive officer and chief financial officer, as appropriate to allow timely decisions regarding required disclosure.

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REPORT OF MANAGEMENT ON INTERNAL CONTROL OVER FINANCIAL REPORTING

The management of Vanguard Health Systems, Inc. is responsible for the preparation, integrity and fair presentation of the consolidated financial statements appearing in our periodic filings with the Securities and Exchange Commission. The consolidated financial statements were prepared in conformity with generally accepted accounting principles appropriate in the circumstances and, accordingly, include certain amounts based on our best judgments and estimates.

Management is also responsible for establishing and maintaining adequate internal control over financial reporting as such term is defined in Rules 13a-15(f) under the Securities and Exchange Act of 1934. Internal control over financial reporting is a process to provide reasonable assurance regarding the reliability of our financial reporting in accordance with accounting principles generally accepted in the United States of America. Our internal control over financial reporting includes a program of internal audits and appropriate reviews by management, written policies and guidelines, careful selection and training of qualified personnel including a dedicated Compliance department and a written Code of Business Conduct and Ethics adopted by our Board of Directors, applicable to all of our directors, officers and employees.

Internal control over financial reporting includes maintaining records that in reasonable detail accurately and fairly reflect our transactions; providing reasonable assurance that transactions are recorded as necessary for preparation of our financial statements; providing reasonable assurance that receipts and expenditures of company assets are made in accordance with management authorization; and providing reasonable assurance that unauthorized acquisition, use or disposition of company assets that could have a material effect on our financial statements would be prevented or detected in a timely manner. Because of its inherent limitations, including the possibility of human error and the circumvention or overriding of control procedures, internal control over financial reporting is not intended to provide absolute assurance that a misstatement of our financial statements would be prevented or detected. Therefore, even those internal controls determined to be effective can provide only reasonable assurance with respect to financial statement preparation and presentation.

Management conducted an evaluation of the effectiveness of our internal control over financial reporting based on the framework in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission. Based on this evaluation, management concluded that the Company's internal control over financial reporting was effective as of June 30, 2010.

This annual report does not include an attestation report of the Company's independent registered public accounting firm regarding internal control over financial reporting because that requirement under Section 404 of the Sarbanes-Oxley Act of 2002 was permanently removed for non-accelerated filers like the Company pursuant to the provisions of Section 989G(a) set forth in the *Dodd-Frank Wall Street Reform and Consumer Protection Act* enacted into federal law in July 2010.

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Changes in Internal Control Over Financial Reporting

There was no change in our internal control over financial reporting during our fiscal quarter ended June 30, 2010 that materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

Item 9B. Other Information.

None.

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PART III

Item 10. Directors, Executive Officers and Corporate Governance.

Our board of directors consists of five members, three of whom were nominated by Blackstone, one of whom was nominated by Morgan Stanley Capital Partners, together with its affiliates (collectively, "MSCP"), and one of whom is our chief executive officer (and, if our chief executive officer is not Charles N. Martin, Jr., such other person designated by members of senior management who hold membership units of Holdings). Blackstone has the right to increase the size of Vanguard's board from five to nine members, with two additional directors to be designated by Blackstone and two additional directors to be independent persons identified by our chief executive officer and acceptable to Blackstone. MSCP and senior management will each continue to be entitled to nominate and elect one director unless and until the earlier of (1) such time as such group ceases to own a number of shares of our common stock and Holdings units that is no less than 50.0% of the number of Class A units in Holdings owned on September 23, 2004, and (2) such time as Blackstone's ownership percentage in Vanguard (factoring in both direct ownership and ownership through Holdings) is less than 10%. Holdings acquired Vanguard pursuant to a merger (the "Merger") on September 23, 2004.

The table below presents information with respect to the members of our board of directors and our executive officers and their ages as of as of August 15, 2010.

Name	Age	Position
Charles N. Martin, Jr.	67	Chairman of the Board & Chief Executive Officer; Director
Kent H. Wallace	55	President & Chief Operating Officer
Keith B. Pitts	52	Vice Chairman
Mark R. Montoney, MD	53	Executive Vice President & Chief Medical Officer
Joseph D. Moore	63	Executive Vice President
Bradley A. Perkins, MD	51	Executive Vice President-Strategy and Innovation & Chief Transformation Officer
Phillip W. Roe	49	Executive Vice President, Chief Financial Officer & Treasurer
Ronald P. Soltman	64	Executive Vice President, General Counsel & Secretary
Dan F. Ausman	55	Senior Vice President-Operations
Reginald M. Ballantyne III	66	Senior Vice President-Market Strategy & Government Affairs
Bruce F. Chafin	54	Senior Vice President-Compliance & Ethics
Paul T. Dorsa	53	Senior Vice President-Development
Larry Fultz	55	Senior Vice President-Human Resources
Joseph J. Mullany	45	Senior Vice President-Operations
Harold H. Pilgrim III	49	Senior Vice President & Chief Development Officer
Graham Reeve	46	Senior Vice President-Operations
James H. Spalding	51	Senior Vice President, Assistant General Counsel & Assistant Secretary
Jana S. Stonestreet	57	Senior Vice President & Chief Nursing Executive
Alan G. Thomas	56	Senior Vice President-Operations Finance
Thomas M. Ways	60	Senior Vice President-Managed Care
Gary D. Willis	45	Senior Vice President, Controller & Chief Accounting Officer
Deanna L. Wise	41	Senior Vice President & Chief Information Officer
Michael A. Dal Bello	39	Director
M. Fazle Husain	46	Director
James A. Quella	60	Director
Neil P. Simpkins	44	Director

Charles N. Martin, Jr. has served as Chairman of the board of directors and Chief Executive Officer of Vanguard since July 1997. Until May 31, 2001, he was also Vanguard's President. From January 1992 until January 1997, Mr. Martin was Chairman, President and Chief Executive Officer of OrNda HealthCorp ("OrNda"), a hospital management company. Prior thereto Mr. Martin was President and Chief Operating Officer of HealthTrust, Inc., a hospital management company, from September 1987 until October 1991. Mr. Martin is also a director of several privately held companies.

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Kent H. Wallace has served as Vanguard's President & Chief Operating Officer since September 2005. Prior thereto he was a Senior Vice President — Operations of Vanguard from February 2003 until September 2005. Prior thereto from July 2001 to December 2002 he was Regional Vice President of Province Healthcare Company of Brentwood, Tennessee, an owner and operator of 20 non-urban, acute care hospitals in 13 states of the United States. During this time Mr. Wallace had managerial responsibility for seven of these hospitals. From June 1999 until June 2001 Mr. Wallace was President and Chief Executive Officer of Custom Curb, Inc. of Chattanooga, Tennessee, a family owned company which manufactured roof accessories. Prior thereto from January 1997 until May 1999 Mr. Wallace was a Vice President — Acquisitions and Development of Tenet Healthcare Corporation of Dallas, Texas, a hospital management company ("Tenet").

Keith B. Pitts has been Vanguard's Vice Chairman since May 2001, was a director of Vanguard from August 1999 until September 2004, and was an Executive Vice President of Vanguard from August 1999 until May 2001. Prior thereto, from November 1997 until June 1999, he was the Chairman and Chief Executive Officer of Mariner Post-Acute Network, Inc. and its predecessor, Paragon Health Network, Inc., which is a nursing home management company. Prior thereto from August 1992 until January 1997, Mr. Pitts served as Executive Vice President and Chief Financial Officer of OrNda.

Mark R. Montoney, MD has been Vanguard's Executive Vice President & Chief Medical Officer since December 2008. Prior to his employment with Vanguard, from July 2005 to December 2008 Dr. Montoney was System Vice President and Chief Medical Officer of OhioHealth Corporation, a not-for-profit regional hospital management company headquartered in Columbus, Ohio, which operates 8 hospitals, over 20 health and surgery centers, and has affiliation agreements with 9 hospitals, within a 40-county area in central Ohio. Prior thereto, from July 2000 to July 2005, Dr. Montoney was Vice President — Quality & Clinical Support, of Riverside Methodist Hospital, a 985-bed tertiary care hospital in Columbus, Ohio.

Joseph D. Moore has served as an Executive Vice President of Vanguard since November 2007. He served as Executive Vice President, Chief Financial Officer and Treasurer of Vanguard from July 1997 until November 2007 and was a director of Vanguard from July 1997 until September 2004. From February 1994 to April 1997, he was Senior Vice President — Development of Columbia/HCA Healthcare Corporation ("Columbia"), a hospital management company. Mr. Moore first joined Hospital Corporation of America (a predecessor of Columbia) in April 1970, rising to Senior Vice President — Finance and Development in January 1993.

Bradley A. Perkins, MD has been Executive Vice President — Strategy and Innovation & Chief Transformation Officer of Vanguard since July 2009. Prior to his employment with Vanguard, Dr. Perkins held various positions with the Centers for Disease Control & Prevention ("CDC") from July 1989 to June 2009, including Chief Strategy & Innovation Officer and Chief, Office of Strategy & Innovation from December 2005 to June 2009, and Deputy Director, Office of Strategy & Innovation, from May 2004 to December 2005.

Phillip W. Roe has been Executive Vice President, Chief Financial Officer and Treasurer since November 2007. He was Senior Vice President, Controller and Chief Accounting Officer of Vanguard from July 1997 to November 2007. Prior thereto he was Senior Vice President, Controller and Chief Accounting Officer of OrNda from September 1996 until January 1997 and was Vice President, Controller and Chief Accounting Officer of OrNda from October 1994 until September 1996.

Ronald P. Soltman has been Vanguard's Executive Vice President, General Counsel and Secretary since July 1997 and was a director of Vanguard from July 1997 until September 2004. From April 1994 until January 1997, he was Senior Vice President, General Counsel and Secretary of OrNda. From February 1994 until March 1994, he was Vice President and Assistant General Counsel of Columbia. From 1984 until February 1994, he was Vice President and Assistant General Counsel of Hospital Corporation of America.

Dan F. Ausman has served as a Senior Vice President — Operations of Vanguard since February 2006. Prior thereto from May 2005 to February 2006 he was Vice President — Operations of Vanguard. From 1998 to April 2005 Mr. Ausman was the President & Chief Executive Officer of Irvine Regional Hospital and Medical Center, a 176-bed acute care hospital in Irvine, CA which is owned by an affiliate of Tenet.

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Reginald M. Ballantyne III joined Vanguard in May 2001 and has served as Senior Vice President - Market Strategy & Government Affairs of Vanguard since January 2002. From 1984 to 2001, he served as President and CEO of PMH Health Resources, Inc. ("PMH"), an Arizona based multi-unit healthcare system. In February 2001, PMH filed a Chapter 11 proceeding in order to implement the sale of the business and assets of PMH to Vanguard. Prior to 1984, Mr. Ballantyne served as President of Phoenix Memorial Hospital in Phoenix, Arizona. Mr. Ballantyne served as Chairman of the American Hospital Association ("AHA") in 1997 and as Speaker of the AHA House of Delegates in 1998. He is a Fellow of the American College of Healthcare Executives ("ACHE") and a recipient of the ACHE Gold Medal Award for Management Excellence. Mr. Ballantyne also served as a member of the national Board of Commissioners for the Joint Commission on Accreditation of Healthcare Organizations and as Chairman of the AHA Committee of Commissioners from 1992 until 1995. Mr. Ballantyne was recently elected Chairman of the Arizona Chamber of Commerce and Industry. He has previously served as a director of Superior Consultant Holdings Corporation and is currently a director of several privately held companies.

Bruce F. Chafin has served as Senior Vice President — Compliance & Ethics of Vanguard since July 1997. Prior thereto, from April 1995 to January 1997, he served as Vice President — Compliance & Ethics of OrNda.

Paul T. Dorsa has served Senior Vice President — Development of Vanguard since September 2008. Prior to his employment with Vanguard, from May 2004 to September 2008 he was the Vice President — Mergers & Acquisition of DaVita Inc., an El Segundo, California-based provider of dialysis services and education for patients with chronic kidney failure and end stage renal disease, managing in the United States more than 1,000 outpatient facilities and acute units in more than 700 hospitals.

Larry Fultz has served as Senior Vice President — Human Resources of Vanguard since February 2009. Prior to his employment with Vanguard, from October 2007 to January 2009 he was Executive Vice President — Human Resources of the Victoria Secret Brand division of Limited Brands, Inc., headquartered in Columbus, Ohio. The Victoria Secret Brand division sells women's intimate and other apparel, personal care and beauty products and accessories under the Victoria's Secret brand name through retail stores, its website and its catalogue. Prior thereto from April 2006 to October 2007, Mr. Fultz was Executive Vice President — Human Resources of the Victoria Secret retail store division of Limited Brands, Inc. Prior to joining Victoria Secret, from September 2000 to April 2006 Mr. Fultz was Vice President — Human Resources of Cintas Corporation, headquartered in Cincinnati, Ohio. Cintas designs, manufactures and implements corporate identity uniform programs, and provides entrance mats, restroom supplies, promotional products, first aid, safety, fire protection products and services and document management services for other businesses.

Joseph J. Mullany has served as a Senior Vice President — Operations of Vanguard since September 2005. Prior thereto from October 2002 to August 2005 he was a Regional Vice President of Essent Healthcare, Inc. of Nashville, TN, an investor-owned hospital management company, responsible for its New England Division. Prior thereto from October 1998 to October 2002 Mr. Mullany was a Division Vice President of Health Management Associates, Inc. of Naples, Florida, an investor-owned hospital management company, responsible for its Mississippi Division.

Harold H. Pilgrim III has served as the Senior Vice President & Chief Development Officer of Vanguard since July 2009. Prior thereto from September 2005 to June 2009 he was a Senior Vice President — Operations of Vanguard. From February 2003 to September 2005 he was Vice President - Business Development of Vanguard, responsible for development for Vanguard's Texas operations. Prior thereto from November 2001 to January 2003 Mr. Pilgrim was Vanguard's Vice President — Investor Relations, and during that period he was also involved in Vanguard's acquisitions and development activities.

Graham Reeve has served as a Senior Vice President — Operations of Vanguard since July 2009. Prior thereto from April 2009 to June 2009 he was Vice President and Chief Operating Officer of Vanguard's Texas operations. From December 2005 to April 2009 he was President and Chief Executive Officer of Vanguard's St. Luke's Baptist Hospital in San Antonio, Texas. Prior thereto from September 2003 to November 2005 he was Vice President — Ambulatory Services of Vanguard's Texas operations. Prior to joining Vanguard, Mr. Reeve was employed by HealthSouth Corporation, a Birmingham, Alabama-based owner of rehabilitation and surgery hospitals and rehabilitation and surgery outpatient centers, holding various positions from December 1995 through August 2003, with his last position being Vice President — Surgical Operations for HealthSouth's southwestern surgery hospitals and surgery centers.

James H. Spalding has served as Senior Vice President, Assistant General Counsel and Assistant Secretary of Vanguard since November 1998. Prior thereto he was Vice President, Assistant General Counsel and Assistant Secretary of Vanguard from July 1997 until November 1998. Prior thereto from April 1994 until January 1997, he served as Vice President, Assistant General Counsel and Assistant Secretary of OrNda.

Jana S. Stonestreet has served as Vanguard's Senior Vice President & Chief Nursing Executive since June 2009. Prior thereto from January 2006 to June 2009, Dr. Stonestreet was Chief Nursing Executive of Vanguard's Texas operations. Prior to joining Vanguard, from June 2004 to January 2006 Dr. Stonestreet was Chief Patient Care Officer of Memorial Hermann Southwest Hospital, a 563-bed hospital located in Houston, Texas.

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Alan G. Thomas has been Senior Vice President — Operations Finance of Vanguard since July 1997. Prior thereto, Mr. Thomas was Senior Vice President — Hospital Financial Operations of OrNda from April 1995 until January 1997. Prior thereto he was Vice President — Reimbursement and Revenue Enhancement of OrNda from June 1994 until April 1995.

Thomas M. Ways has served as Senior Vice President — Managed Care of Vanguard since March 1998. Prior thereto from February 1997 to February 1998, he was Chief Executive Officer of MSO/Physician Practice Development for the Southern California Region of Tenet. Prior thereto from August 1994 to January 1997, he was Vice President — Physician Integration of OrNda.

Gary D. Willis has served as Senior Vice President, Controller and Chief Accounting Officer of Vanguard since May 2008. From February 2006 to May 2008, he was Senior Vice President and Chief Accounting Officer of LifePoint Hospitals ("LifePoint"), a hospital management company based in Brentwood, Tennessee. From December 2002 to February 2006, he was Vice President and Controller of LifePoint.

Deanna L. Wise has served as Senior Vice President and Chief Information Officer of Vanguard since November 2006. Prior thereto from August 2004 to October 2006 she was the Chief Information Officer of Vanguard's operating region managing its Phoenix-area healthcare facilities. From November 2002 until August 2004 she was chief information officer of the Maricopa Integrated Health System in Phoenix, Arizona, which was a county integrated healthcare system including an acute care hospital, health clinics and health plans. Prior thereto, from October 1997 to November 2002 she was the director of applications of Ascension Health — Central Indiana Health System in Indianapolis, Indiana, a regional healthcare management organization supervising the operations of twelve acute care hospitals.

Michael A. Dal Bello became a member of Vanguard's board of directors on September 23, 2004. Mr. Dal Bello is a Managing Director in the Private Equity Group of Blackstone and has been with the firm since 2002. While at Blackstone, Mr. Dal Bello has been actively involved in Blackstone's healthcare investment activities. Prior to joining Blackstone, Mr. Dal Bello received an M.B.A. from Harvard Business School in 2002. Mr. Dal Bello worked at Hellman & Friedman LLC from 1998 to 2000 and prior thereto at Bain & Company. He currently serves, or since July 1, 2005 has served, on the board of representatives or directors of Apria Healthcare Group Inc., Alliant Holdings I, Inc., Team Health Holdings, Inc., Team Finance LLC, Biomet, Inc., Global Tower Partners, Catalent Pharma Solutions, Inc. and Sithe Global.

M. Fazle Husain became a member of Vanguard's board of directors on November 7, 2007. Mr. Husain is a Managing Director of Metalmark Capital, the private equity division of Citigroup Alternative Investments. Prior to joining Metalmark, Mr. Husain was with Morgan Stanley & Co. for 18 years, where he was a Managing Director in the private equity and venture capital investment business. Mr. Husain currently serves, or since July 1, 2005 has served, on the board of directors of SouthernCare, Inc., National Healing Corporation, Cross Country Health Care, Inc., Allscripts Healthcare Solutions Inc., the Medicines Company and Healthstream Inc.

James A. Quella became a member of Vanguard's board of directors on September 11, 2007. Mr. Quella is a Senior Managing Director and Senior Operating Partner in the Private Equity Group at Blackstone. Prior to joining Blackstone in 2004, Mr. Quella was a Managing Director and Senior Operating Partner with DLJ Merchant Banking Partners-CSFB Private Equity from June 2000 to February 2004. Prior to that, Mr. Quella worked at Mercer Management Consulting and Strategic Planning Associates, its predecessor firm, from September 1981 to January 2000 where he served as a Senior Consultant to chief executive officers and senior management teams, and was Co-Vice Chairman with shared responsibility for overall management of the firm. Mr. Quella currently serves, or since July 1, 2005 has served, as a director of Allied Waste Industries, Inc., Houghton-Mifflin, Celanese Corporation, Graham Packaging Holdings Company, Intelenet Global Services, The Nielsen Company, Michaels Stores, Inc., Freescale Semiconductor, Inc. and Catalent Pharma Solutions, Inc.

Neil P. Simpkins became a member of Vanguard's board of directors on September 23, 2004. Mr. Simpkins has served as a Senior Managing Director in the Private Equity Group of Blackstone since December 1999. From 1993 until the time he joined Blackstone, Mr. Simpkins was a Principal at Bain Capital. Prior to joining Bain Capital, Mr. Simpkins was a consultant at Bain & Company in London and the Asia Pacific region. He currently serves, or since July 1, 2005 has served, as Chairman of the board of directors of TRW Automotive Holdings Corp., as a member of the board of representatives of Team Finance LLC and as a member of the board of directors of Apria Healthcare Group Inc., Summit Materials, LLC and Team Health Holdings, Inc.

There are no family relationships between any director, executive officer, or person nominated or chosen to become a director or executive officer.

Composition of the Board of Directors

General

The board of directors of Vanguard consists of five members, three of whom were designated by Blackstone, one of whom was designated by MSCP and one of whom is our chief executive officer (and, if our chief executive officer is not Charles N. Martin, Jr., such other person designated by our senior management investors). Blackstone has the right to increase the size of Vanguard's board from five to nine members, with two additional directors to be designated by Blackstone and two additional directors to be independent persons identified by our chief executive officer and acceptable to Blackstone. MSCP and, subject to the conditions above, senior management, will each continue to be entitled to designate one director unless and until the respective group ceases to own at least 50.0% of the Class A membership units in VHS Holdings LLC ("Holdings") owned on September 23, 2004. Holdings acquired Vanguard pursuant to a merger on September 23, 2004 (the "Merger"). The legal right to make these designations to constitute the entire board of directors of Vanguard is set forth in the Amended and Restated Limited Liability Company Operating Agreement of Holdings dated as of September 23, 2004 (the "Operating Agreement").

Since these board of directors designations were made by our principal stockholders pursuant to the Operating Agreement rather than nominations determined by our board of directors, we are unaware of the specific experience, qualifications, attributes or skills that led to each stockholder's conclusion that, in light of our business and structure, each of the persons so designated should serve as one of our directors. However, we note that (1) each of the three persons designated by Blackstone to be one of our directors is either a Senior Managing Director (Messrs. Quella and Simpkins) or a Managing Director (Mr. Dal Bello) in Blackstone's Private Equity Group, with each having at least five years of employment with Blackstone's private equity business and over ten years of experience in the private equity industry; (2) the person designated by MSCP (Mr. Husain) to be one of our directors is a Managing Director of Metalmark Capital, a private equity entity, which manages the MSCP funds owning shares in us, with Mr. Husain having over 20 years experience in the private equity and venture capital investment business; and (3) the person designated by our senior management investors (Mr. Martin) to be one of our directors has been our chairman and chief executive officer since we were founded in 1997, and prior thereto was chairman, president and chief execute officer of OrNda, a hospital management company, from 1992 to 1997 and president and chief operating officer of HealthTrust, Inc., a hospital management company, from 1987 to 1991.

Committees

Our board of directors currently does not have any standing committees, including an audit committee. Our entire board of directors is acting as our audit committee to oversee our accounting and financial reporting processes and the audits of our financial statements, as allowed under the Securities Exchange Act of 1934 for issuers without securities listed on a national securities exchange or on an automated national quotation system. Additionally, because our securities are not so listed, our board of directors is not required to have on it a person who qualifies under the rules of the Securities and Exchange Commission as an "audit committee financial expert" or as having accounting or financial management expertise under the similar rules of the national securities exchanges. While our board of directors has not designated any of its members as an audit committee financial expert, we believe that each of the current board members is fully qualified to address any accounting, financial reporting or audit issues that may come before it.

Code of Ethics

We have adopted a Code of Business Conduct and Ethics that applies to all of our officers and employees, including our principal executive officer, principal financial officer and principal accounting officer, which has been posted on our Internet website at www.vanguardhealth.com/pdfs/codeofbusinessconductandethics.pdf. Our Code of Business Conduct and Ethics is a "code of ethics", as defined in Item 406(b) of Regulation S-K. Please note that our Internet website address is provided as an inactive textual reference only. We will make any legally required disclosures regarding amendments to, or waivers of, provisions of our code of ethics on our Internet website.

Compensation Committee Interlocks and Insider Participation

During fiscal 2010, we had no compensation committee of our board of directors. Charles N. Martin, Jr., one of our named executive officers, participated in deliberations of our board of directors concerning executive officer compensation during fiscal 2010. Also, during fiscal 2010, Keith B. Pitts, one of our named executive officers, served on the board of directors of SouthernCare, Inc., one of whose executive officers, Michael J. Parsons, served on our board of directors during a portion of fiscal 2010. Both our board of directors and the board of directors of SouthernCare, Inc. act as the compensation committees for each such entity, each such entity having no such standing compensation committee or other committee performing similar function. In November 2009 Mr. Parsons informed us that he declined to stand for re-election to our board of directors and, as a result, Mr. Parsons left our board of directors, effective November 3, 2009.

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Director Compensation

During fiscal 2010, our directors who are either our employees or affiliated with our private equity Sponsors did not receive any fees or other compensation for their services as our directors. We reimburse all of our directors for travel expenses and other out-of-pocket costs incurred in connection with attendance at meetings of the board.

As described in the table below, during fiscal 2010, Michael J. Parsons, a director for a portion of the year who was not our employee or an affiliate of our Sponsors, received our current standardized director compensation plan for our independent directors of $20,500 for the portion of the year he served on the board.

The following table summarizes all compensation for our non-employee directors (other than our Sponsor-affiliated directors) for our fiscal year ended June 30, 2010.

Name	Fees earned or paid in cash ($)	Stock awards	Option awards	Non-equity incentive plan compensation ($)	Change in pension value and nonqualified deferred compensation earnings	All other compensation	Total
Michael J. Parsons	20,500	—	—	—	—	—	20,500

(1) The director compensation in the above table reflects the annual cash retainer paid by us to any independent, non-employee director of $60,000 per year, with the $20,500 representing the portion of the fiscal year that this director served on our board. The employee director and the Sponsor-affiliated directors receive no additional compensation for serving on our board and, as a result, are not listed in the table above.

Item 11. Executive Compensation.

Compensation Discussion and Analysis

Overview

This section discusses the principles underlying our executive compensation policies and decisions. It provides qualitative information regarding the manner in which compensation is earned by our executive officers and places in context the data presented in the tables that follow. In addition, in this section, we address the compensation paid or awarded during fiscal year 2009 to: Charles N. Martin, Jr., our Chief Executive Officer (principal executive officer); Phillip W. Roe, our Chief Financial Officer (principal financial officer); and three other executive officers who were our three other most highly compensated executive officers in fiscal year 2010, as follows: Keith B. Pitts, our Vice Chairman; Kent H. Wallace, our President and Chief Operating Officer; Bradley A. Perkins, MD, our Executive Vice President-Strategy & Innovation & Chief Transformation Officer; and Mark R. Montoney, MD, our Executive Vice President & Chief Medical Officer. We refer to these six executive officers as our "named executive officers."

On September 23, 2004, we were acquired in the Merger by private equity investment funds associated with Blackstone, which invested $494.4 million in our equity for a 66% equity interest. Private equity funds associated with our former equity sponsor, MSCP, retained a 17.3% equity interest in us by reinvesting $130.0 million in our equity. In addition, 12 of our 23 executive officers at the time of the Merger retained an 11.4% equity interest in us by reinvesting $85.7 million in us (such $85.7 million is exclusive of amounts invested by our executive officers in Holdings' Class B, C and D units, as discussed below). As a result of the Merger, we are privately held and controlled by private equity funds associated with Blackstone and MSCP (the "Sponsors") with a board of directors made up of five representatives of the Sponsors and our Chief Executive Officer. As discussed in more detail below, various aspects of named executive officer compensation were negotiated and determined at the time of the Merger.

As a privately-owned company with a relatively small board of directors, our entire board of directors has historically acted as our Compensation Committee (hereinafter referred to either as the "Committee", the "Compensation Committee" or the "board of directors"). Our executive compensation program is overseen and administered by the Compensation Committee. The Compensation Committee operates somewhat informally without a written charter and has responsibility for discharging the responsibilities of the board of directors relating to the compensation of our executive officers and related duties. As a member of the Compensation Committee, our Chief Executive Officer presents cash, equity and benefits compensation recommendations to the Compensation Committee for its consideration and approval. The Compensation Committee reviews these proposals and makes all final compensation decisions for executive officers by exercising its discretion in accepting, modifying or rejecting any such recommendations.

Philosophy of Executive Compensation Program

The overall aim of our executive compensation program is to promote our strategic business initiatives, financial performance objectives and the creation and maintenance of equity value. The following are the principal objectives in the design of our executive compensation program:

- Attract, retain, and motivate superior management talent critical to our long-term success with compensation that is competitive within the marketplace;
- Maintain a reasonable balance among base salary, annual cash incentive payments and long-term equity-based incentive compensation and other benefits;
- Ensure that compensation levels reflect the internal value and future potential of each executive and the achievement of outstanding individual results;
- Link executive compensation to the creation and maintenance of long-term equity value;
- Promote equity ownership by executives to align their interests with the interests of our equity holders; and
- Ensure that incentive compensation is linked to the achievement of specific financial and strategic objectives, which are established in advance and approved by the compensation committee.

To meet these objectives, our executive compensation program balances short-term and long-term performance goals and mixes fixed and at-risk compensation that is directly related to stockholder value and overall performance.

Compensation Determination Process

Our board of directors has historically made all determinations regarding the compensation for our executive officers.

During our fiscal year ended June 30, 2010, the board of directors did not retain the services of any external compensation consultant. Our Chief Executive Officer, Charles N. Martin, Jr., as a member of the board of directors, presented his compensation recommendations to the full board of directors on all executive compensation matters other than with respect to his own compensation and participated in discussions and deliberations of the board of directors when executive compensation matters were discussed. Although other named executive officers also attended the board meetings when executive compensation matters were discussed and participated in such board discussions, they would do so only if and when required by the board of directors and such attendance has been rare in recent years. Any deliberations and decisions by the board of directors regarding compensation for Mr. Martin or other named executive officers took place while the board was is in executive session without such persons in attendance.

We believe that compensation to our executive officers should be aligned closely with our short-term and long-term financial performance goals. As a result, a portion of executive compensation will be "at risk" and will be tied to the attainment of previously established financial goals. However, we also believe that it is prudent to provide competitive base salaries and benefits to attract and retain superior talent in order to achieve our strategic objectives.

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Elements of Our Executive Compensation Program

In fiscal year 2010, the principal elements of our compensation for our executive officers, including our named executive officers were:

- Base salaries;
- Annual cash incentive opportunities;
- Long-term equity-based incentives; and
- Benefits and executive perquisites.

Each of these elements is discussed in further detail below.

Base Salaries

Annual base salaries reflect the fixed component of the compensation for an executive's ongoing contribution to the operating performance of his or her functional area of responsibility with us. The Committee believes that base salaries must be competitive based upon the scope of responsibilities and market compensation of similar executives but that a substantial portion of compensation should also be reserved for other compensation elements that are directly related to company performance. To determine market levels of base salary compensation, our Human Resources Department typically provides our Chief Executive Officer and the Committee with market data from the U.S. healthcare provider industry which it obtained in our fiscal year ended 2009 (which is the last time it was done as of the date of this report) from the following information sources: Mercer, Sullivan, Cotter & Associates; Salary.com; and Management Performance International, Inc. All of such market data was broad-based (e.g., the Mercer data came from 130 hospitals and healthcare systems, for-profit as well as non-profit) and was used only to assist the Chief Executive Officer and the Committee to obtain a general understanding of current base salary levels in comparable executive positions. Thus, the Committee did no benchmarking against a peer group of companies in establishing base salaries in our fiscal year 2009 (which is the last time it was done). Other factors such as internal equity and comparability are also considered when establishing a base salary for a given executive. The Committee also utilizes the experience, market knowledge and insight of its members in evaluating the competitiveness of current salary levels. Our Human Resources Department is also a resource for such additional information as needed by our Chief Executive Officer or by the Committee.

Generally, base salaries of all executive officers, including the named executive officers, are reviewed and adjusted by the Committee once per year based upon the recommendations of our Chief Executive Officer (except he makes no recommendation as to his own salary). In turn, our Chief Executive Officer bases his recommendations upon his assessment of each executive's performance, our overall budgetary guidelines and market data provided to him by our Human Resources Department. In previous fiscal years, the annual salary review for executive officers (including the named executive officers) was done effective January 1 of each year. However, in our fiscal year ended June 30, 2009, the annual salary review was done effective April 1, 2009, and the next salary review was then expected to occur effective July 1, 2010, with future yearly reviews currently planned to remain at July 1 of each year (which is the first day of our fiscal year). As a result, our executive officer raises in our fiscal year ended June 30, 2009 (which is the last time it was done), including those of the named executive officers, were increased by additional amounts to reflect the 15-month salary review cycle. Due to budgeting constraints our Chief Executive Officer made no recommendations to the Committee for salary increases during our fiscal year ended June 30, 2010, or effective July 1, 2010, as originally anticipated. It is not clear when the Committee will next make an annual salary review for our executive officers. In addition to the annual salary review, based upon the recommendations of our Chief Executive Officer, the Committee may also adjust base salaries at other times during the year in connection with promotions, increased responsibilities or to maintain competitiveness in the market.

In our fiscal year ended June 30, 2010, the base salaries of our executive officers, including our named executive officers, were not increased. The annual base salary rates of our named executive officers, as of June 30, 2010, were as follows: Mr. Martin: $1,098,079; Mr. Roe: $525,000; Mr. Pitts: $685,000; Mr. Wallace: $685,000; Dr. Perkins: $675,000 and Dr. Montoney: $522,750. The salary for each named executive officer for our fiscal year ended June 30, 2010, is reported in the Summary Compensation Table below.

Annual Cash Incentive Compensation

Annual Incentive Plan

Annual cash incentive awards are available to our named executive officers, as well as to our other executive officers, under the Vanguard Health Systems, Inc. 2001 Annual Incentive Plan (the "Annual Incentive Plan"). The Annual Incentive Plan is designed to align our executives' short-term cash compensation opportunities with our annual financial and operational goals and the growth objectives of our stockholders and to motivate our executives' annual performance.

Under the Annual Incentive Plan, the Committee establishes specific earnings-related or operations-related goals for all of our executive officers, including our named executive officers, for the fiscal year based upon the recommendations of our Chief Executive Officer. The executive officers are eligible to receive a cash award or awards based primarily on the extent to which we meet our overall pre-established earnings and/or cash flow and/or other operations-related goals. Typically, in recent years the goals for all executive officers have been company-wide, except for the three executive officers who are based in our operating regions. The Committee determines one or more target awards for each executive officer, designates an overall performance level or levels required to earn each target award and may also determine threshold performance levels at which minimum awards are earned and performance levels that result in maximum awards to be paid. Target awards may vary among executives based on competitive market practices for comparable positions, their decision-making authority and their ability to affect financial and operational performance. In addition to performance-related awards, the Committee may make and pay out discretionary cash awards at any time. The Committee has the discretion to adjust the annual performance targets during the year in the event of acquisitions and divestitures, restructured or discontinued operations, or other extraordinary or unusual events occurring during the year. The Committee evaluates the allocation factors within the Annual Incentive Plan on an annual basis and has the flexibility to adjust the structure including allocation percentages as needed in order to better align the incentives under the Annual Incentive Plan.

For fiscal 2010, the Annual Incentive Plan target awards for our named executive officers were 50% based upon our company achieving a consolidated Adjusted EBITDA performance level goal of $332,898,501 and 50% based upon our company achieving a consolidated free cash flow performance level goal of $183,129,265. The Committee set threshold and maximum awards for the named executive officers for fiscal 2010 under the Annual Incentive Plan. For the named executive officers, threshold awards of an aggregate of 10% of the target awards were payable upon reaching 91% of the Adjusted EBITDA goal and 91% of the free cash flow goal, with increased awards of 20% to 90% of the target awards payable upon our company reaching 92% to 99% of the Adjusted EBITDA goal and the free cash flow goal. For the named executive officers maximum awards of an aggregate of 150% of the target awards were payable upon reaching 110% of the Adjusted EBITDA goal and 110% of the free cash flow goal, with increased awards of 105% to 145% of the target awards payable upon our company reaching 101% to 109% of the Adjusted EBITDA goal and the free cash flow goal.

Under the Annual Incentive Plan, the target percentages of base salary set for fiscal 2010 and the threshold, target and maximum payments for each of the named executive officers for fiscal 2010 were as follows.

Percentage of Base Salary	Charles N. Martin, Jr.	Phillip W. Roe	Keith B. Pitts	Kent H. Wallace	Bradley A. Perkins	Mark R. Montoney
Target	100%	70%	90%	90%	90%	70%
Threshold	10%	7%	9%	9%	9%	7%
Maximum	150%	105%	135%	135%	135%	105%
Financial Weightings						
Adjusted EBITDA(1)	50%	50%	50%	50%	50%	50%
Free cash flow(2)	50%	50%	50%	50%	50%	50%

(1) Adjusted EBITDA is defined by us as income (loss) before interest expense (net of interest income), income taxes, depreciation and amortization, non-controlling interests, gain or loss on the disposal of assets, equity method income, stock compensation, monitoring fees and expenses, realized holding loss on investments, debt extinguishment costs, acquisition related expenses, impairment loss and discontinued operations, net of taxes. Monitoring fees and expenses represent fees and reimbursed expenses paid to affiliates of The Blackstone Group and Metalmark Subadvisor LLC for advisory and oversight services.

(2) Free cash flow is defined by us as Adjusted EBITDA minus capital expenditures except those construction projects which we are allowed to exclude from our covenant limiting our annual capital expenditures found in our principal credit facility.

All of our named executive officers earned 90% of their target awards with respect to the adjusted EBITDA performance goal under our Annual Incentive Plan for fiscal 2010 and 145% of their target awards with respect to the free cash flow performance goal under the Plan for fiscal 2010. These awards were approved by the Committee and will be paid to our named executive officers prior to September 30, 2010 in the individual amounts set forth in the column of the Summary Compensation Table entitled "Non-Equity Incentive Plan Compensation", except that the amounts earned in excess of 100% of the target awards are payable as follows: 1/3 in September 2010, 1/3 in September 2011, and 1/3 in September 2012.

The Committee has historically attempted to maintain consistency year over year with respect to the difficulty of achieving the financial performance goals under our Annual Incentive Plan. The financial performance goals used by the Committee in recent years (and in our fiscal year 2010, as set forth above) for the annual incentive awards for most of our executive officers (Adjusted EBITDA and free cash flow) are identical to or derived from our consolidated annual Adjusted EBITDA and capital expenditures budgets approved at the beginning of each fiscal year by our board of directors. Our consolidated annual Adjusted EBITDA budget, and, thus, the annual Adjusted EBITDA financial target, typically increases each year to promote continuous growth consistent with our business plan. Despite these increases, the financial performance targets are designed to be realistic and attainable though slightly aggressive, requiring in each fiscal year strong performance and execution that in our view provides an annual incentive firmly aligned with stockholder interests. This balance is reflected in the fact that none of our named executive officers earned any awards under the Annual Incentive Plan for fiscal year 2007 when our Company's financial performance was not strong, but they did earn their full target awards under the Annual Incentive Plan for fiscal years 2008 and 2009 when our Company's financial performance was much stronger and they earned 90% of their Adjusted EBITDA target awards and all of their free cash flow target awards for fiscal year 2010 when our Company's performance was reasonably strong.

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Long Term Incentive Plan

On August 18, 2009, our board of directors approved for all of our executive officers a new long term cash incentive compensation plan called the "Vanguard Health Systems, Inc. 2009 Long Term Incentive Plan" (the "Long Term Plan"). The Long Term Plan was designed to secure the continuity and retention of our executive officers by paying them additional cash incentive compensation on a long term basis for meeting our annual financial and operational goals and the growth objectives of our stockholders and to further motivate them both as to annual and long-term performance. The Long Term Plan supplements our Annual Incentive Plan which provides our executive officers with an opportunity to earn cash incentive compensation payable all, or substantially all, on a short term basis.

In conformity with the provisions of the Long Term Plan, starting in our fiscal year ended June 30, 2010 our board of directors established a specific earnings-related or operations-related goal or goals for all of our executive officers. The executive officers will be eligible to receive a cash award or awards based primarily on the extent to which we meet our pre-established earnings and/or other operations-related goals. However, under the Long Term Plan the cash incentive compensation payable to the executive officers for meeting their goals and earning their awards will be payable to them, without any interest, on a long term basis, in a lump sum typically a few years after the measuring period is over or in installments over a few years (the "payment date" or "payment dates"). The board of directors will determine one or more target awards for each executive officer, designate a performance level or levels for Vanguard which is required to earn each target award and may also determine threshold performance levels at which minimum awards are earned and performance levels that result in maximum awards to be paid. Target awards may vary among executives based on competitive market practices for comparable positions, their decision-making authority and their ability to affect financial and operational performance. In addition to performance-related awards, the board of directors may also make discretionary awards at any time under the Long Term Plan. If an officer's employment terminates before any payment date, the officer will forfeit any award due on any payment date or dates which should occur after his termination date (except where both a change of control of Vanguard has occurred and the officer was terminated subsequent to the change of control without cause).

Also, the board of directors has the discretion to adjust the annual performance targets during the year in the event of acquisitions and divestitures, restructured or discontinued operations, or other extraordinary or unusual issues occurring during the year. The board of directors will evaluate the allocation factors within the Long Term Plan on an annual basis and has the flexibility to adjust the structure including allocation percentages as needed in order to better align the incentives under the Long Term Plan.

For fiscal 2010 the board of directors set target awards for our executive officers under the Long Term Plan based solely on Vanguard achieving a consolidated Adjusted EBITDA performance level goal of $338,252,216. Target award levels for our executive officers ranged from 30% to 50% of their base salaries. These target award levels were 50% for our Chairman and Chief Executive Officer (Charles N. Martin, Jr.), 35% for our Chief Financial Officer (Phillip W. Roe), 45% for the following other named executive officers: our Vice Chairman (Keith B. Pitts); our President and Chief Operating Officer (Kent H. Wallace); our Chief Transformation Officer (Bradley A. Perkins, MD), and 35% for our Chief Medical Officer (Mark R. Montoney, MD). The board of directors also set maximum awards for our executive officers under the Long Term Plan for the fiscal year 2010 based solely on Vanguard achieving a 10% higher consolidated Adjusted EBITDA performance level goal than for the performance level goal of $338,252,216 for the target awards. Maximum award levels for our executive officers ranged from 60% to 100% of their base salaries. These maximum award levels were 100% for our Chairman and Chief Executive Officer (Charles N. Martin, Jr.), 70% for our Chief Financial Officer (Phillip W. Roe); 90% for the following other named executive officers: our Vice Chairman (Keith B. Pitts), our President and Chief Operating Officer (Kent H. Wallace); our Chief Transformation Officer (Bradley A. Perkins, MD); and 70% for our Chief Medical Officer (Mark R. Montoney, MD). The board of directors set the payment dates for the awards as 1/3 in September 2011, 1/3 in September 2012 and 1/3 in September 2013. The term "named executive officer" as used above in this report refers to our executive officers for whom disclosure was required under Item 402(c) of Regulation S-K. Adjusted EBITDA is defined by us as income (loss) before interest expense (net of interest income), income taxes, depreciation and amortization, non-controlling interests, gain or loss on the disposal of assets, equity method income, stock compensation, monitoring fees and expenses, realized holding loss on investments, debt extinguishment costs, acquisition costs, impairment loss and discontinued operations, net of taxes.

None of our named executive officers earned any awards under the Long Term Plan for fiscal 2010.

Long-Term Equity-Based Incentive Compensation

Our executive officer compensation has a substantial equity component as we believe superior equity investors' returns are achieved through a culture that focuses on long-term performance by our named executive officers and other key employees. By providing our executives with an equity stake in the company, we are better able to align the interests of our named executive officers and our other equity holders, who are principally the Sponsors. Because employees are able to profit from stock options only if our stock price increases relative to the stock option's exercise price, we believe stock options provide meaningful incentives to employees to achieve increases in the value of our stock over time.

As discussed elsewhere in this report, at the time of the Merger, Messrs. Martin, Roe, Pitts and Wallace were allowed by the Sponsors to each purchase certain amounts of Class B, C and D units in our parent entity, VHS Holdings LLC, which units function as equity incentive units in our capital structure. For example, such B and D units vested 20% a year over five years from September 2004 to September 2009, and the C units will only vest upon the eighth anniversary of their grant on September 23, 2014 (or earlier upon a Liquidity Event). Since September 2004, we have also maintained the Vanguard Health Systems, Inc. 2004 Stock Option Plan and from time to time we have granted options to purchase our common stock to all of the named executive officers pursuant to this plan, except for Mr. Martin. In making long-term equity incentive grants of options to the named executive officers, certain factors are considered, including but not limited to, the position the executive has or is taking with us, the present equity ownership levels of the named executive officer, and the level of the executive's total annual compensation package compared to similar positions at other healthcare companies. There is no set program schedule for option grants under the plan to the named executive officers, but most typically option grants to them (as well as other key employees) are made upon hiring or upon promotion. However, our named executive officers and other employees are also eligible to receive additional or "refresher" grants from time to time. We do not have a set program for the award of refresher grants, and the Committee retains discretion to make stock option awards to employees at any time. Since the Merger Mr. Martin has recommended grants to the Committee in respect of all proposed option grantees, including the named executive officers, except for himself. The Committee reviews the recommendations from Mr. Martin and makes the final determination and approval in respect of all grants. Since the Merger no options under the plan have been granted to Mr. Martin. During fiscal 2010 options were granted under the plan only to two named executive officers, Dr. Perkins, who was granted 6,000 options on August 18, 2009, and Dr. Montoney who was granted 2,500 options on August 18, 2009.

Prior to this report, 65% of the options under each option grant have vested 20% a year over 5 years and 35% vest only upon the eighth anniversary of the date of the grant. The exercise price of all of our option grants has been set by the Committee at no less than the fair market value of a share of the common stock as of the grant date, as determined by the Committee in good faith and supplemented and supported by an independent third party valuation. We do not have any program or plan obligation that requires us to grant stock options on specified dates, and we have not made equity grants in connection with the release or withholding of material non-public information.

Benefits and Executive Perquisites

The Committee believes that attracting and retaining superior management talent requires an executive compensation program that is competitive in all respects with the programs provided at similar companies. In addition to salaries, annual cash incentive compensation and equity awards, competitive executive compensation programs include retirement and welfare benefits and reasonable executive perquisites.

Retirement Benefits

Substantially all of our salaried employees, including our named executive officers, participate in our 401(k) savings plan. Employees are permitted to defer a portion of their income under the 401(k) plan. At our discretion, we may make a matching contribution of either (1) up to 50%, subject to annual limits established under the Internal Revenue Code, of the first 6% of an employee's contributions to the 401(k) plan as determined each year or (2) in respect of a few of our employees who came to us with plans in place having a larger match than this match, a match of 100% of the first 5% of an employee's contributions to the 401(k) plan. Most recently, we authorized such maximum discretionary amounts as a match on employees' aggregate 401(k) plan contributions for calendar year 2007, including the named executive officers. Employee contributions to the 401(k) plan are fully vested immediately. Our matching contributions to the 401(k) plan vest to the employee's account over time based upon the employee's years of service with us, with 20% of our contribution vesting after 2 years of service, 40% after 3 years, 60% after 4 years, 80% after 5 years and 100% after 6 years. Participants may receive distribution from their 401(k) accounts any time after they cease service with us.

We maintain no defined benefit plans or non-qualified deferred compensation plans.

Other Benefits

All executive officers, including the named executive officers, are eligible for other benefits including: medical, dental, short-term disability and life insurance. The executives participate in these plans on the same basis, terms, and conditions as other administrative employees. In addition, we provide long-term disability insurance coverage on behalf of the named executive officers at an amount equal to 60% of current base salary (up to $10,000 per month). The named executive officers also participate in our vacation, holiday and sick day program which provides paid leave during the year at various amounts based upon the executive's position and length of service.

Perquisites

Our executive officers may have limited use of our corporate plane for personal purposes as well as other very modest usual and customary perquisites. All perquisites for the named executive officers are reflected in the All Other Compensation column of the Summary Compensation Table and the accompanying footnotes.

Our Employment Agreements with the Named Executive Officers

We have entered into written employment agreements with all of our named executive officers. On June 1, 1998, we entered into a written employment agreement with our Chief Executive Officer (Mr. Martin) which was amended and restated on September 23, 2004 to extend the term of the employment agreement for five years and to provide that the Merger did not constitute a change in control under the agreement. On September 1, 1999, we entered into a written employment agreement with Keith B. Pitts to be our Executive Vice President for a term expiring on September 1, 2004. Effective May 31, 2001, Mr. Pitts was promoted to the position of Vice Chairman. On September 23, 2004, his employment agreement was amended and restated to extend the term of the employment agreement for five years, and to provide that the Merger did not constitute a change in control under the agreement. On November 15, 2007, we entered into written employment agreements with our Chief Operating Officer and our Chief Financial Officer (Messrs. Wallace and Roe, respectively) for terms expiring on November 15, 2012. On December 31, 2008, we entered into a written employment agreement with Mark R. Montoney, MD to be our Executive Vice President and Chief Medical Officer for a term expiring on December 31, 2013. On July 1, 2009, we entered into a written employment agreement with Bradley A. Perkins, MD to be our Executive Vice President-Strategy & Innovation and Chief Transformation Officer for a term expiring on June 30, 2014.

The term of each employment agreement will renew automatically for additional one-year periods, unless the agreement is terminated by us or by the named executive officer by delivering notice of termination no later than 90 days before the end of the five-year term or any such renewal term. The base salaries of Messrs. Martin, Roe, Pitts, Wallace and Montoney under the written employment agreements have been since April 1, 2009, and were as of the date of this report, $1,098,079, $525,000, $685,000, $685,000 and $522,750, respectively; and the base salary of Dr. Perkins under his written employment agreement has been since July 1, 2009 and was as of the date of this report $675,000. Pursuant to these agreements the executives are eligible to participate in an annual bonus plan giving each of them an opportunity to earn an annual bonus determined by our board of directors, as well as retirement, medical and other customary employee benefits. The terms of these agreements state that if the executive terminates his employment for Good Reason (as defined in the agreements) or if we terminate the executive's employment without Cause (as defined in the agreements), he will receive within a specified time after the termination a payment of up to three times the sum of (1) his annual salary plus (2) the average of the bonuses given to him in the two years immediately preceding his termination.

Our Severance Protection Agreements

We provide all of our executives at the Vice President level and above with severance protection agreements granting them severance payments in amounts of 200% to 250% of annual salary and bonus, except for those executives who have written employment agreements with us. Generally, severance payments are due under these agreements if a change in control (as defined in the agreements) occurs and employment of the executive is terminated during the term of the agreement by us (or our successor) without Cause (as defined in the agreements) or by the executive for Good Reason (as defined in the agreements). In addition, the agreements state that, in the event of a Potential Change in Control (defined as the time at which an agreement which would result in a change in control is signed, an acquisition attempt relating to us is publicly announced or there is an increase in the number of shares owned by one of our 10% shareholders by 5% or more), the executives have an obligation to remain in our employ until the earliest of (1) six months after the Potential Change in Control; (2) a change in control; (3) a termination of employment by us; or (4) a termination of employment by the executive for Good Reason (treating Potential Change in Control as a change in control for the purposes of determining whether the executive had a Good Reason) or due to death, disability or retirement. On September 23, 2004, all the outstanding severance protection agreements were amended and restated to provide that the Merger did not constitute a change in control under the agreements and that we would not terminate the agreements prior to the third anniversary of the closing of the Merger.

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Stock Ownership

We do not have a formal policy requiring stock ownership by management. Notwithstanding the absence of a requirement, our senior managers, including all of our named executive officers, have committed significant personal capital to our company in connection with the consummation of the Merger. See the beneficial ownership chart below under "Security Ownership of Certain Beneficial Owners and Management." Our stock is not publicly traded and is subject to a stockholder agreement that limits a stockholder's ability to transfer his or her shares. See "Holdings Limited Liability Company Agreement" and "Stockholders Agreement" under "Certain Relationships and Related Person Transactions."

Impact of Tax and Accounting Rules

The forms of our executive compensation are largely dictated by our capital structure and have not been designed to achieve any particular accounting treatment. We do take tax considerations into account, both to avoid tax disadvantages and to obtain tax advantages where reasonably possible consistent with our compensation goals (tax advantages for our executives benefit us by reducing the overall compensation we must pay to provide the same after-tax income to our executives). Thus our severance pay plans are designed or are being reviewed to take account of and avoid "parachute" excise taxes under Section 280G of the Internal Revenue Code. Similarly we have taken steps to structure and assure that our executive compensation program is applied in compliance with Section 409A of the Internal Revenue Code. Since we currently have no publicly traded common stock, we are not currently subject to the $1,000,000 limitation on deductions for certain executive compensation under Section 162(m) of the Internal Revenue Code, although that limitation will be considered if our common stock becomes publicly traded. Incentives paid to executives under our annual incentive plan are taxable at the time paid to our executives.

Recovery of Certain Awards

We do not have a formal policy for recovery of annual incentives paid on the basis of financial results which are subsequently restated. Under the Sarbanes-Oxley Act, our chief executive officer and chief financial officer must forfeit incentive compensation paid on the basis of financial statements for which they were responsible and which need to be restated. In the event of such a restatement, we would expect to recover affected bonuses and incentive compensation. If another situation potentially warranting recovery of awards arises, we would consider our course of action in light of the particular facts and circumstances, including the culpability of the individuals involved.

Risk Analysis of Compensation Plans

After analysis, we believe that our compensation policies and practices for our employees, including our executives, do not encourage excessive risk or unnecessary risk-taking and in our opinion the risks arising from such compensation policies and practices are not reasonably likely to have a material adverse effect on us. Our compensation programs have been balanced to focus our key employees on both short- and long-term financial and operational performance.

Summary Compensation Table

The following table sets forth, for the fiscal years ended June 30, 2010, 2009 and 2008, the compensation earned by the Chief Executive Officer and Chief Financial Officer and the four other most highly compensated executive officers of the registrant, Vanguard, at the end of Vanguard's fiscal year ended June 30, 2010. We refer to these persons as our named executive officers.

Name and Principal Position	Year	Salary ($)	Bonus ($)	Non-Equity Incentive Plan Compensation ($)(a)	Option Awards ($)(b)	All Other Compensation ($)(c)	Total
Charles N. Martin, Jr.							
Chairman of the Board &	2010	1,098,079	—	1,290,243	—	14,208	2,402,530
Chief Executive Officer	2009	1,062,238	—	1,454,956	—	13,758	2,530,952
	2008	1,050,291	—	1,050,291	—	13,608	2,114,190
Phillip W. Roe							
Executive Vice President,	2010	525,000	—	431,813	—	8,352	965,165
Chief Financial Officer &	2009	487,500	—	486,939	—	7,640	982,079
Treasurer	2008	440,192	—	332,500	537,683	7,620	1,317,995
Keith B. Pitts							
Vice Chairman	2010	685,000	—	724,388	—	8,592	1,417,980
	2009	652,633	—	816,864	—	8,142	1,477,639
	2008	641,845	100,000	577,661	403,262	7,992	1,730,760
Kent H. Wallace							
President &	2010	685,000	—	724,388	—	9,132	1,418,520
Chief Operating Officer	2009	621,250	—	816,864	1,617,712	8,142	3,063,968
	2008	600,000	100,000	540,000	403,262	7,992	1,651,254
Bradley A. Perkins, MD							
Executive Vice President &	2010	675,000	—	713,813	2,083,935	24,506	3,497,254
Chief Transformation	2009	2,596(d)	—	—	—	—	2,596
Officer	2008	—	—	—	—	—	—
Mark R. Montoney, MD							
Executive Vice President &	2010	522,750	—	429,962	868,306	52,707	1,873,725
Chief Medical Officer	2009	—	—	—	—	—	—
	2008	—	—	—	—	—	—

(a) The Compensation Committee determined the amount of Annual Incentive Plan compensation that was earned by each of these named executive officers for fiscal 2010. This amount will be paid to each named executive officer in September 2010, except, for Messrs. Martin, Roe, Pitts, Wallace, Perkins and Montoney, amounts earned in excess of 100% of their target awards for exceeding the free cash flow performance goal under the Plan for fiscal year 2010 (such amounts being $247,068 for Mr. Martin, $82,688 for Mr. Roe, $138,713 for Mr. Pitts, $138,713 for Mr. Wallace, $136,688 for Dr. Perkins and $82,333 for Dr Montoney) are payable as follows: 1/3 in September 2010, 1/3 in September 2011 and 1/3 in September 2012. See "Compensation Discussion and Analysis — Annual Cash Incentive Compensation" for more details in respect of the incentive plan awards.

(b) Option Awards reflect the aggregate grant date fair value of the option award computed in accordance with ASC Topic 718, *"Compensation — Stock Compensation"* (excluding estimates of forfeitures) with respect to options to purchase shares of our common stock which have been awarded under our 2004 Stock Incentive Plan in our 2010, 2009 and 2008 fiscal years to five of our named executive officers. See Note 13 of the Notes to our consolidated financial statements for the fiscal year ended June 30, 2010 included in this report for assumptions used in calculation of these amounts. The actual number of Option Awards granted in fiscal 2010 is shown in the "Grants of Plan Based Awards in Fiscal Year 2010" table set forth below.

(c) The amounts disclosed under All Other Compensation in the Summary Compensation Table for fiscal 2010 represent: (1) the following amounts of our matching contributions made under our 401(k) plan: Mr. Martin: $7,350; Mr. Roe: $7,350; Mr. Pitts: $7,350; and Mr. Wallace: $7,350; (2) the following amounts of insurance premiums paid by Vanguard with respect to group term life insurance: Mr. Martin: $6,858; Mr. Roe $1,002; Mr Pitts: $1,242; Mr. Wallace: $1,782; Dr. Perkins: $1,246 and Dr. Montoney: $1,294 and (3) perquisites and other personal benefits as follows: Dr. Perkins: $23,260 for reimbursement of expenses related to his relocation to Nashville, Tennessee upon commencement of his employment on June 30, 2009 and Dr. Montoney: $51,413 for reimbursement of expenses related to his relocation to Nashville, Tennessee upon commencement of his employment on December 31, 2008. The relocation reimbursement for Dr. Perkins and Dr. Montoney includes reimbursement of payroll taxes related to the relocation benefits of $5,470 and $12,078, respectively, determined based upon the estimated marginal federal income tax rate applicable to each individual and the employee Medicare tax rate.

(d) This amount reflects solely one day of employment in fiscal year 2009 (June 30, 2009).

Grants of Plan-Based Awards in Fiscal Year 2010

Name	Grant Date	Estimated Future Payouts Under Non-Equity Incentive Plan Awards(a) Threshold ($)	Target ($)	Maximum ($)	All Other Option Awards: Number of Securities Underlying Options(b)(#)	Exercise or Base Price of Option Awards (b)($/share)	Grant Date Fair Value of Option Awards(b)($)
Charles N. Martin, Jr.							
AIP (c)	n/a	109,808	1,098,079	1,647,119			
LTIP (d)	n/a	—	549,040	1,098,079			
Phillip W. Roe							
AIP	n/a	36,750	367,500	551,250			
LTIP	n/a	—	183,750	367,500			
Keith B. Pitts							
AIP	n/a	61,650	616,500	924,750			
LTIP	n/a	—	308,250	616,500			
Kent H. Wallace							
AIP	n/a	61,650	616,500	924,750			
LTIP	n/a	—	308,250	616,500			
Bradley A. Perkins							
AIP	n/a	60,750	607,500	911,250			
LTIP	n/a	—	303,750	607,500			
	8/18/09				2,100	656.94	943,530
	8/18/09				2,100	656.94	1,140,405
	8/18/09				1,800	2,599.53	—
Mark R. Montoney							
AIP	n/a	36,593	365,925	548,888			
LTIP	n/a	—	182,963	365,925			
	8/18/09				875	656.94	393,138
	8/18/09				875	656.94	475,168
	8/18/09				750	2,599.53	—

(a) The threshold, target and maximum amounts in these columns have been provided in accordance with Item 402(d) of Regulation S-K and show the range of payouts targeted for fiscal 2010 performance under the Annual Incentive Plan and the Long Term Incentive Plan. For fiscal year 2010, each of the named executive officers earned non-equity incentive plan awards only under the Annual Incentive Plan, the Committee approved them and they will be paid in cash to the named executive officers in September 2010 (except for certain portions thereof payable in September 2011 and September 2012, as disclosed in footnote (a) to the Summary Compensation Table) and the full amounts of the awards are reflected in the Summary Compensation Table under the column labeled "Non-Equity Incentive Plan Compensation." See "Compensation Discussion and Analysis — Annual Cash Incentive Compensation — Annual Incentive Plan" for a detailed description of our Annual Incentive Plan, and see "Compensation Discussion and Analysis — Annual Cash Incentive Compensation-Long Term Incentive Plan" for a detailed description of our Long Term Incentive Plan.

(b) These stock options were awarded under the 2004 Stock Incentive Plan by the Committee as part of the named executive officer's long term equity incentive compensation. None of these options were granted with exercise prices below the fair market value of the underlying common stock on the date of grant. The exercise prices of these options were subsequently reduced by $400.47 in connection with the Refinancing so that the exercise prices are now $656.94, $656.94 and $2,599.53, respectively. Because we are a privately-held company, the Committee determines the fair market value of our common stock primarily from an independent appraisal of our common stock which we obtain no less frequently than annually. The terms of these option awards are described in more detail below under "Narrative Disclosure to Summary Compensation Table and Grants of Plan-Based Awards in Fiscal 2010 Table — Our 2004 Stock Incentive Plan." We utilize a Black-Scholes-Merton model to estimate the fair value of options granted. The aggregate grant date fair value of the option award

computed in accordance with ASC Topic 718, *"Compensation — Stock Compensation"* (excluding estimates of forfeitures) with respect to these option grants is reflected in the "Option Awards" column of the Summary Compensation Table.

(c) AIP in this table means our Annual Incentive Plan.

(d) LTIP in this table means our Long Term Incentive Plan.

Narrative Disclosure to Summary Compensation Table and Grants of Plan-Based Awards in Fiscal 2009 Table

Holdings LLC Units Plan

Holdings acquired Vanguard in the Merger on September 23, 2004. The following contains a summary of the material terms of the Holdings LLC Units Plan, which we refer to as the 2004 Unit Plan, pursuant to which Holdings granted the right to purchase units to members of our management on September 23, 2004 in connection with consummation of the Merger. On September 23, 2004, all of our named executive officers (except for Dr. Perkins and Dr. Montoney who were not employees on that date), and certain other members of our management, were granted the right to purchase units under the 2004 Units Plan by the Sponsors. Holdings does not own any property or assets other than the shares of Vanguard common stock acquired in connection with the Merger and the warrants to purchase additional shares of Vanguard common stock, described in further detail below. See "Certain Relationships and Related Transactions — Holdings Warrants".

General

The 2004 Unit Plan permits the grant of the right to purchase Class A Units, Class B Units, Class C Units and Class D Units to employees of Holdings or its affiliates. Originally, as adopted on September 23, 2004, a maximum of 117,067 Class A Units, 41,945 Class B Units, 41,945 Class C Units and 35,952 Class D Units were available for awards under the 2004 Unit Plan. On September 23, 2004, certain members of management purchased all 117,067 Class A Units for an aggregate purchase price of $117,067,000 and all 41,945 Class B units, all 41,945 Class C Units and all 35,952 of the Class D Units were purchased for an aggregate purchase price of $5.7 million. An additional 300 Class A Units were added to the Plan on February 22, 2005, and purchased for $300,000 by certain members of management on that date who did not participate in the purchases on September 23, 2004.

Administration

The 2004 Unit Plan is administered by a committee of Holdings' board of representatives or, in the board of representatives' discretion, the board of representatives. The committee has the sole discretion to determine the employees to whom awards may be granted under the 2004 Unit Plan, the number and/or class of Units to be covered by an award, the purchase price, if any, of such awards, determine the terms and conditions of any award and determine under what circumstances awards may be settled or cancelled. The committee is authorized to interpret the 2004 Unit Plan, to establish, amend and rescind any rules and regulations relating to the 2004 Unit Plan, and to make any other determinations that it deems necessary or desirable for the administration of the plan. The committee may correct any defect or supply any omission or reconcile any inconsistency in the 2004 Unit Plan in the manner and to the extent the committee deems necessary or desirable.

Adjustments Upon Certain Events

In the event of any changes in the Units by reason of any reorganization, recapitalization, merger, unit exchange or any other similar transaction, the board of representatives, in its sole discretion, may adjust (1) the number or kind of Units or other securities that may be issued or reserved for issuance pursuant to the 2004 Unit Plan or pursuant to any outstanding awards or (2) any other affected terms of such awards.

Amendment and Termination

The Holdings board of representatives may amend or terminate the 2004 Unit Plan at any time, provided that no amendment or termination is permitted that would diminish any rights of a management member pursuant to a previously granted award without his or her consent, subject to the committee's authority to adjust awards upon certain events as described in the previous paragraph. No awards may be made under the 2004 Unit Plan after the tenth anniversary of the effective date of the plan.

Holdings LLC Units Held by Certain of our Managers

The units of Holdings consist of Class A units (subdivided into Class A-1 units and Class A-2 units), Class B units, Class C units and Class D units. As of August 15, 2010, approximately 59.3% of Holdings' Class A Units were held by Blackstone, approximately 20.8% were held by MSCP, approximately 15.0% were held by certain members of our management (or members of their families, or trusts for the benefit of them or their families) and approximately 4.9% were held by other investors. The Class B units, Class C units and Class D units are held exclusively by members of our senior management (or trusts for their benefit) and all such units were purchased on September 23, 2004.

Of our named executive officers, Charles N. Martin, Jr. beneficially owns 40,000 class A units, 8,913 class B units, 8,913 class C units and 7,640 class D units, Phillip W. Roe beneficially owns 3,030 class A units, 2,097 class B units, 2,097 class C units and 1,798 class D units; Keith B. Pitts beneficially owns 11,000 class A units, 5,243 class B units, 5,243 class C units and 4,494 class D units; Kent H. Wallace beneficially owns 850 class A units, 2,622 class B units, 2,622 class C units and 2,247 class D units; and Bradley A. Perkins, MD and Mark R. Montoney, MD own no units. As of the date of this report, none of the class C units are vested, but 100% of the Class B and D units are vested. See the vesting provisions in respect of the class A, B, C and D units in the discussion immediately below.

Terms of the Holdings' Class A Units, Class B Units, Class C Units and Class D Units

The following is a summary of certain terms of the Holdings' Class A-1 units, Class B units, Class C units and Class D units and certain rights and restrictions applicable to those units. For a description of certain terms of Holdings' Class A-2 units, see "Certain Relationships and Related Transactions — Holdings Warrants".

Class A-1 units have economic characteristics that are similar to those of shares of common stock in a private corporation but have a priority with respect to return of invested capital, as described further below. Subject to applicable law and certain terms of the limited liability company operating agreement, only the holders of Class A units are entitled to vote on any matter. Class A units are not subject to any vesting restrictions. The Class B units, Class C units and Class D units generally do not entitle the holder thereof to vote on matters of Holdings which require member consent, and such units are subject to the vesting provisions described below.

Class B units vest in five equal annual installments on the first five anniversaries of the date of purchase, subject to an employee's continued service with Holdings and its affiliates. However, the Class B units will vest earlier upon a change of control of Holdings. In the event of an employee's termination of employment with Vanguard, other than due to termination by Vanguard for "cause" or by the employee without "good reason", the employee shall be deemed vested in any Class B unit that would otherwise have vested in the calendar year in which such termination of employment occurs. No employee who holds Class B units will receive any distributions made by Holdings (other than certain distributions made by Holdings to holders of units to satisfy certain tax obligations arising from the holding of such units) until the holders of the Class A-1 units receive the aggregate amount invested for such Class A-1 units. Following the return by Holdings of the aggregate amount invested for the Class A-1 units, the holders of Class B units will, concurrently with the holders of Class C units and Class D units in respect of their respective investment in such units, be entitled to receive the amount of their investment in the Class B units. Once all the aggregate investment amount invested for all of the units has been returned to their holders, the vested Class B units will share in any distributions made by Holdings pro rata with the Class A-1 units and vested Class C units until such time as the holders of Class A-1 units have received an amount in respect of such Class A-1 units equal to three times the amount of their investment in such Class A-1 units, at which point the holders of vested Class B units will share in any further distributions made by Holdings pro rata with the Class A-1 units, vested Class C units and vested Class D units.

Class C units vest on the eighth anniversary of the date of purchase, subject to the employee's continued service with Holdings and its affiliates. However, the Class C units will vest earlier upon the occurrence of a sale by Blackstone of at least 25.0% of its Class A units at a price per Class A unit exceeding $2,099.53. No employee who holds Class C units will receive any distributions made by Holdings (other than certain distributions made by Holdings to holders of units to satisfy certain tax obligations arising from the holding of such units) until the holders of the Class A-1 units receive the aggregate amount invested for such Class A-1 units. Following the return by Holdings of the aggregate amount invested for the Class A-1 units, the holders of Class C units will, concurrently with the holders of Class B units and Class D units in respect of their respective investments in such units, be entitled to receive the amount of their investment in the Class C units. Once all the aggregate investment amount invested for all of the units has been returned to their holders, the vested Class C units will share in any distributions made by Holdings pro rata with the Class A-1 units and vested Class B units until such time as the holders of Class A-1 units have received an amount in respect of such Class A-1 units equal to three times the amount of their investment in such Class A-1 units, at which point the holders of vested Class C units will share in any further distributions made by Holdings pro rata with the Class A-1 units, vested Class B units and vested Class D units.

Class D units vest in five equal annual installments on the fifth anniversary of the date of purchase, subject to an employee's continued service with Holdings and its affiliates. However, the Class D units will vest earlier upon a change of control of Holdings. In the event of an employee's termination of employment with Vanguard, other than due to termination by Vanguard for "cause" or by the employee without "good reason", the employee shall be deemed vested in any Class D unit that would otherwise have vested in the calendar year in which such termination of employment occurs. No employee who holds Class D units will receive any distributions made by Holdings (other than certain distributions made by Holdings to holders of units to satisfy certain tax obligations arising from the holding of such units) until the holders of the Class A-1 units receive the aggregate amount invested for such Class A-1 units. Following the return by Holdings of the aggregate amount invested for the Class A-1 units, the holders of Class D units will, concurrently with the holders of Class B units and Class C units in respect of their respective investment in such units, be entitled to receive the amount of their investment in the Class D units., Once all the aggregate investment amount invested for all of the units has been returned to their holders and the holders of the Class A-1 units have received an amount in respect of such Class A-1 units equal to three times the amount of their investment in such Class A-1 units, the vested Class D units will share in any distributions made by Holdings pro rata with the Class A-1 units, the vested Class B units and the vested Class C units.

The timing and amount of distributions to be made by Holdings, other than certain distributions made by Holdings to holders of units to satisfy certain tax obligations arising from the holding of such units, is determined by the board of representatives of Holdings in its discretion. In addition, Holdings may not make distributions to holders of Class B units, Class C units and Class D units other than with shares of common stock underlying the Holdings Warrants (or any proceeds received in respect of such shares).

Certain Rights and Restrictions Applicable to the Units Held by Our Managers

The units in Holdings held by members of our management are not transferable except in limited circumstances or with the prior approval of the board of representatives of Holdings. In addition, the units held by members of our senior management (other than Class A units) may be repurchased by Holdings or Vanguard, and in certain cases, other members of senior management and/or Blackstone and MSCP, in the event that the employees cease to be employed by us. Unvested units may be repurchased at a price equal to the lower of cost and fair market value, and vested units may be repurchased at a price equal to the fair market value of such units, except in the event of a termination for "cause", in which event the purchase price would be the lower of cost and fair market value. Any such units to be repurchased will be repurchased in cash, or, in certain limited instances, for a promissory note, shares of our common stock or Holdings Warrants. The limited liability company agreement further requires that in the event that any unvested Class B, C or D units are repurchased by Holdings prior to a change of control (or in the case of the Class C units, a "Liquidity Event" (as defined in such agreement)), then, as determined by the chief executive officer of the Company and approved by the board of representatives of Holdings, such repurchased units will be regranted to members of senior management who hold units in Holdings, or other securities having equivalent economics will be issued to other key employees of Vanguard under the 2004 Stock Incentive Plan.

Blackstone has the ability to force the employees to sell their units along with Blackstone if Blackstone decides to sell its units. Also, the employees that hold units are entitled to participate in certain sales by Blackstone. In addition, in the event that the members of management receive shares of common stock in respect of their units, they will have limited rights to participate in subsequent registered public offerings of our common stock. See "Certain Relationships and Related Transactions — Registration Rights Agreement".

Our 2004 Stock Incentive Plan

General

Since all Units have been granted under the 2004 Unit Plan, we intend for our option and restricted stock units program pursuant to our 2004 Stock Incentive Plan to be the primary vehicle currently for offering long-term incentives and rewarding our executive officers, managers and key employees. Because of the direct relationship between the value of an option and the value of our stock, we believe that granting options or restricted stock units is the best method of motivating our executive officers to manage our Company in a manner that is consistent with our interests and our stockholders' interests. We also regard our option and restricted stock unit program as a key retention tool.

We adopted the 2004 Stock Incentive Plan upon consummation of the Merger which permits the grant of non-qualified stock options, incentive stock options, stock appreciation rights, restricted stock, restricted stock units and other stock-based awards to our employees or our affiliates' employees. Shares covered by awards that expire, terminate or lapse are again available for option or grant under the 2004 Stock Incentive Plan. The total number of shares of our common stock which may be issued under the 2004 Stock Incentive Plan in future grants of options or restricted stock units as of August 15, 2010, was 28,109. All of our previous option plans were terminated upon consummation of the Merger on September 23, 2004.

Administration

The 2004 Stock Incentive Plan is administered by the Committee or, in the sole discretion of the board of directors, the board of directors. The Committee has the sole discretion to determine the employees, representatives and consultants to whom awards may be granted under the 2004 Stock Incentive Plan and the manner in which such awards will vest. Options, stock appreciation rights, restricted stock and other stock-based awards will be granted by the Committee to employees, representatives and consultants in such numbers and at such times during the term of the 2004 Stock Incentive Plan as the Committee shall determine. The Committee is authorized to interpret the 2004 Stock Incentive Plan, to establish, amend and rescind any rules and regulations relating to the 2004 Stock Incentive Plan, and to make any other determinations that it deems necessary or desirable for the administration of the plan. The Committee may correct any defect or supply any omission or reconcile any inconsistency in the 2004 Stock Incentive Plan in the manner and to the extent the Committee deems necessary or desirable.

Stock Options and Stock Appreciation Rights

Options granted under the 2004 Stock Incentive Plan are vested and exercisable at such times and upon such terms and conditions as may be determined by the Committee, but in no event will an option be exercisable more than 10 years after it is granted. Under the 2004 Stock Incentive Plan, the exercise price per share for any option awarded is determined by the Committee, but may not be less than 100% of the fair market value of a share on the day the option is granted with respect to incentive stock options.

Stock option grants under the 2004 Stock Incentive Plan are generally made at the commencement of employment and occasionally following a significant change in job responsibilities or on a periodic basis to meet other special retention or performance objectives. All stock options granted by our board of directors to date under the 2004 Stock Incentive Plan have been granted at or above the fair market value of our common stock at the grant date based upon the most recent appraisal of our common stock. We have not back-dated any option awards.

As a privately-owned company, there has been no market for our common stock. Accordingly, in fiscal year 2010, we had no program, plan or practice pertaining to the timing of stock option grants to executive officers, coinciding with the release of material non-public information.

An option may be exercised by paying the exercise price in cash or its equivalent, and/or, to the extent permitted by the Committee, shares, a combination of cash and shares or, if there is a public market for the shares, through the delivery of irrevocable instruments to a broker to sell the shares obtained upon the exercise of the option and to deliver to us an amount equal to the exercise price.

The Committee may grant stock appreciation rights independent of or in conjunction with an option. The exercise price of a stock appreciation right is an amount determined by the Committee. Generally, each stock appreciation right entitles a participant upon exercise to an amount equal to (a) the excess of (1) the fair market value on the exercise date of one share over (2) the exercise price, times (b) the number of shares covered by the stock appreciation right. Payment will be made in shares or in cash or partly in shares and partly in cash (any shares valued at fair market value), as determined by the committee.

As of August 15, 2010, options to purchase 113,040 shares of our common stock (the "New Options") were outstanding under the 2004 Stock Incentive Plan. The New Options were granted in part as "time options," and in part as "performance options" which vest and become exercisable ratably on a yearly basis on each of the first five anniversaries following the date of grant (or earlier upon a change of control). 35% of the options granted were time options with an exercise price equal to the greater of the fair market price per share or $1,000 per share at the time of grant (reduced to a range of $599.53 to $767.03 per share subsequent to the Refinancing). 30% of the options granted were performance options with an exercise price of $3,000.00 per share (reduced to $2,599.53 per share subsequent to the Refinancing). 35% of the options granted were "liquidity options" with an exercise price equal to greater of the fair market price per share or $1,000 per share at the time of grant (reduced to a range of $599.53 to $767.03 per share subsequent to the Refinancing) that become fully vested and exercisable upon the completion of any of certain designated business events ("liquidity events"), and in any event on the eighth anniversary of the date of grant. Any shares of our common stock issued upon the exercise of such options are governed by a stockholders agreement, which is described below under "Certain Relationships and Related Transactions — Stockholders Agreement."

In respect of our named executive officers, as of as of August 15, 2010, Mr. Martin has been granted no New Options, while Mr. Roe has been granted 3,008 New Options, Mr. Pitts has been granted 1,500 New Options, Mr. Wallace has been granted 13,500 New Options, Dr. Perkins has been granted 6,000 New Options and Dr. Montoney has been granted 5,000 New Options. During fiscal year 2010, the Committee granted 6,000 New Options to Dr. Perkins and 2,500 New Options to Dr. Montoney, but no other named executive officer was granted any New Options.

Awards of Restricted Stock Units

On July 1, 2010, the Committee commenced the issuance of restricted stock units under the 2004 Stock Incentive Plan. As with its stock options grants, the Committee plans generally to make its grants of restricted stock units at the commencement of employment and occasionally following a significant change in job responsibilities or on a periodic basis to meet other special retention or performance objectives.

As of August 15, 2010, restricted stock units (the "RSUs") in respect of 3,455 shares of our common stock were outstanding under the 2004 Stock Incentive Plan. The RSUs were granted in part as "time vesting RSUs," which vest ratably on a yearly basis on each of the first five anniversaries following the date of grant (or earlier upon a change of control), and in part as "liquidity event RSUs" that become fully vested and exercisable upon the completion of any of certain designated business events ("liquidity events"), and in any event on the eighth anniversary of the date of grant. Upon vesting, we will issue to the grantee of the RSUs a number of shares of our common stock equal to the number of RSUs which have vested and upon such stock issuance the RSUs are extinguished. Any shares of our common stock issued upon the vesting of RSUs are governed by a stockholders agreement, which is described below under "Certain Relationships and Related Transactions — Stockholders Agreement."

Of our named executive officers, only Dr. Perkins has been issued RSUs and he has been issued 1,512 RSUs. During fiscal year 2010 no named executive officers were granted any RSUs.

Other Stock-Based Awards

The Committee, in its sole discretion, may grant restricted stock, stock awards, stock appreciation rights, unrestricted stock and other awards that are valued in whole or in part by reference to, or are otherwise based on the fair market value of our shares. Such other stock-based awards shall be in such form, and dependent on such conditions, as the Committee shall determine, including, without limitation, the right to receive, or vest with respect to, one or more shares (or the equivalent cash value of such shares) upon the completion of a specified period of service, the occurrence of an event and/or the attainment of performance objectives.

Adjustments Upon Certain Events

In the event of any stock dividend or split, reorganization, recapitalization, merger, share exchange or any other similar transaction, the Committee, in its sole discretion, may adjust (1) the number or kind of shares or other securities that may be issued or reserved for issuance pursuant to the 2004 Stock Incentive Plan or pursuant to any outstanding awards, (2) the option price or exercise price and/or (3) any other affected terms of such awards. In the event of a change of control, the Committee may, in its sole discretion, provide for the (1) termination of an award upon the consummation of the change of control, but only if such award has vested and been paid out or the participant has been permitted to exercise the option in full for a period of not less than 30 days prior to the change of control, (2) acceleration of all or any portion of an award, (3) payment of a cash amount in exchange for the cancellation of an award, which, in the case of options and stock appreciation rights, may equal the excess, if any, of the fair market value of the shares subject to such options or stock appreciation rights over the aggregate option price or grant price of such option or stock appreciation rights, and/or (4) issuance of substitute awards that will substantially preserve the otherwise applicable terms of any affected awards previously granted hereunder.

Amendment and Termination

The Committee may amend or terminate the 2004 Stock Incentive Plan at any time, provided that no amendment or termination shall diminish any rights of a participant pursuant to a previously granted award without his or her consent, subject to the Committee's authority to adjust awards upon certain events (described under "Adjustments Upon Certain Events" above). No awards may be made under the 2004 Stock Incentive Plan after the tenth anniversary of the effective date of the plan.

Outstanding Equity Awards at Fiscal 2010 Year-End

The following table summarizes the outstanding equity awards held by each named executive officer at at June 30, 2010. The table reflects options to purchase common stock of Vanguard which were granted under the 2004 Stock Incentive Plan.

Name	Number of Securities Underlying Unexercised Options (#) Exercisable(a)	Number of Securities Underlying Unexercised Options (#) Unexercisable(b)	Option Exercise Price ($)(c)	Option Expiration Date
Phillip W. Roe	283(d)	70(d)	749.90	11/3/15
	—	353(e)	749.90	11/3/15
	242(d)	60(d)	2,599.53	11/3/15
	280(f)	420(f)	599.53	2/5/18
	—	700(g)	599.53	2/5/18
	240(f)	360(f)	2,599.53	2/5/18
Keith B. Pitts	210(f)	315(f)	599.53	2/5/18
	—	525(g)	599.53	2/5/18
	180(f)	270(f)	2,599.53	2/5/18
Kent H. Wallace	687(d)	171(d)	749.90	11/3/15
	—	858(e)	749.90	11/3/15
	589(d)	147(d)	2,599.53	11/3/15
	1,274(j)	318(j)	749.90	11/28/15
	—	1,592(k)	749.90	11/28/15
	1,092(j)	272(j)	2,599.53	11/28/15
	210(f)	315(f)	599.53	2/5/18
	—	525(g)	599.53	2/5/18
	180(f)	270(f)	2,599.53	2/5/18
	350(l)	1,400(l)	656.94	5/5/19
	—	1,750(m)	656.94	5/5/19
	300(l)	1,200(l)	2,599.53	5/5/19
Bradley A. Perkins, MD	—	2,100(h)	656.94	8/18/19
	—	2,100(i)	656.94	8/18/19
	—	1,800(h)	2,599.53	8/18/19
Mark R. Montoney, MD	175(n)	700(n)	656.94	2/4/19
	—	875(o)	656.94	2/4/19
	150(n)	600(n)	2,599.53	2/4/19
	—	875(h)	656.94	8/18/19
	—	875(i)	656.94	8/18/19
	—	750(h)	2,599.53	8/18/19

(a) This column represents the number of stock options that had vested and were exercisable as of June 30, 2010.

(b) This column represents the number of stock options that had not vested and were not exercisable as of June 30, 2010.

(c) The exercise price for the options was never less than the grant date fair market value of a share of Vanguard common stock as determined by the Compensation Committee. The original exercise price as of the grant date was reduced by $400.47 in connection with the Refinancing during fiscal 2010.

(d) 20% of the options represented by this option grant vest and become exercisable on each of the first five anniversaries of the November 3, 2005 grant date of these options (or earlier upon a change of control). 80% of this option grant was vested as of June 30, 2010.

(e) 100% of the options represented by this option grant vest and become exercisable on the eighth anniversary of the November 3, 2005 grant date of these options (or earlier upon a liquidity event).

(f) 20% of the options represented by this option grant vest and become exercisable on each of the first five anniversaries of the February 5, 2008 grant date of these options (or earlier upon a change of control). 40% of this option grant was vested as of June 30, 2010.

(g) 100% of the options represented by this option grant vest and become exercisable on the eighth anniversary of the February 5, 2008 grant date of these options (or earlier upon a liquidity event).

(h) 20% of the options represented by this option grant vest and become exercisable on each of the first five anniversaries of the August 18, 2009 grant date of these options (or earlier upon a change of control). None of this option grant was vested as of June 30, 2010.

(i) 100% of the options represented by this option grant vest and become exercisable on the eighth anniversary of the August 18, 2009 grant date of these options (or earlier upon a liquidity event)

(j) 20% of the options represented by this option grant vest and become exercisable on each of the first five anniversaries of the November 28, 2005 grant date of these options (or earlier upon a change of control). 80% of this option grant was vested as of June 30, 2010.

(k) 100% of the options represented by this option grant vest and become exercisable on the eighth anniversary of the November 28, 2005 grant date of these options (or earlier upon a liquidity event).

(l) 20% of the options represented by this option grant vest and become exercisable on each of the first five anniversaries of the May 5, 2009 grant date of these options (or earlier upon change of control) 20% of this option grant was vested as of June 30, 2010.

(m) 100% of the options represented by this option grant vest and become exercisable on the eighth anniversary of the May 5, 2009 grant date of these options (or earlier upon a liquidity event).

(n) 20% of the options represented by this option grant vest and become exercisable on each of the first five anniversaries of the February 4, 2009 grant date of these options (or earlier upon change of control) 20% of this option grant was vested as of June 30, 2010.

(o) 100% of the options represented by this option grant vest and become exercisable on the eighth anniversary of the February 4, 2009 grant date of these options (or earlier upon a liquidity event).

Option Exercises and Stock Vested in Fiscal 2010

No named executive officer exercised any Vanguard stock options during fiscal 2010 nor were any restricted stock awards vested during fiscal 2010. Vanguard made no restricted stock or restricted stock unit awards of its common stock from the September 23, 2004 date of the consummation of the Merger through June 30, 2010.

Pension Benefits for Fiscal 2010

Vanguard maintains a 401(k) plan as previously discussed in the Compensation Discussion and Analysis. Vanguard maintains no defined benefit plans.

Nonqualified Deferred Compensation for Fiscal 2010

None of the named executive officers receive nonqualified deferred compensation benefits.

Potential Payments upon Termination or Change-in-Control

As discussed above, we have entered into definitive employment agreements with all six of the named executive officers (Messrs. Martin, Roe, Pitts, Wallace, Perkins and Montoney). The terms of these agreements are described above under Compensation Discussion and Analysis.

The following table describes the potential payments and benefits under our compensation and benefit plans and arrangements to which the named executive officers would be entitled upon a termination of their employment under their employment agreements. The amounts set forth in the table assume a termination of employment on June 30, 2010 (the last business day of our last completed fiscal year).

Name	Cash Severance Payment ($)	Continuation of Medical/Welfare Benefits (present value) ($)	Total Termination Benefits ($)
Charles N. Martin, Jr.			
- Voluntary retirement	—	—	—
- Involuntary termination	4,701,405	24,210	4,725,615
- Involuntary or Good Reason termination after change in control	7,052,108	24,210	7,076,318
Phillip W. Roe			
- Voluntary retirement	—	—	—
- Involuntary termination	1,869,439	18,862	1,888,301
- Involuntary or Good Reason termination after change in control	2,804,159	18,862	2,823,021
Keith B. Pitts			
- Voluntary retirement	—	—	—
- Involuntary termination	2,764,525	22,448	2,786,973
- Involuntary or Good Reason termination after change in control	4,146,788	22,448	4,169,236
Kent H. Wallace			
- Voluntary retirement	—	—	—
- Involuntary termination	2,726,864	24,210	2,751,074
- Involuntary or Good Reason termination after change in control	4,090,296	24,210	4,114,506
Bradley A. Perkins, MD			
- Voluntary retirement	—	—	—
- Involuntary termination	1,350,000	24,210	1,374,210
- Involuntary or Good Reason termination after change in control	2,025,000	24,210	2,049,210
Mark A. Montoney, MD			
- Voluntary retirement	—	—	—
- Involuntary termination	1,247,784	18,862	1,266,646
- Involuntary or Good Reason termination after change in control	1,871,676	18,862	1,890,538

Cash severance payments; Timing. Represents, for each of Messrs. Martin, Roe, Pitts, Wallace, Perkins and Montoney, (1) if it relates to an involuntary termination without Cause by us prior to a change of control, a payment of 2 times the named executive officer's base salary and average annual incentive actually paid during the last two years plus an additional amount equal to such officer's pro rata annual target incentive for the year of termination and (2) if it relates to an involuntary termination without cause by us or a Good Reason termination by the executive after a change-in-control, payment of 3 times the named executive officer's base salary and average annual incentive actually paid during the last two years plus an additional amount equal to such officer's pro rata annual target incentive for the year of termination. All of these severance payments are "lump sum" payments by us to the named executive officers due within 5 days of termination of employment, except that the amounts of severance described above payable to Messrs. Martin, Roe, Pitts, Wallace, Perkins and Montoney in respect of a termination of their employment prior to a change of control are payable monthly in equal monthly installments starting with the month after employment terminates and ending with the month that their 5-year employment agreements terminate (which is September 2010 for Messrs. Martin and Pitts, November 2012 for Messrs. Roe and Wallace, June 2014 for Dr. Perkins and December 2013 for Dr. Montoney)

Continuation of health, welfare and other benefits. Represents the value of coverage for 18 months following a covered termination equivalent to our current active employee medical, dental, life, long-term disability insurances and other covered benefits.

Accrued Pay and Regular Retirement Benefits. The amounts shown in the table above do not include payments and benefits to the extent they are provided on a non-discriminatory basis to salaried employees generally upon termination of employment. These include:

- Accrued salary and vacation pay and earned but unpaid bonus.
- Distributions of plan balances under our 401(k) plan.

Death and Disability. A termination of employment due to death or disability does not entitle the named executive officers to any payments or benefits that are not available to salaried employees generally.

Involuntary Termination and Change-in-Control Severance Pay Program. As described above, each of our named executive officers is entitled to severance pay in the event that his employment is terminated by us without Cause (as defined in the employment agreement) or if the named executive officer terminates the agreement as a result of our breach of his employment agreement. Additionally, each such executive is entitled to severance pay under his employment agreements in the event that he terminates the agreement after a change-in-control if his termination is for Good Reason (as defined in the employment agreement).

Under our executive severance pay program, no payments due in respect of a change of control are "single trigger," that is, payments of severance due to the named executive officers merely upon a change-in-control. All of our change-in-control payments are "double trigger", due to the executive only subsequent to a change-in-control and after a termination of employment has occurred.

Obligations of Named Executive Officers. Under their employment agreements, all of our named executive officers have the following obligations to us:

- Not to disclose our confidential business information,
- Not to solicit for employment any of our employees for a period expiring two years after the termination of their employment; and
- Not to accept employment with or consult with, or have any ownership interest in, any hospital or hospital management entity for a period expiring two years after the termination of their employment, except there shall be not such prohibitions if (1) we terminate the executive under his employment agreement or (2) the executive terminates his agreement for Good Reason or because we have breached his agreement.

Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters.

As of August 15, 2010, Holdings directly owned 624,104 of the outstanding shares of the common stock of Vanguard (representing a 83.3% ownership interest), certain investment funds affiliated with Blackstone directly owned 125,000 of the outstanding shares of the common stock of Vanguard (representing a 16.7% ownership interest) and no other person or entity had a direct beneficial ownership interest in the common stock of Vanguard, except for certain key employees who held an aggregate of 40,039 exercisable options into 40,039 shares of the common stock of Vanguard as of such date. However, ignoring only the direct ownership of Holdings in the common stock of Vanguard, the following table sets forth information with respect to the direct or indirect beneficial ownership of the common stock of Vanguard as of as of August 15, 2010 by (1) each person (other than Holdings) known to own beneficially more than 5.0% of the common stock of Vanguard, (2) each named executive officer, (3) each of our directors and (4) all executive officers and directors as a group. The indirect beneficial ownership of the common stock of Vanguard reflects the direct beneficial ownership of all Class A units and all vested Class B and D units of Holdings. None of the shares listed in the table is pledged as security pursuant to any pledge arrangement or agreement. Additionally, there are no arrangements with respect to the share, the operation of which may result in a change in control of Vanguard.

Notwithstanding the beneficial ownership of the common stock of Vanguard presented below, the limited liability company agreement of Holdings governs the holders' exercise of their voting rights with respect to election of Vanguard's directors and certain other material events. See "Certain Relationships and Related Party Transactions — Holdings Limited Liability Company Agreement."

Name of Beneficial Owner	Shares of Common Stock	Ownership Percentage
Blackstone Funds(1)	494,930	66.1%
MSCP Funds(2)	130,000	17.4%
Charles N. Martin, Jr.(3)	56,553	7.5%
Phillip W. Roe(4)	7,970	1.1%
Keith B. Pitts(5)	21,127	2.8%
Kent H. Wallace(6)	10,401	1.4%
Bradley A. Perkins, MD(7)	780	*
Mark R. Montoney, MD(8)	650	*
M. Fazle Husain(9)	126,750	16.9%
James A. Quella(1)	494,930	66.1%
Neil P. Simpkins(1)	494,930	66.1%
Michael A. Dal Bello(10)	—	—%
All directors and executive officers as a group (26 persons)(11)	781,179	94.9%

* Represents less than 1%.

(1) Includes common stock interests directly and indirectly owned by each of Blackstone FCH Capital Partners IV L.P., Blackstone FCH Capital Partners IV-A L.P., Blackstone FCH Capital Partners IV-B L.P., Blackstone Capital Partners IV-A L.P., Blackstone Family Investment Partnership IV-A L.P., Blackstone Health Commitment Partners L.P. and Blackstone Health Commitment Partners-A L.P. (the "Blackstone Funds"), for which Blackstone Management Associates IV L.L.C. ("BMA") is the general partner having voting and investment power over the membership interests in Holdings and the shares in Vanguard held or controlled by each of the Blackstone Funds. Messrs. Quella and Simpkins are members of BMA, but disclaim any beneficial ownership of the membership interests or the shares beneficially owned by BMA. Mr. Stephen A. Schwarzman is the founding member of BMA and as such may be deemed to share beneficial ownership of the membership interests or shares held or controlled by the Blackstone Funds. Mr. Schwarzman disclaims beneficial ownership of such membership interests and shares. The address of BMA and the Blackstone Funds is c/o The Blackstone Group L.P., 345 Park Avenue, New York, New York 10154.

(2) The MSCP Funds consist of the following six funds: Morgan Stanley Capital Partners III, L.P., MSCP III 892 Investors, L.P., Morgan Stanley Capital Investors, L.P., Morgan Stanley Dean Witter Capital Partners IV, L.P., MSDW IV 892 Investors, L.P., and Morgan Stanley Dean Witter Capital Investors IV, L.P. The address of each of Morgan Stanley Capital Partners III, L.P., MSCP III 892 Investors, L.P., Morgan Stanley Dean Witter Capital Partners IV, L.P. and MSDW IV 892 Investors, L.P. is c/o Metalmark Capital LLC, 1177 Avenue of the Americas, New York, New York 10036. The address of each of Morgan Stanley Capital Investors, L.P. and Morgan Stanley Dean Witter Capital Investors IV, L.P. is c/o Morgan Stanley, 1585 Broadway, New York, New York 10036. Metalmark Capital LLC shares investment and voting power with Morgan Stanley Capital Partners III, L.P., MSCP III 892 Investors, L.P., Morgan Stanley Dean Witter Capital Partners IV, L.P. and MSDW IV 892 Investors, L.P. over 126,750 of these 130,000 shares of Vanguard common stock indirectly owned by these four funds.

(3) Includes 8,913 B units and 7,640 D units in Holdings which are vested or vest within 60 days of as of August 15, 2010. Also, includes an aggregate of 5,000 A units in Holdings owned by two Charles N. Martin, Jr. Irrevocable Grantor Retained Annuity Trusts, of which Mr. Martin is Trustee and one of the beneficiaries.

(4) Includes 1,045 options on Vanguard common stock and 2,097 B units and 1,798 D units in Holdings which are vested or vest within 60 days of August 15, 2010.

(5) Includes 390 options on Vanguard common stock and 5,243 B units and 4,494 D units in Holdings which are vested or vest within 60 days of August 15, 2010.

(6) Includes 4,682 options on Vanguard common stock which are vested or vest within 60 days of August 15, 2010.

(7) Consists solely of 780 options on Vanguard common stock which are vested or vest within 60 days of August 15, 2010.

(8) Consists solely of 650 options on Vanguard common stock which are vested or vest within 60 days of August 15, 2010.

(9) Mr. Husain is a Managing Director of Metalmark Capital LLC and exercises shared voting or investment power over the membership interests in Holdings owned by Morgan Stanley Capital Partners III, L.P., MSCP III 892 Investors, L.P., Morgan Stanley Dean Witter Capital Partners IV, L.P., and MSDW IV 892 Investors, L.P. and, as a result, may be deemed to be the beneficial owner of such membership interests and the 126,750 shares of Vanguard common stock indirectly owned by these four funds. Mr. Husain disclaims beneficial ownership of such membership interests and shares of common stock as a result of his employment arrangements with Metalmark, except to the extent of his pecuniary interest therein ultimately realized. Metalmark Capital does not have investment and voting power with respect to 3,250 shares of Vanguard common stock indirectly owned by Morgan Stanley Capital Investors, L.P. and Morgan Stanley Dean Witter

Capital Investors IV, L.P. and these 3,250 shares are not included in the 126,750 shares contained in this table for Mr. Husain.

(10) Mr. Dal Bello is an employee of Blackstone, but has no investment or voting control over the shares beneficially owned by Blackstone.

(11) Includes 20,781 options in Vanguard and 28,574 B units and 24,492 D units in Holdings which have vested or vest within 60 days of August 15, 2010.

Item 13. Certain Relationships and Related Transactions, and Director Independence.

Holdings Limited Liability Company Agreement

Blackstone, MSCP, Baptist Health Services ("Baptist") and the Rollover Management Investors beneficially own capital stock in our company through Holdings, both through the ownership of Class A Units and, in the case of certain Rollover Management Investors Class B, C and D membership units in Holdings as part of a new equity incentive program. As part of the transactions, Holdings was also issued certain warrants to purchase shares of our common stock, as described in further detail below. The limited liability company operating agreement of Holdings provides for the control of the shares of Vanguard held by Holdings. MSCP and Baptist currently own all of their shares of Vanguard through their ownership of Holdings. Blackstone currently owns shares of Vanguard through its ownership of Holdings and its direct ownership of 125,000 shares of Vanguard common stock as described in this offering memorandum.

Holdings is controlled by a five-member board of representatives, currently consisting of five individuals, three of whom are nominees of Blackstone, one of whom is a nominee of MSCP and one of whom is our chief executive officer, Charles N Martin, Jr. At Blackstone's election, the size of the board of representatives may be increased to nine members, with two additional representatives to be designated by Blackstone and two additional representatives to be independent representatives identified by Mr. Martin and acceptable to Blackstone. If at any time our chief executive officer is not Mr. Martin, the Rollover Management Investors will have the right to designate one representative to the board (the "Manager Representative") so long as the Rollover Management Investors continue to own a number of shares of our common stock and Holdings units that is no less than 50% of the number of Class A units in Holdings owned immediately after the completion of the Merger. MSCP will continue to be entitled to nominate and elect one representative so long as MSCP continues to own a number of shares of our common stock and Holdings units that is no less than 50% of the number of Class A units in Holdings owned immediately after the completion of the Merger. These requirements will cease to apply at such time as Blackstone's indirect ownership in Vanguard is less than 10%.

The limited liability company agreement of Holdings provides that, subject to limited exceptions, units are not transferable absent the prior consent of the board of representatives of Holdings and are subject to certain redemption rights by the limited liability company provided certain conditions are met in connection with the redemption. With respect to the Class B, C and D units only, the limited liability company agreement also has call provisions applicable in the event of certain termination events relating to a Rollover Management Investor's employment.

Stockholders Agreement

Recipients of options to purchase the Company's common stock and recipients of restricted stock units exchangeable for shares of the Company's common stock are required to enter into a stockholders agreement governing such grantees' rights and obligations with respect to the common stock underlying such options and restricted stock units. The stockholders agreement includes provisions similar to those set forth in the limited liability company agreement of Holdings with respect to restrictions on transfer of shares of common stock, rights of first refusal, call rights, tag-along rights and drag-along rights as well as certain other provisions. The transfer restrictions apply until the earlier of the fifth anniversary of the date the grantee becomes a party to the stockholders agreement, or a change in control of the Company. The right of first refusal provision gives the Company a right of first refusal at any time after the fifth anniversary of the date the grantee became a party to the stockholders agreement and prior to the earlier of a change in control of the Company or a registered public offering of our common stock meeting certain specified criteria. The call provisions provide rights with respect to the shares of our common stock held by the stockholder, whether or not such shares were acquired upon the exercise of an option or in exchange for the extinguishment of restricted stock units, except for shares received upon conversion of or in redemption for Class A membership units in Holdings pursuant to the limited liability company agreement of Holdings. Such call rights are applicable in the event of certain termination events relating to the grantee's employment with the Company.

Holdings Warrants

At the completion of the Merger, we issued Class B, C and D warrants to Holdings (the "Holdings Warrants"), exercisable for up to 41,945, 41,945 and 35,952 shares of our common stock, respectively. These warrants will enable Holdings to deliver shares to, or otherwise allow participation in proceeds received by Holdings by, members of our senior management holding vested Class B, C and D units of Holdings (and which Holdings is entitled to repurchase in certain circumstances upon termination of employment. Each Holdings Warrant is not subject to vesting restrictions and may be exercised by Holdings at any time. The exercise price of the Class B and C Holdings Warrants is $599.53 per share, and the exercise price of the Class D Holdings Warrants is $2,599.53 per share, subject to adjustment pursuant to customary anti-dilution provisions, including in the event of extraordinary cash dividends by the Company or certain other recapitalization or similar events. In addition, subject to limited exceptions, the exercise price of the warrants is reduced upon transfer by Blackstone, MSCP, Baptist or any Rollover Management Investor of shares of common stock of the Company to third parties by an amount equal to the quotient of the fair market value of the consideration received by the transferring party and the total number of shares of common stock outstanding as of immediately prior to such transfer measured on a fully-diluted basis. Payment of the exercise price may be made, at the option of the holder, in cash or by a cashless exercise on a net basis. The Holdings Warrants are not transferrable by Holdings absent the consent of MSCP's and management's representatives on the board of Holdings.

Transaction and Monitoring Fee Agreement

In connection with the Merger, we entered into a transaction and monitoring fee agreement with affiliates of Blackstone and MSCP pursuant to which these entities agreed to provide certain structuring, advisory and management services to us. In consideration for ongoing consulting and management advisory services, we are required to pay to the Blackstone affiliate an annual fee of $4.0 million and to the MSCP affiliate an annual fee of $1.2 million for the first five years and thereafter an annual fee of $600,000.

Under the agreement, we paid to the Blackstone affiliate upon the closing of the Merger a transaction fee of $20.0 million. In the event that the Blackstone affiliate receives any additional fees in connection with an acquisition or disposition involving us or our subsidiaries, the MSCP affiliate will receive an additional fee equal to 15.0% of such fees paid to the Blackstone affiliate or, if Blackstone provides equity financing in connection with the transaction, a fee equal to the portion of the aggregate fees payable by us in such transaction, if any, based upon the amount of equity financing provided by MSCP relative to the total equity financing provided by MSCP, Blackstone and any other parties.

The transaction and monitoring fee agreement also requires Vanguard to pay or reimburse the Blackstone and MSCP affiliates for reasonable out-of-pocket expenses in connection with, and indemnify them for liabilities arising from, the services provided pursuant to the agreement.

In the event or in anticipation of a change of control or initial public offering of the Company, the Blackstone affiliate may elect to have Vanguard pay to such affiliate and the MSCP affiliate lump sum cash payments equal to the present value (using a discount rate equal to the yield to maturity on the date of notice of such event of the class of outstanding U.S. government bonds having a final maturity closest to the tenth anniversary of such written notice) of all then-current and future consulting and management advisory fees payable under the agreement (assuming that the termination date of the agreement was the tenth anniversary of the closing of the Merger, subject, in the case of the MSCP affiliate, to the requirement that the amount payable to such affiliate may not be less than 15% or the sum of the aggregate fees required to be paid to Blackstone under the agreement less the amount of fees already paid to the MSCP affiliate.

The transaction and monitoring fee agreement will remain in effect with respect to each affiliate of the Sponsors until the earliest of (1) Blackstone or MSCP, as the case may be, beneficially owning less than 5.0% of Vanguard's common equity on a fully diluted basis, (2) the completion of a lump-sum payout as described above or (3) termination of the agreement upon the mutual consent of the Blackstone or MSCP affiliate, as the case may be, and Vanguard. Upon termination of the MSCP affiliate as a party to the agreement, the affiliate will be entitled to the excess, if any, of 15.0% of the aggregate amount of fees required to be paid to date to the Blackstone affiliate under the agreement minus any monitoring fees already paid to the MSCP affiliate.

Under the transaction and monitoring fee agreement during fiscal year 2010, Vanguard paid to the Blackstone affiliate the annual $4.0 million fee referred to above.

Under the transaction and monitoring fee agreement during fiscal year 2010, Vanguard paid to the MSCP affiliate a $736,611 fee.

Registration Rights Agreement

In connection with the Merger, we entered into a registration rights agreement with Blackstone, MSCP, Baptist and the Rollover Management Investors, pursuant to which we may be required from time to time to register the sale of our shares held by Blackstone, MSCP, Baptist and the Rollover Management Investors. Under the registration rights agreement, Blackstone and MSCP are each entitled to require us (but in the case of MSCP, on no more than two occasions, subject to limited exceptions) to register the sale of shares held by Blackstone or MSCP, as applicable, on its behalf and may request us to make available shelf registration statements permitting sales of shares into the market from time to time over an extended period. In addition, the members of Holdings (including certain members of management) will have the ability to exercise certain piggyback registration rights with respect to shares of common stock of the Company held by them in connection with registered offerings requested by Blackstone or MSCP or initiated by us.

Employer Health Program Agreement with a Blackstone Affiliate, Equity Healthcare LLC

Effective July 1, 2008, we entered into an employer health program agreement with Equity Healthcare LLC ("Equity Healthcare"). Equity Healthcare negotiates with providers of standard administrative services for health benefit plans as well as other related services for cost discounts and quality of service monitoring capability by Equity Healthcare. Because of the combined purchasing power of its client participants, Equity Healthcare is able to negotiate pricing terms for providers that are believed to be more favorable than the companies could obtain for themselves on an individual basis.

In consideration for Equity Healthcare's provision of access to these favorable arrangements and its monitoring of the contracted third parties' delivery of contracted services to us, we pay Equity Healthcare a fee of $2 per participating employee per month ("PEPM Fee"). As of June 30, 2010, we had approximately 12,350 employees enrolled in our health benefit plans.

Equity Healthcare may also receive a fee ("Health Plan Fees") from one or more of the health plans with whom Equity Healthcare has contractual arrangements if the total number of employees joining such health plans from participating companies exceeds specified thresholds. If and when Equity Healthcare reaches the point at which the aggregate of its receipts from the PEPM Fee and the Health Plan Fees have covered all of its allocated costs, it will apply the incremental revenues derived from all such fees to (a) reduce the PEPM Fee otherwise payable by us; (b) avoid or reduce an increase in the PEPM Fee that might otherwise have occurred on contract renewal; or (c) arrange for additional services to us at no cost or reduced cost.

Equity Healthcare is an affiliate of Blackstone, with whom Michael A. Dal Bello, James A. Quella and Neil P. Simpkins, members of our board of directors, are affiliated and in which they may have an indirect pecuniary interest.

Commercial Transactions with Sponsor Portfolio Companies

Blackstone, MSCP and Metalmark each sponsor private equity funds which have ownership interests in a broad range of companies. We have entered into commercial transactions in the ordinary course of our business with some of these companies, including the sale of goods and services and the purchase of goods and services. None of these transactions or arrangements is of great enough value to be considered material to us.

Policy on Transactions with Related Persons

The Vanguard board of directors recognizes the fact that transactions with related persons present a heightened risk of conflicts of interests and/or improper valuation (or the perception thereof). In February 2007, the board of directors adopted a written policy reflecting existing practices to be followed in connection with any transaction between the company and a "related person."

Any transaction with the company in which a director, executive officer or beneficial holder of more than 5% of the total equity of the company, or any immediate family member of the foregoing (each, a "related person") has a direct or indirect material interest, and where the amount involved exceeds $120,000, must be specifically disclosed by the company in its public filings. Any such transaction would be subject to the company's written policy respecting the review, approval or ratification of related person transactions.

Under this policy:

- the company or any of its subsidiaries may employ a related person in the ordinary course of business consistent with the company's policies and practices with respect to the employment of non-related persons in similar positions; and
- any other related person transaction that would be required to be publicly disclosed must be approved or ratified by the board of directors, a committee thereof or if it is impractical to defer consideration of the matter until a board or committee meeting, by a non-management director who is not involved in the transaction.

If the transaction involves a related person who is a director or an immediate family member of a director, that director may not participate in the deliberations or vote. In approving or ratifying a transaction under this policy, the board of directors, the committee or director considering the matter must determine that the transaction is fair to the company and may take into account, among other factors deemed appropriate, whether the transaction is on terms not less favorable than terms generally available to an unaffiliated third-party under the same or similar circumstances and the extent of the related person's interest in the transaction.

During fiscal year 2010, there were no transactions between the Company and a related person requiring approval under this policy.

Director Independence

Our board of directors has not made a formal determination as to whether each director is "independent" because we have no equity securities listed for trading on a national securities exchange or in an automated inter-dealer quotation system of a national securities association, which has requirements that a majority of its board of directors be independent. All five of our directors have either been appointed by our equity Sponsors or are employed by us (Mr. Martin, our chairman and chief executive officer). Thus, we do not believe any of our directors would be considered independent under the New York Stock Exchange's definition of independence.

Item 14. Principal Accounting Fees and Services.

Fees Paid to the Independent Auditor

The following table presents fees for professional services rendered by Ernst & Young LLP for the audit of Vanguard's annual financial statements for 2009 and 2010, and fees billed for audit-related services, tax services and all other services rendered by Ernst & Young LLP for fiscal years 2009 and 2010.

	2009	2010
Audit Fees (1)	$ 852,712	$ 1,251,362
Audit-related fees	1,995	26,995
Audit and audit-related fees	854,707	1,278,357
Tax fees (2)	133,384	301,149
All other fees (3)	1,002,563	573,215
Total fees (4)	$ 1,990,654	$ 2,152,721

(1) Audit fees for 2009 and 2010 include fees for the audit of the annual consolidated financial statements, reviews of the condensed consolidated financial statements included in Vanguard's quarterly reports, debt offering comfort letters and statutory audits.

(2) Tax fees for 2009 and 2010 consisted principally of fees for tax advisory services.

(3) All other fees for 2009 and 2010 consisted of assistance in identification of Medicaid eligible days for inclusion in the Medicare cost reports for Medicare disproportionate share reimbursement, assistance in validating average wage rates in our markets used in Medicare reimbursement; assistance in preparing reports for us relating to payer matters; and assistance in preparing occupational mix survey data in accordance with CMS requirements

(4) Ernst & Young LLP full time, permanent employees performed all of the professional services described in this chart.

Pre-Approval Policies and Procedures

In February 2004, our board of directors first adopted an audit and non-audit services pre-approval policy and in November 2004 and May 2006 the board amended and restated this policy. This policy sets forth the Board's procedures and conditions pursuant to which services proposed to be performed by the Company's regular independent auditor (and those other independent auditors for whom pre-approvals are legally necessary) are presented to the Board for pre-approval. Normally, the policy would have been approved by the audit committee and ratified by the board of directors, but in February 2004, November 2004 and May 2006 we had no audit committee and, as a result, the full board of directors has the responsibility for all matters that are usually the responsibility of the audit committee.

The policy provides that the board of directors shall pre-approve audit services, audit-related services, tax services and those other services that it believes to be routine and recurring services that do not impair the independence of the auditor. Under the policy, our Chief Accounting Officer is responsible for determining whether services provided by the independent auditor are included as part of those services already pre-approved or whether separate approval from the board of directors is required. All services performed for us by Ernst & Young LLP, our independent registered public accounting firm, subsequent to the adoption of the policy have been pre-approved by the board of directors. The board of directors has concluded that the audit-related services, tax services and other non-audit services provided by Ernst & Young LLP in fiscal year 2009 were compatible with the maintenance of the firm's independence in the conduct of its auditing functions. In addition, to safeguard the continued independence of the independent auditors, the policy prevents our independent auditors from providing services to us that are prohibited under Section 10A(g) of the Securities Exchange Act of 1934, as amended.

PART IV

Item 15. Exhibits and Financial Statement Schedules.

(a) List of documents filed as part of this report.

(1) Financial Statements. The accompanying index to financial statements on page 98 of this report is provided in response to this item.

(2) Financial Statement Schedules. All schedules are omitted because the required information is either not present, not present in material amounts or presented within the consolidated financial statements

(3) Exhibits. The exhibits filed as part of this report are listed in the Exhibit Index which is located at the end of this report.

(b) Exhibits.

See Item 15(a)(3) of this report.

(c) Financial Statement Schedules.

See Item 15(a)(2) of this report.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

VANGUARD HEALTH SYSTEMS, INC.	Date
By: /s/ Charles N. Martin, Jr. Charles N. Martin, Jr. Chairman of the Board & Chief Executive Officer	August 26, 2010

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/s/ Charles N. Martin, Jr. Charles N. Martin, Jr.	Chairman of the Board & Chief Executive Officer; Director (Principal Executive Officer)	August 26, 2010
/s/ Phillip W. Roe Phillip W. Roe	Executive Vice President, Chief Financial Officer & Treasurer (Principal Financial Officer)	August 26, 2010
/s/ Gary D. Willis Gary D. Willis	Senior Vice President, Controller & Chief Accounting Officer (Principal Accounting Officer)	August 26, 2010
/s/ Michael A. Dal Bello Michael A. Dal Bello	Director	August 26, 2010
/s/ M. Fazle Husain M. Fazle Husain	Director	August 26, 2010
/s/ James A. Quella James A. Quella	Director	August 26, 2010
/s/ Neil P. Simpkins Neil P Simpkins	Director	August 26, 2010

Supplemental Information to be Furnished With Reports Filed Pursuant to Section 15(d) of the Act by Registrants Which Have Not Registered Securities Pursuant to Section 12 of the Act.

No annual report or proxy material has been sent to security holders.

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EXHIBIT INDEX

Exhibit No.	Description
2.1	Agreement and Plan of Merger, dated as of July 23, 2004, among VHS Holdings LLC, Health Systems Acquisition Corp. and Vanguard Health Systems, Inc.(1)
2.2	First Amendment to the Agreement and Plan of Merger, dated as of September 23, 2004, among VHS Holdings LLC, Health Systems Acquisition Corp. and Vanguard Health Systems, Inc.(1)
2.3	Indemnification Agreement, dated as of July 23, 2004, among VHS Holdings LLC, Vanguard Health Systems, Inc., and the stockholders and holders of options set forth therein(1)(3)
2.4	Purchase and Sale Agreement dated as of June 10, 2010, by and among The Detroit Medical Center, Harper-Hutzel Hospital, Detroit Receiving Hospital and University Health Center, Children's Hospital of Michigan, Rehabilitation Institute, Inc., Sinai Hospital of Greater Detroit, Huron Valley Hospital, Inc., Detroit Medical Center Cooperative Services, DMC Orthopedic Billing Associates, LLC, Metro TPA Services, Inc. and Michigan Mobile PET CT, LLC (collectively, as Seller) and VHS of Michigan, Inc., VHS Harper-Hutzel Hospital, Inc., VHS Detroit Receiving Hospital, Inc., VHS Children's Hospital of Michigan, Inc., VHS Rehabilitation Institute of Michigan, Inc., VHS Sinai-Grace Hospital, Inc., VHS Huron Valley-Sinai Hospital, Inc., VHS Detroit Businesses, Inc. and VHS Detroit Ventures, Inc. (collectively, as Buyer) and Vanguard Health Systems, Inc.(6)
3.1	Amended and Restated Certificate of Incorporation of Vanguard Health Systems, Inc.(1)
3.2	By-Laws of Vanguard Health Systems, Inc.(7)
4.1	Indenture, relating to the 8% Senior Notes, dated as of January 29, 2010, among Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., Vanguard Health Systems, Inc. and the Guarantors party thereto and U.S. Bank National Association, as Trustee(24)
4.2	Registration Rights Agreement, dated as of January 29, 2010, relating to the 8% Senior Notes due 2018, among Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., Vanguard Health Systems, Inc. and the other guarantors named therein and Banc of America Securities LLC, Barclays Capital Inc. Citigroup Global Markets Inc., Deutsche Bank Securities Inc., Goldman, Sachs & Co. and Morgan Stanley & Co. Incorporated(24)
4.3	Registration Rights Agreement, concerning Vanguard Health Systems, Inc., dated as of September 23, 2004(1)
4.4	First Supplemental Indenture, dated as of February 25, 2010, among Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the Guarantors party thereto and the Trustee(25)
4.5	Second Supplemental Indenture, dated as of July 14, 2010, relating to the 8% Senior Notes due 2018, among Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., Vanguard Health Systems, Inc., the other guarantors named therein and U.S. Bank National Association, as trustee(5)
4.6	Registration Rights Agreement, dated as of July 14, 2010, relating to the 8% Senior Notes due 2018, among Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., Vanguard Health Systems, Inc. the other guarantors named therein and Bank of America Securities LLC and Barclays Capital Inc. on behalf of themselves and as representatives of the several initial purchasers listed on Schedule I thereto(5)

Exhibit No.	Description
10.1	Credit Agreement, dated as of January 29, 2010, among Vanguard Health Holding Company II, LLC, Vanguard Health Holding Company I, LLC, the lenders from time to time party thereto, Bank of America, N.A., as Administrative Agent, and the other parties thereto(24)
10.2	Security Agreement, dated as of January 29, 2010, made by each assignor party thereto in favor of Bank of America, N.A., as collateral agent(25)
10.3	Vanguard Guaranty, dated as of January 29, 2010, made by and among Vanguard Health Systems, Inc. in favor of Bank of America, N.A., as administrative agent(25)
10.4	Subsidiaries Guaranty, dated as of January 29, 2010, made by and among each of the guarantors party thereto in favor of Bank of America, N.A., as administrative agent(25)
10.5	Pledge Agreement, dated as of January 29, 2010, among each of the pledgors party thereto and Bank of America, N.A., as collateral agent(25)
10.6	Transaction and Monitoring Fee Agreement, dated as of September 23, 2004, among Vanguard Health Systems, Inc., Blackstone Management Partners IV L.L.C., and Metalmark Management LLC(1)
10.7	Amended and Restated Limited Liability Company Operating Agreement of VHS Holdings LLC, dated as of September 23, 2004(1)
10.8	Vanguard Health Systems, Inc. 2004 Stock Incentive Plan(1)(3)
10.9	VHS Holdings LLC 2004 Unit Plan(1)(3)
10.10	Vanguard Health Systems, Inc. 2001 Annual Incentive Plan(2)(3)
10.11	Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Charles N. Martin, Jr., dated as of September 23, 2004(1)(3)
10.12	Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Joseph D. Moore, dated as of September 23, 2004(1)(3)
10.13	Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Ronald P. Soltman, dated as of September 23, 2004(1)(3)
10.14	Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Keith B. Pitts, dated as of September 23, 2004(1)(3)
10.15	Form of Amended and Restated Severance Protection Agreement of Vanguard Health Systems, Inc. dated as of September 23, 2004 for Vice Presidents and above (1)(3)
10.16	Amended and Restated Agreement Between the Shareholders of VHS Acquisition Subsidiary Number 5, Inc. executed on September 8, 2004, but effective as of September 1, 2004(1)
10.17	Certificate of Designations, Preferences and Rights of Series A Preferred Stock of VHS Acquisition Subsidiary Number 5, Inc., dated as of September 8, 2004(1)
10.18	License Agreement between Baptist Health System and VHS San Antonio Partners, L.P. dated as of January 1, 2003(4)
10.19	Form of Performance Option Under 2004 Stock Incentive Plan(1)(3)
10.20	Form of Time Option Under 2004 Stock Incentive Plan(1)(3)

Exhibit No.	Description
10.21	Form of Liquidity Event Option Under 2004 Stock Incentive Plan(1)(3)
10.22	Stockholders Agreement Concerning Vanguard Health Systems, Inc., dated as of November 4, 2004, by and among Vanguard Health Systems, Inc., VHS Holdings LLC, Blackstone FCH Capital Partners IV L.P. and its affiliates identified on the signature pages thereto and the employees identified on the signature pages thereto(1)
10.23	Amendment No. 1 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Charles N. Martin, Jr., dated as of December 1, 2004(1)(3)
10.24	Amendment No. 1 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Joseph D. Moore, dated as of December 1, 2004(1)(3)
10.25	Amendment No. 1 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Ronald P. Soltman, dated as of December 1, 2004(1)(3)
10.26	Amendment No. 1 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Keith B. Pitts, dated as of December 1, 2004(1)(3)
10.27	First Amendment of VHS Holdings LLC 2004 Unit Plan(3)(7)
10.28	Form of Restricted Stock Unit Agreement (Time Vesting RSUs) used under Vanguard Health Systems, Inc 2004 Stock Incentive Plan (3)
10.29	Form of Restricted Stock Unit Agreement (Liquidity Event RSUs) used under Vanguard Health Systems, Inc 2004 Stock Incentive Plan (3)
10.30	Amendment No. 2 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Charles N. Martin, Jr., dated as of December 1, 2005(3)(9)
10.31	Amendment No. 2 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc and Joseph D. Moore, dated as of December 1, 2005(3)(9)
10.32	Amendment No. 2 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Ronald P. Soltman, dated as of December 1, 2005(3)(9)
10.33	Amendment No. 2 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Keith B. Pitts, dated as of December 1, 2005(3)(9)
10.34	Amendment No. 1, dated as of November 3, 2005, to Amended and Restated Limited Liability Company Operating Agreement of VHS Holdings LLC(9)
10.35	Amendment Number 1 to the Vanguard Health Systems, Inc 2004 Stock Incentive Plan, effective November 28, 2005(3)(9)
10.36	Amendment Number 2 to the Vanguard Health Systems, Inc. 2004 Stock Incentive Plan, effective February 15, 2006(3)(10)
10.37	Amendment Number 3 to the Vanguard Health Systems, Inc 2004 Stock Incentive Plan, effective April 15, 2006(3)(10)
10.38	Amendment Number 4 to the Vanguard Health Systems, Inc. 2004 Stock Incentive Plan, effective November 13, 2006(3)(12)
10.39	Amendment No. 3 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Charles N. Martin, Jr , dated as of October 1, 2007(3)(15)

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Exhibit No.	Description
10.40	Amendment No. 3 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Keith B. Pitts, dated as of October 1, 2007(3)(15)
10.41	Amendment No. 3 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Joseph D. Moore, dated as of October 1, 2007(3)(15)
10.42	Amendment No. 4 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Joseph D. Moore, dated as of November 7, 2007(3)(15)
10.43	Amendment No. 3 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Ronald P. Soltman, dated as of October 1, 2007(3)(15)
10.44	Employment Agreement between Vanguard Health Systems, Inc. and Kent H. Wallace dated as of November 15, 2007(3)(15)
10.45	Employment Agreement between Vanguard Health Systems, Inc. and Phillip W. Roe dated as of November 15, 2007(3)(15)
10.46	Form of Amendment No. 1 to Severance Protection Agreement dated as of October 1, 2007, entered into between Vanguard Health Systems, Inc. and each of its executive officers (other than Messrs. Martin, Pitts, Moore, Soltman, Wallace and Roe who each have entered into employment agreements with the registrant)(3)(15)
10.47	Amendment Number 5 to the Vanguard Health Systems, Inc. 2004 Stock Incentive Plan, effective May 6, 2008 (3)(16)
10.48	Letter dated May 13, 2008, from the Arizona Health Care Cost Containment System to VHS Phoenix Health Plan, LLC, countersigned by VHS Phoenix Health Plan, LLC on May 13, 2008 awarding Contract No. YH09-0001-07(17)
10.49	Waiver No. 1 dated as of May 22, 2008, to Amended and Restated Limited Liability Company Operating Agreement of VHS Holdings LLC, dated as of September 23, 2004, as amended by Amendment No. 1, dated as of November 3, 2005(20)
10.50	Amendment No. 5 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Joseph D. Moore, dated as of June 30, 2008(3)(20)
10.51	Form of Severance Protection Agreement of Vanguard Health Systems, Inc. in use for Vice Presidents and above employed after October 1, 2007(3)(20)
10.52	Arizona Health Care Cost Containment System Administration RFP re Contract No. YH09-0001-07 with VHS Phoenix Health Plan, LLC awarded May 13, 2008(20)
10.53	Solicitation Amendments to RFP numbers One, Two, Three, Four and Five dated February 29, 2008, March 14, 2008, March 26, 2008, March 28, 2008 and April 10, 2008, respectively, to Arizona Health Care Cost Containment System Administration Contract No. YH09-0001-07 with VHS Phoenix Health Plan, LLC(20)
10.54	Contract Amendment Number 1, executed on September 23, 2008, but effective as of October 1, 2008, to the Arizona Health Care Cost Containment System Administration Contract No. YH09-0001-07 between VHS Phoenix Health Plan, LLC and the Arizona Health Care Cost Containment System(21)

Exhibit No.	Description
10.55	Contract Amendment Number 2, executed on January 16, 2009, but effective as of January 15, 2009, to the Arizona Health Care Cost Containment System Administration Contract No. YH09-0001-07 between VHS Phoenix Health Plan, LLC and the Arizona Health Care Cost Containment System(18)
10.56	Contract Amendment Number 3, executed on April 6, 2009, but effective as of May 1, 2009, to the Arizona Health Care Cost Containment System Administration Contract No. YH09-0001-07 between VHS Phoenix Health Plan, LLC and the Arizona Health Care Cost Containment System(19)
10.57	Contract Amendment Number 4, executed on July 7, 2009, but effective as of August 1, 2009, to the Arizona Health Care Cost Containment System Administration Contract No. YH09-0001-07 between VHS Phoenix Health Plan, LLC and the Arizona Health Care Cost Containment System (8)
10.58	Contract Amendment Number 5, executed on July 7, 2009, but effective as of August 1, 2009, to the Arizona Health Care Cost Containment System Administration Contract No. YH09-0001-07 between VHS Phoenix Health Plan, LLC and the Arizona Health Care Cost Containment System (8)
10.59	Amendment Number 6 to the Vanguard Health Systems, Inc. 2004 Stock Incentive Plan, effective February 13, 2009(3)(19)
10.60	Form of Indemnification Agreement between the Company and each of its directors and executive officers (3)(22)
10.61	Amendment No. 4 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Charles N. Martin, Jr., dated as of May 5, 2009(3)(8)
10.62	Amendment No. 4 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Keith B. Pitts, dated as of May 5, 2009(3)(8)
10.63	Amendment No. 4 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Ronald P. Soltman, dated as of May 5, 2009(3)(8)
10.64	Amendment No. 1 to Employment Agreement between Vanguard Health Systems, Inc. and Kent H. Wallace, dated as of May 5, 2009(3)(8)
10.65	Amendment No. 1 to Employment Agreement between Vanguard Health Systems, Inc. and Phillip W. Roe, dated as of May 5, 2009(3)(8)
10.66	Employment Agreement between Vanguard Health Systems, Inc. and Mark R. Montoney, M.D. dated as of December 31, 2008(3)(8)
10.67	Amendment No. 1 to Employment Agreement between Vanguard Health Systems, Inc. and Mark R. Montoney, M.D. dated as of May 5, 2009(3)(8)
10.68	Employment Agreement between Vanguard Health Systems, Inc. and Bradley A. Perkins dated as of July 1, 2009(3)(8)
10.69	Vanguard Health Systems, Inc. 2009 Long Term Incentive Plan (3)(23)
10.70	Amendment No. 7 to Vanguard Health Systems, Inc. 2004 Stock Incentive Plan (3)(23)
10.71	Contract Amendment Number 6, executed on September 17, 2009, but effective as of October 1, 2009, to the Arizona Health Care Cost Containment System Administration Contract No. YH09-0001-07 between VHS Phoenix Health Plan, LLC and the Arizona Health Care Cost Containment System(11)

Exhibit No.	Description
10.72	Contract Amendment Number 7, executed on September 17, 2009, but effective as of October 1, 2009, to the Arizona Health Care Cost Containment System Administration Contract No YH09-0001-07 between VHS Phoenix Health Plan, LLC and the Arizona Health Care Cost Containment System(11)
10.73	Contract Amendment Number 8, executed on September 17, 2009, but effective as of October 1, 2009, to the Arizona Health Care Cost Containment System Administration Contract No. YH09-0001-07 between VHS Phoenix Health Plan, LLC and the Arizona Health Care Cost Containment System(11)
10.74	Contract Amendment Number 9, executed on October 13, 2009, but effective as of October 1, 2009, to the Arizona Health Care Cost Containment System Administration Contract No. YH09-0001-07 between VHS Phoenix Health Plan, LLC and the Arizona Health Care Cost Containment System(11)
10.75	Amendment No. 1, dated as of November 3, 2009, to Stockholders Agreement Concerning Vanguard Health Systems, Inc., dated as of November 4, 2004, by and among Vanguard Health Systems, Inc., VHS Holdings LLC, Blackstone FCH Capital Partners IV L.P. and its affiliates identified on the signature pages thereto and Charles N. Martin, Jr., as proxyholder for certain employees party thereto (13)
10.76	Amendment No. 2, dated as of January 13, 2010, to Amended and Restated Limited Liability Company Operating Agreement of VHS Holdings, LLC (25)
10.77	Amendment No. 3, dated as of January 28, 2010, to Amended and Restated Limited Liability Company Operating Agreement of VHS Holdings, LLC (25)
12.1	Computation of Ratios of Earnings to Fixed Charges
21.1	Subsidiaries of Vanguard Health Systems, Inc.
31.1	Certification of CEO pursuant to Rule 13a-14(a)/15d-14(a) as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
31.2	Certification of CFO pursuant to Rule 13a-14(a)/15d-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
32.1	Certification of CEO pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
32.2	Certification of CFO pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
99.1	Asset Purchase Agreement, dated as of March 17, 2010, among West Suburban Medical Center, Westlake Community Hospital, Resurrection Services, Resurrection Ambulatory Services, VHS Westlake Hospital, Inc., and VHS West Suburban Medical Center, Inc (14)
99.2	First Amendment to Asset Purchase Agreement dated as of July 31, 2010, among West Suburban Medical Center, Westlake Community Hospital, Resurrection Services, Resurrection Ambulatory Services, VHS Westlake Hospital, Inc., VHS West Suburban Medical Center, Inc., VHS Acquisition Subsidiary Number 4, Inc., Midwest Pharmacies, Inc. and MacNeal Physicians Group, LLC(14)

(1) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Registration Statement on Form S-4 first filed on November 12, 2004 (Registration No. 333-120436)

(2) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Registration Statement on Form S-1 first filed on October 19, 2001 (Registration No. 333-71934).

(3) Management compensatory plan or arrangement.

(4) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Current Report on Form 8-K dated January 14, 2003, File No. 333-71934.

(5) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Current Report on Form 8-K dated July 19, 2010, File No. 333-71934.

(6) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Current Report on Form 8-K dated June 15, 2010, File No. 333-71934.

(7) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Annual Report on Form 10-K for the annual period ended June 30, 2005, File No. 333-71934.

(8) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Annual Report on Form 10-K for the annual period ended June 30, 2009, File No. 333-71934.

(9) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended December 31, 2005, File No. 333-71934.

(10) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended March 31, 2006, File No. 333-71934

(11) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended September 30, 2009, File No. 333-71934.

(12) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended December 31, 2006, File No. 333-71934.

(13) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended December 31, 2009, File No. 333-71934.

(14) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Current Report on Form 8-K dated August 4, 2010, File No. 333-71934.

(15) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended December 31, 2007, File No. 333-71934.

(16) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Current Report on Form 8-K dated May 9, 2008, File No. 333-71934.

(17) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Current Report on Form 8-K dated May 16, 2008, File No. 333-71934.

(18) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended December 31, 2008, File No. 333-71934

(19) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended March 31, 2009, File No. 333-71934.

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(20) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Annual Report on Form 10-K for the annual period ended June 30, 2008, File No. 333-71934.

(21) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended September 30, 2008, File No. 333-71934.

(22) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Current Report on Form 8-K dated May 6, 2009, File No. 333-71934.

(23) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Current Report on Form 8-K dated August 21, 2009, File No. 333-71934.

(24) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Current Report on Form 8-K, dated February 3, 2010, File No. 333-71934.

(25) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Registration Statement on Form S-4 first filed on March 3, 2010 (Registration No. 333-165157)

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, D.C. 20549

FORM 10-K

(Mark One)

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the fiscal year ended June 30, 2009

OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from _____ to _____

Commission File Number: 333-71934

VANGUARD
HEALTH SYSTEMS

VANGUARD HEALTH SYSTEMS, INC.

(Exact name of registrant as specified in its charter)

Delaware	**62-1698183**
(State or other jurisdiction of incorporation or organization)	*(I.R.S. Employer Identification No.)*

20 Burton Hills Boulevard, Suite 100
Nashville, TN 37215
(Address and zip code of principal executive offices)

(615) 665-6000
(Registrant's telephone number, including area code)

Securities Registered Pursuant to Section 12(b) of the Act: None
Securities Registered Pursuant to Section 12(g) of the Act: None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. ☐Yes ☒No

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. ☒Yes ☐No

Indicate by check mark whether the registrant (1) has filed all reports required to be filed under Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports) and (2) has been subject to such filing requirements for the past 90 days. ☒Yes ☐No

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of the Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files.) Yes☐ No☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of the registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendments to this Form 10-K. ☒

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer or a smaller reporting company. See the definitions of "large accelerated filer", "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer ☐	Accelerated filer ☐
Non-accelerated filer ☒ (Do not check if a smaller reporting company)	Smaller reporting company ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). ☐Yes ☒No

There were 749,550 shares of registrant's common stock outstanding as of September 1, 2009 (all of which are privately owned and not traded on a public market).

Documents incorporated by reference: None

VANGUARD HEALTH SYSTEMS, INC.
ANNUAL REPORT ON FORM 10-K
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VANGUARD HEALTH SYSTEMS, INC.

CAUTIONARY STATEMENT REGARDING FORWARD-LOOKING STATEMENTS

This annual report on Form 10-K contains "forward-looking statements" within the meaning of the federal securities laws that are intended to be covered by safe harbors created thereby. Forward-looking statements are those statements that are based upon management's plans, objectives, goals, strategies, future events, future revenue or performance, capital expenditures, financing needs, plans or intentions relating to acquisitions, business trends and other information that is not historical information. These statements are based upon estimates and assumptions made by the Company's management that, although believed to be reasonable, are subject to numerous factors, risks and uncertainties that could cause actual outcomes and results to be materially different from those projected. When used in this annual report on Form 10-K, the words "estimates," "expects," "anticipates," "projects," "plans," "intends," "believes," "forecasts," "continues," or future or conditional verbs, such as "will," "should," "could" or "may," and variations of such words or similar expressions are intended to identify forward-looking statements.

These factors, risks and uncertainties include, among other things, statements relating to:

- Our high degree of leverage
- Our ability to incur substantially more debt
- Operating and financial restrictions in our debt agreements
- The impact of the tightened credit markets and economic recession on our ability to service or refinance our debt
- Our ability to successfully implement our business strategies
- Our ability to successfully integrate our recent and any future acquisitions
- The highly competitive nature of the healthcare industry
- Governmental regulation of the industry, including Medicare and Medicaid reimbursement levels
- Pressures to contain costs by managed care organizations and other insurers and our ability to negotiate acceptable terms with these third party payers
- Our ability to attract and retain qualified management and healthcare professionals, including physicians and nurses
- Potential federal or state reform of healthcare
- Future governmental investigations
- Potential management information systems failures and the significant costs of systems integrations
- The availability of capital to fund our corporate growth strategy
- Potential lawsuits or other claims asserted against us
- Our ability to maintain or increase patient membership and control costs of our managed healthcare plans
- Changes in general economic conditions, including the current U.S. economic recession, that could adversely impact our operating results, financial position and cash flows
- Our exposure to the increased amounts of and collection risks associated with uninsured accounts and the co-pay and deductible portions of insured accounts
- Cost of professional and general liability insurance and increases in the quantity and severity of professional liability claims
- Our ability to maintain and increase patient volumes and control the costs of providing services, including salaries and benefits, supplies and bad debts
- Our failure to comply, or allegations of our failure to comply, with applicable laws and regulations
- The geographic concentration of our operations
- Technological and pharmaceutical improvements that increase the cost of providing, or reduce the demand for, healthcare services
- Potential substantial liabilities arising from unfavorable retrospective reviews by governmental or other payers of the medical necessity of medical procedures performed at our hospitals
- Lost future revenues from payer contract terminations resulting from their unfavorable retrospective reviews of the medical necessity of medical procedures performed at our hospitals

See "Item 1A – Risk Factors" for further discussion. We assume no obligation to update any forward-looking statements.

PART I

Item 1. Business.

Company Overview

We own and operate acute care hospitals, complementary outpatient facilities and related health plans principally located in urban and suburban markets. We currently operate 15 acute care hospitals which, as of June 30, 2009, had a total of 4,135 beds in the following four locations:

- San Antonio, Texas
- metropolitan Phoenix, Arizona
- metropolitan Chicago, Illinois
- Massachusetts

Historically, we have concentrated our operations in markets with high population growth and median income in excess of the national average. Our objective is to help communities achieve health for life by delivering an ideal patient-centered experience in a highly reliable environment of care. We must continue to strengthen our financial operations to fund further investment in these communities. During the year ended June 30, 2009, we generated revenues of $3,199.7 million. During this period 78.8% of our total revenues were derived from acute care hospitals and complementary outpatient facilities.

Our general acute care hospitals offer a variety of medical and surgical services including emergency services, general surgery, internal medicine, cardiology, obstetrics, orthopedics and neurology. In addition, certain of our facilities provide on-campus and off-campus services including outpatient surgery, physical therapy, radiation therapy, diagnostic imaging and laboratory services. We also own three strategically important managed care health plans: a Medicaid managed health plan, Phoenix Health Plan, that served approximately 176,200 members as of June 30, 2009 in Arizona; Abrazo Advantage Health Plan, a managed Medicare and dual-eligible health plan that served approximately 2,800 members as of June 30, 2009 in Arizona; and MacNeal Health Providers a preferred provider network that served approximately 39,700 member lives in metropolitan Chicago as of June 30, 2009 under capitated contracts covering only outpatient and physician services.

We are a Delaware corporation formed in July 1997. Our principal executive offices are located at 20 Burton Hills Boulevard, Suite 100, Nashville, Tennessee, 37215 and our telephone number at that address is (615) 665-6000. Our corporate website address is www.vanguardhealth.com. Information contained on our website does not constitute part of this Annual Report on Form 10-K. The terms "we", "our", "the Company", "us", "registrant" and "Vanguard" as used in this report refer to Vanguard Health Systems, Inc. and its subsidiaries as a consolidated entity, except where it is clear from the context that such terms mean only Vanguard Health Systems, Inc. "Subsidiaries" means direct and indirect corporate subsidiaries of Vanguard Health Systems, Inc. and partnerships, joint ventures and limited liability companies in which such subsidiaries are partners or members.

The Merger

On July 23, 2004, Vanguard executed an agreement and plan of merger (the "Merger Agreement") with VHS Holdings LLC ("Holdings") and Health Systems Acquisition Corp., a newly formed Delaware corporation ("Acquisition Corp."), pursuant to which on September 23, 2004 Acquisition Corp. merged with and into Vanguard, with Vanguard being the surviving corporation (the "Merger"). In the Merger, holders of the outstanding Vanguard capital stock, options to acquire Vanguard common stock and other securities convertible into Vanguard common stock received aggregate consideration of approximately $1,248.6 million.

The Blackstone Group, together with its affiliates (collectively, "Blackstone"), funded the Merger in part by subscribing for and purchasing approximately $494.9 million aggregate amount of (1) Class A membership units in Holdings and (2) common stock of Acquisition Corp. (merged with and into Vanguard), in an amount equal to

$125.0 million of such common stock. In addition, Morgan Stanley Capital Partners, together with its affiliates (collectively, "MSCP"), subscribed for and purchased Class A membership units in Holdings by contributing to Holdings a number of shares of Vanguard common stock equal to (1) $130.0 million divided by (2) the per share consideration payable for each share of Vanguard common stock in connection with the Merger. Certain senior members of management and certain other stockholders of Vanguard (the "Rollover Management Investors") subscribed for and purchased Class A membership units in Holdings, having an aggregate purchase price of approximately $119.1 million, by (a) paying cash using the proceeds of consideration received in connection with the Merger and/or (b) contributing shares of Vanguard common stock in the same manner as MSCP. Baptist Health Services ("Baptist"), the former owner of our division, Baptist Health System of San Antonio, also purchased $5.0 million of Class A membership units in Holdings. Immediately after completion of the Merger in September 2004, Blackstone, MSCP (together with Baptist) and the Rollover Management Investors held approximately 66.1%, 18.0% and 15.9%, respectively, of the common equity of Vanguard (most of which is indirectly held through the ownership of the Class A membership units in Holdings). Certain members of senior management also purchased $5.7 million of the equity incentive units in Holdings.

Our Mission and Business Strategies

Our mission is to help communities achieve health for life. We expect to change the way healthcare is delivered in our communities through our corporate and regional business strategies. We have established a corporate values framework that includes safety, excellence, respect, integrity and accountability to support both our mission and the corporate and regional business strategies that will define our future success. Some of the more key elements of our business strategy are outlined below.

Delivery of an ideal patient-centered experience

We expect all of our facilities to provide the best available experience for our patients. To achieve this goal, we must create a highly reliable environment of care that yields superior safety and quality outcomes. We have implemented and will continue to implement various programs to improve the quality of care we provide including our patient safety initiative. We are working with an external consulting group to implement a company-wide patient safety model that will combine information technology advancement such as bedside medication barcoding with nursing process improvements to create a high reliability organization. Our commitment to quality of care starts at the top of our organization and spreads to all levels. Not only must our care be reliable, but our care must also be efficient and compassionate.

Providing efficient and compassionate care requires collaboration and open communication lines between the patients, physicians, nurses and payers. We have implemented best practices to provide our patients quick access to key services they need to improve their health. We have rapid response teams and hourly nurse rounding in place at all of our hospitals to ensure that any patient health issues are communicated and addressed in a timely manner. We have invested and will continue to invest significant capital to strengthen information technology within our facilities that enable physicians, nurses and other clinicians to coordinate patient care from the time the patients arrive at our facilities to the time they leave.

We have implemented a comprehensive patient satisfaction monitoring program to measure our success in providing an ideal patient-centered experience. The patient satisfaction results are shared with all of our leadership teams and are a component of incentive compensation plans for those leaders.

Nurse leadership initiatives

Our most valuable resource in improving the health of our patients is our nurse workforce. We are in the early stages of implementing a nursing professional practice model that will transform our delivery of patient care. This externally-validated model incorporates leadership, clinical practice, professional development and interdisciplinary collaboration to foster nursing practice that is evidence-based, innovative and patient-focused. The model will identify the most important goals to achieve clinical excellence and will incorporate best practices and process input from all levels within the nursing organization. The goals established as part of the model will be formally measured against nationally recognized sources for core measure benchmarking and will establish nursing peer reviews and detailed action plans to improve upon any areas where goals are not met.

The success of this model depends upon our ability to gain the trust and loyalty of our nurse leadership teams and line staff. We will continue to invest in nurse recruiting and retention programs that provide our nurses clinical advancement opportunities, preceptor and training programs, work-life balance flexibility and competitive compensation necessary to engage our nurses in this professional practice model. We are currently considering initiatives such as talent evaluations, coaching programs, premier preceptor programs and hospital nurse advisory councils to incorporate into our professional practice model. We believe that an engaged nurse workforce that shares our values and commitment to exemplary nursing care will improve the care experience for our patients, inspire the confidence of physicians practicing in our hospitals and reduce our financial costs of replacing nursing professionals or utilizing costly temporary nursing resources. We will utilize comprehensive nurse satisfaction surveys to measure whether the model is being embraced by the nursing staff and if the initiatives included in the model result in a more engaged workforce.

Physician collaboration and alignment

In order to help our communities achieve health for life, we must work collaboratively with physicians to provide clinically superior healthcare services. The first step in this process is to ensure that physician resources are available to provide the necessary services to our patients. During fiscal 2009, we recruited approximately 150 physicians to the communities we serve through both employment and non-employment initiatives. During fiscal 2010, we expect to recruit approximately 200 additional physicians primarily through employment arrangements. Most of these recruiting initiatives relate to primary care or hospitalist physicians, but certain specialists will also be targeted such as: cardiovascular, neurology, obstetrics/gynecology, orthopedics and urology. We will continue to provide significant corporate and regional resources to assist in the relocation and management of these new physician practices.

Delivering an ideal patient-centered experience requires that we align the goals of the physicians who practice in our hospitals to the goals previously discussed in our nursing professional practice model while respecting physician care decisions and methods of practice. We have implemented multiple initiatives including physician leadership councils, physician training programs and information technology upgrades to ease the flow of on-site and off-site communication between physicians, nurses and patients in order to effectively align the interest of all patient caregivers. These initiatives are just some of those included in our clinical integration roadmap.

Two significant initiatives that are currently underway to achieve physician alignment are our employed hospitalist strategy and our medical officer leadership strategy. We have currently implemented our new hospitalist model in most of our Arizona hospitals and are beginning implementation in a second market. We intend to commit significant resources during fiscal 2010 to grow our employed hospitalist program. We believe that hospitalists provide an effective means through which care can be coordinated between specialist physicians and our nursing staff. The existence of a strong, reputable group of hospitalists provides confidence to admitting physicians that their patients will receive high-quality, coordinated care on a 24-hour, 7-day basis while in our hospitals. The hospitalist model should improve patient satisfaction due to the increase in the number of specialized physician encounters the patients experience. To facilitate care standards for our physicians, we have established chief medical officers at each of our corporate, regional and hospital levels. These officers work with our physician leadership councils to drive our quality of core initiatives. We will continue to utilize physician satisfaction surveys and physician leadership council discussions to measure our physician integration success.

Expansion of services and care efficiencies

We continue to identify services that are in demand in the communities we serve that we do not provide or else only provide on a limited basis. Some of our more significant planned service additions during fiscal year 2010 include the following: women's and children's services in Phoenix; radiology and urology services in Chicago; cardiology services in Massachusetts and orthopedics and women's services in San Antonio. We also plan to launch standardization projects for our emergency and operating room departments across the company during fiscal 2010 that will result in process improvements, better patient throughput and more satisfied patients.

One area where we plan to use technology to improve care efficiencies is in our intensive care units. Due to shortages in the availability of intensivists, we are working to implement electronic intensive care units ("EICUs") at certain of our hospitals. EICUs will provide constant monitoring of intensive care patients even when an intensivist

is not available at the bedside and will enhance communications to both the hospitalist and the specialty physicians of patient conditions. We expect this initiative to improve lengths of stay by shortening the transition time between intensive care beds and general beds and to improve mortality rates.

Strengthening our financial operations to fund continuing community investment

In order to continue to invest in the capital, information and human resources necessary to improve health in our communities, we must continue to generate strong financial returns. We believe that payment mechanisms for hospital providers will continue to transition during the upcoming years, and hospitals will need to transform their delivery of care in order to be successful. We expect to combine a population health strategy with a complex clinical program strategy based on fee for episode as reimbursement transitions away from fee for service. Additionally, quality of care measures have become an increasingly important factor in governmental and managed care reimbursement. We monitor core measures and other quality of care indicators on a monthly basis and continuously implement process improvements to improve clinical quality.

Many payers, including Medicare and several large managed care organizations, currently require providers to report certain quality measures in order to receive the full amount of payment increases that were awarded automatically in the past. For federal fiscal year 2010, Medicare expanded the number of quality measures to 47 from 43 during federal fiscal year 2009. These measures include risk-adjusted outcomes measures such as 30-day mortality measures for patients who suffered a heart attack, heart failure or pneumonia; additional measures related to patients who underwent surgical procedures such as hospital-acquired infections data; and several patient satisfaction indicators. Many large managed care organizations have developed quality measurement criteria that are similar to or even more stringent than the Medicare requirements. We believe that pay for performance reimbursement will continue to evolve, and that quality measure scores themselves will determine reimbursement. This is evidenced by the Center for Medicare Services' ("CMS") new reforms effective October 1, 2008 that took the first steps toward preventing Medicare from making additional payments to hospitals for treating patients that acquired one of eleven identified hospital-acquired conditions during a hospital stay.

In addition to meeting the reporting or adherence requirements related to core measure scores, we must also continue to successfully negotiate favorable payment rates with our most significant managed care payers. Our service expansion initiatives and organic market growth gives us an expanded presence in the markets we serve and provides opportunities for us to negotiate better rates with these managed care organizations. During fiscal 2009, our San Antonio hospitals also were awarded participation in the CMS ACE demonstration project for cardiology and orthopedic services. We believe that this reimbursement program will be beneficial to us if we are able to efficiently manage the care of those patients.

Our Competitive Strengths

Concentrated Local Market Positions in Attractive Markets

We believe that our markets are attractive because of their favorable demographics, competitive landscape, payer mix and opportunities for expansion. Ten of our 15 hospitals are located in markets with long-term population growth rates in excess of the national average and all of our acute care hospitals are located in markets in which the median household income is above the national average. For the fiscal year ended June 30, 2009, we derived approximately 67% of our total revenues from the San Antonio and metropolitan Phoenix markets, which have high long-term growth projections. Our facilities in these markets primarily serve Bexar County, Texas, which encompasses most of the metropolitan San Antonio area and Maricopa County, Arizona, which encompasses most of the metropolitan Phoenix area. Our strong market positions provide us with opportunities to offer integrated services to patients, receive more favorable reimbursement terms from a broader range of third party payers and realize regional operating efficiencies. The U.S. Census Bureau projects that the number of individuals aged 65 and older will increase by an average of 3.0% each year during the years 2010 to 2020 so that those individuals aged 65 and older would represent approximately 18.6% of the total U.S. population by 2020. Our presence in high growth markets combined with the general aging of the United States population and expected longer life expectancies should result in higher demand for healthcare services and provide growth opportunities for us well into the future.

Strong Management Team with Significant Equity Investment

Our senior management has an average of more than 20 years of experience in the healthcare industry at various organizations, including OrNda Healthcorp, HCA Inc. and HealthTrust, Inc. Many of our senior managers have been with Vanguard since its founding in 1997, and 11 of our 20 members of senior management have worked together managing healthcare companies for up to 30 years, either continuously or from time to time. In connection with consummation of the Merger, the Rollover Management Investors purchased Class A membership units in Holdings having an aggregate purchase price of approximately $119.1 million which then represented approximately 15.9% of our equity interests.

Proven Ability to Complete and Integrate Acquisitions

Including our first acquisition in 1998, we have selectively acquired 18 hospitals, 12 of which were formerly not-for-profit hospitals. We have subsequently sold 3 of these hospitals and ceased acute care operations in another. We believe our success in completing acquisitions is due in large part to our disciplined approach to making acquisitions. Prior to completing an acquisition, we carefully review the operations of the target facility and develop a strategic plan to improve performance. We have routinely rejected acquisition candidates that did not meet our financial and operational criteria.

We believe our historical performance demonstrates our ability to identify underperforming facilities and improve the operations of acquired facilities. When we acquire a hospital, we generally implement a number of measures to lower costs, and we often make significant investments in the facility to expand existing services and introduce new services, strengthen the medical staff and improve our overall market position. We expect to continue to grow revenues and profitability in the markets in which we operate by improving quality of care, increasing the depth and breadth of services provided and through the implementation of additional operational enhancements.

The Markets We Serve

San Antonio, Texas

In the San Antonio market, as of June 30, 2009, we owned and operated 5 hospitals with a total of 1,741 licensed beds and related outpatient service locations complementary to the hospitals. We acquired these hospitals in January 2003 from the non-profit Baptist Health Services (formerly known as Baptist Health System) and continue to operate the hospitals as the Baptist Health System. The acquisition followed our strategy of acquiring a significant market share in a growing market, San Antonio, Texas. Our facilities primarily serve the residents of Bexar County which encompasses most of the metropolitan San Antonio area.

During the years ended June 30, 2008 and 2009, we generated approximately 32.1% and 29.6% of our total revenues, respectively, in this market. We have invested approximately $461.0 million of capital in this market since we purchased these hospitals.

Metropolitan Phoenix, Arizona

In the Phoenix market, as of June 30, 2009, we owned and operated 5 hospitals with a total of 988 licensed beds and related outpatient service locations complementary to the hospitals, a prepaid Medicaid managed health plan, Phoenix Health Plan ("PHP"), and a managed Medicare and dual-eligible health plan, Abrazo Advantage Health Plan ("AAHP"). Phoenix is the fifth largest city in the U.S. and has been one of the fastest growing major metropolitan areas during the past ten years. Our facilities primarily serve the residents of Maricopa County, which encompasses most of the metropolitan Phoenix area.

During the years ended June 30, 2008 and 2009, exclusive of PHP and AAHP, we generated approximately 18.8% and 17.9% of our total revenues, respectively, in this market. Three of our hospitals in this market were formerly not-for-profit hospitals. We believe that payers will choose to contract with us in order to give their enrollees a comprehensive choice of providers in the western and northern Phoenix areas. Recently, we have negotiated improvements in our payer rates at our Phoenix hospitals generally, and Arizona's state Medicaid program remains a comprehensive provider of healthcare coverage to low income individuals and families. We

believe our network strategy will position us to continue to negotiate favorable rate increases with managed care payers and to build upon our network's comprehensive range of integrated services. In addition, our ownership of PHP and AAHP will allow us to enroll eligible patients, who would not otherwise be able to pay for healthcare services, into our health plan or into other state-approved plans.

Metropolitan Chicago, Illinois

In the Chicago metropolitan area, as of June 30, 2009, we owned and operated 2 hospitals with 766 licensed beds, and related outpatient service locations complementary to the hospitals. Weiss Hospital is operated by us in a consolidated joint venture corporation in which we own 80.1% and the University of Chicago Hospitals owns 19.9% of the equity interests. During the years ended June 30, 2008 and 2009, we generated approximately 14.9% and 14.6%, respectively, of our total revenues in this market.

We chose MacNeal Hospital and Weiss Hospital, both former not-for-profit facilities, as our first two entries into the largely not-for-profit metropolitan Chicago area. Both MacNeal and Weiss Hospitals are large, well-equipped, university-affiliated hospitals with strong reputations and medical staffs. We believe we have captured a large share of the patients in MacNeal Hospital's immediate surrounding service area, which encompasses the cities of Berwyn and Cicero, Illinois. MacNeal offers tertiary services such as open heart surgery that patients would otherwise have to travel outside the local community to receive. We have also established fully-integrated healthcare systems at MacNeal and Weiss Hospitals by operating free-standing primary care and occupational medicine centers and a large commercial reference laboratory. As of June 30, 2009, these health systems employed 67 physicians including 32 primary care physicians. Our network of 21 primary care and occupational medicine centers allows us to draw patients to MacNeal and Weiss from around the metropolitan Chicago area. Both hospitals partner with various medical schools, the most significant being the University of Chicago Medical School and the University of Illinois Medical School, to provide medical training through residency programs in multiple specialties. In addition, MacNeal Hospital runs a successful free-standing program in family practice, one of the oldest such programs in the state of Illinois, and Weiss Hospital also runs a successful free-standing residency program in internal medicine. Our medical education programs help us to attract quality physicians to both the hospitals and our network of primary care and occupational medicine centers.

Massachusetts

In Massachusetts, as of June 30, 2009, we owned and operated 3 hospitals with a total of 640 licensed beds and related healthcare services complementary to the hospitals. These hospitals include Saint Vincent Hospital located in Worcester and MetroWest Medical Center, a two-campus hospital system comprised of Framingham Union Hospital in Framingham and Leonard Morse Hospital in Natick. These hospitals were acquired by us on December 31, 2004. We believe that opportunities for growth through increased market share exist in the Massachusetts area through the possible addition of new services, partnerships and the implementation of a strong primary care physician strategy. During the years ended June 30, 2008 and 2009, the Massachusetts facilities represented 19.7% and 18.3% of our total revenues, respectively.

Saint Vincent Hospital, located in Worcester, is a 321-bed teaching hospital with an extensive residency program. Worcester is located in central Massachusetts and is the second largest city in Massachusetts. The service area is characterized by a patient base that is older, more affluent and well-insured. Saint Vincent Hospital is focused on strengthening its payer relationships, developing its primary care physician base and expanding its offerings in cardiology, orthopedics, radiology and minimally-invasive surgery capabilities.

MetroWest Medical Center's two campus system has a combined total of 319 licensed beds with locations in Framingham and Natick, in the suburbs west of Boston. These facilities serve communities that are generally well-insured. We are seeking to develop strong ambulatory care capabilities in these service areas, as well as to expand our oncology, radiology, women's services and cardiology services.

Our Facilities

We owned and operated 15 acute care hospitals as of June 30, 2009. The following table contains information concerning our hospitals:

Hospital	City	Licensed Beds	Date Acquired
Texas			
Baptist Medical Center	San Antonio	636	January 1, 2003
Northeast Baptist Hospital	San Antonio	367	January 1, 2003
North Central Baptist Hospital	San Antonio	268	January 1, 2003
Southeast Baptist Hospital	San Antonio	175	January 1, 2003
St. Luke's Baptist Hospital	San Antonio	295	January 1, 2003
Arizona			
Maryvale Hospital	Phoenix	232	June 1, 1998
Arrowhead Hospital	Glendale	220	June 1, 2000
Phoenix Baptist Hospital	Phoenix	236	June 1, 2000
Paradise Valley Hospital	Phoenix	136	November 1, 2001
West Valley Hospital (1)	Goodyear	164	September 4, 2003
Illinois			
MacNeal Hospital	Berwyn	427	February 1, 2000
Louis A. Weiss Memorial Hospital (2)	Chicago	339	June 1, 2002
Massachusetts			
MetroWest Medical Center – Leonard Morse Hospital	Natick	141	December 31, 2004
MetroWest Medical Center - Framingham Union Hospital	Framingham	178	December 31, 2004
Saint Vincent Hospital at Worcester Medical Center	Worcester	321	December 31, 2004
Total Licensed Beds		4,135	

(1) This hospital was constructed, not acquired.

(2) This hospital is operated by us in a consolidated joint venture corporation in which we own 80.1% of the equity interests and the University of Chicago Hospitals owns 19.9% of the equity interests.

In addition to the hospitals listed in the table above, as of June 30, 2009, we owned certain outpatient service locations complementary to our hospitals and two surgery centers in Orange County, California. We also own and operate a limited number of medical office buildings in conjunction with our hospitals which are primarily occupied by physicians practicing at our hospitals.

Our Hospital Operations

Acute Care Services

Our hospitals typically provide the full range of services commonly available in acute care hospitals, such as internal medicine, general surgery, cardiology, oncology, neurosurgery, orthopedics, obstetrics, diagnostic and emergency services, as well as select tertiary services such as open-heart surgery and level II and III neonatal intensive care. Our hospitals also generally provide outpatient and ancillary healthcare services such as outpatient surgery, laboratory, radiology, respiratory therapy and physical therapy. We also provide outpatient services at our imaging centers and ambulatory surgery centers. Certain of our hospitals have a limited number of psychiatric, skilled nursing and rehabilitation beds.

Management and Oversight

Our senior management team has extensive experience in operating multi-facility hospital networks and plays a vital role in the strategic planning for our facilities. A hospital's local management team is generally comprised of a chief executive officer, chief operating officer, chief financial officer and chief nursing officer. Local management teams, in consultation with our corporate staff, develop annual operating plans setting forth revenue growth strategies through the expansion of offered services and the recruitment of physicians in each community, as well as plans to improve operating efficiencies and reduce costs. We believe that the ability of each local management team to identify and meet the needs of our patients, medical staffs and the community as a whole is critical to the success of our hospitals. We base the compensation for each local management team in part on its ability to achieve the goals set forth in the annual operating plan, including quality of care, patient satisfaction and financial measures.

Boards of trustees at each hospital, consisting of local community leaders, members of the medical staff and the hospital chief executive officer, advise the local management teams. Members of each board of trustees are identified and recommended by our local management teams and serve three-year staggered terms. The boards of trustees establish policies concerning medical, professional and ethical practices, monitor these practices and ensure that they conform to our high standards. We have recently formed Physician Advisory Councils at each of our hospitals that focus on quality of care, clinical integration and other issues important to physicians and make recommendations to the boards of trustees as necessary. We maintain company-wide compliance and quality assurance programs and use patient care evaluations and other assessment methods to support and monitor quality of care standards and to meet accreditation and regulatory requirements.

We also provide support to the local management teams through our corporate resources in areas such as revenue cycle, business office, legal, managed care, clinical efficiency, physician services and other administrative functions. These resources also allow for sharing best practices and standardization of policies and processes among all of our hospitals.

Attracting Patients

We believe that the most important factors affecting a patient's choice in hospitals are the reputation of the hospital's nursing staff for delivering quality care, the availability and expertise of physicians caring for patients at the facility and the location and convenience of the hospital. Other factors that affect utilization include local demographics and population growth, local economic conditions and the hospital's success in contracting with a wide range of local payers.

Outpatient Services

The healthcare industry has experienced a general shift during recent years from inpatient services to outpatient services as Medicare, Medicaid and managed care payers have sought to reduce costs by shifting lower-acuity cases to an outpatient setting. Advances in medical equipment technology and pharmacology have supported the shift to outpatient utilization, which has resulted in an increase in the acuity of inpatient admissions. However, we expect inpatient admissions to recover over the long-term as the baby boomer population reaches ages where inpatient admissions become more prevalent. We have responded to the shift to outpatient services through expanding service offerings and increasing the throughput and convenience of our emergency departments, outpatient surgery facilities and other ancillary units in our hospitals. We also own two ambulatory surgery centers in Orange County, California, interests in diagnostic imaging centers in San Antonio, Texas, outpatient diagnostic imaging centers in metropolitan Phoenix, Arizona and a network of primary care and occupational medicine centers in metropolitan Chicago, Illinois. We continually upgrade our resources, including procuring excellent physicians and nursing staff and utilizing technologically advanced equipment, to support our comprehensive service offerings to capture inpatient volumes from the baby boomers. We have focused on core services including cardiology, neurology, oncology, orthopedics and women's services. We also operate sub-acute units such as rehabilitation, skilled nursing facilities and psychiatric services, where appropriate, to meet the needs of our patients while increasing volumes and increasing care management efficiencies.

Operating Statistics

The following table sets forth certain operating statistics from continuing operations for the periods indicated. Acute care hospital operations are subject to fluctuations due to seasonal cycles of illness and weather, including increased patient utilization during the cold weather months and decreases during holiday periods.

	Year Ended June 30,				
	2005	2006	2007	2008	2009
Number of hospitals at end of period (a)	15	15	15	15	15
Number of licensed beds at end of period (b)	3,907	3,937	4,143	4,181	4,135
Discharges (c)	147,798	162,446	166,873	169,668	167,880
Adjusted discharges - hospitals (d)	231,322	261,056	264,698	270,076	274,767
Average length of stay (days) (e)	4.2	4.3	4.3	4.3	4.2
Average daily census (f)	1,708	1,921	1,978	2,008	1,945
Net patient revenue per adjusted hospital discharge (g)	$ 6,859	$ 7,319	$ 7,766	$ 8,110	$ 8,623
Total surgeries (h)	101,368	113,043	113,833	110,877	114,348
Member lives (i)	146,700	146,200	145,600	149,600	218,700

(a) The number of hospitals at the end of each period represents hospitals included in continuing operations.

(b) Licensed beds are those beds for which a facility has been granted approval to operate from the applicable state licensing agency.

(c) Represents the total number of patients discharged (in the facility for an overnight stay) from our hospitals and is used by management and certain investors as a general measure of inpatient volumes.

(d) Adjusted discharges-hospitals is used by management and certain investors as a general measure of combined inpatient and outpatient volumes and is computed by multiplying discharges by the sum of gross hospital inpatient and outpatient revenues and then dividing the result by gross hospital inpatient revenues. This computation enables management to assess hospital volumes by a combined measure of inpatient and outpatient volumes.

(e) Average length of stay represents the average number of days admitted patients stay in our hospitals.

(f) Average daily census represents the average number of patients in our hospitals each day during our ownership.

(g) Net revenue per adjusted hospital discharge is calculated by dividing hospital net patient revenues by hospital adjusted discharges and measures the average net payment expected to be received for a patient's hospital stay.

(h) Total surgeries represent the sum of inpatient surgeries and outpatient surgeries performed at our hospitals or ambulatory surgery centers.

(i) Member lives represents the total number of enrollees in our Arizona prepaid managed health plans and our Chicago capitated health plan as of the end of the respective period.

Our Health Plan Operations

Phoenix Health Plan

In addition to our hospital operations, we own three health plans. PHP is a prepaid Medicaid managed health plan that currently serves nine counties in the Phoenix, Arizona area. We acquired PHP in May 2001. We are able to enroll eligible patients in our hospitals into PHP or other approved Medicaid managed health plans who otherwise would not be able to pay for their hospital expenses. We believe the volume of patients generated through our health plans will help attract quality physicians to the communities our hospitals serve.

For the year ended June 30, 2009, we derived approximately $577.7 million of our total revenues from PHP. PHP had approximately 176,200 enrollees as of June 30, 2009, and derives substantially all of its revenues through a contract with the Arizona Health Care Cost Containment System ("AHCCCS"), which is Arizona's state Medicaid

program. The contract requires PHP to arrange for healthcare services for enrolled Medicaid patients in exchange for monthly capitation payments and supplemental payments from AHCCCS. PHP subcontracts with physicians, hospitals and other healthcare providers to provide services to its enrollees. These services are provided regardless of the actual costs incurred to provide these services. We receive reinsurance and other supplemental payments from AHCCCS to cover certain costs of healthcare services that exceed certain thresholds.

As part of its contract with AHCCCS, PHP is required to maintain a performance guarantee in the amount of $40.0 million. Vanguard maintains this performance guarantee on behalf of PHP in the form of surety bonds totaling $40.0 million with independent third party insurers that expire on October 1, 2009. We were also required to arrange for $5.0 million in letters of credit to collateralize our $40.0 million in surety bonds with the third party insurers. The amount of the performance guaranty that AHCCCS requires is based upon the membership in the health plan and the related capitation amounts paid to us.

Our current contract with AHCCCS commenced on October 1, 2008 and covers members in nine Arizona counties: Apache, Coconino, Gila, Maricopa, Mohave, Navajo, Pima, Pinal and Yavapai. This contract covers the three-year period beginning October 1, 2008 and ending September 30, 2011. Our previous contract with AHCCCS covered only Gila, Maricopa and Pinal counties. AHCCCS has the option to renew the new contract, in whole or in part, for two additional one-year periods commencing on October 1, 2011 and on October 1, 2012.

Abrazo Advantage Health Plan

Effective January 1, 2009, AAHP became a Medicare Advantage Prescription Drug Special Needs Plan provider under a contract with CMS. This allows AAHP to offer Medicare and Part D drug benefit coverage for Medicare members and dual-eligible members (those that are eligible for Medicare and Medicaid). PHP has historically served dual-eligible members through its AHCCCS contract. As of June 30, 2009, approximately 2,800 members were enrolled in AAHP, most of whom were previously enrolled in PHP. For the year ended June 30, 2009, we derived approximately $40.1 million of our total revenues from AAHP.

MacNeal Health Providers

The operations of MHP are somewhat integrated with our MacNeal Hospital in Berwyn, Illinois. For the year ended June 30, 2009, we derived approximately $60.2 million of our total revenues from MHP. MHP generates revenues from its contracts with health maintenance organizations from whom it took assignment of capitated member lives as well as third party administration services for other providers. As of June 30, 2009, MHP had contracts in effect covering approximately 39,700 capitated member lives. Such capitation is limited to physician services and outpatient ancillary services and does not cover inpatient hospital services. We try to utilize MacNeal Hospital and its medical staff as much as possible for the physician and outpatient ancillary services that are required by such capitation arrangements. Revenues of MHP are dependent upon health maintenance organizations in the metropolitan Chicago area continuing to assign capitated-member lives to health plans like MHP as opposed to entering into direct fee-for-service arrangements with healthcare providers.

Competition

The hospital industry is highly competitive. We currently face competition from established, not-for-profit healthcare systems, investor-owned hospital companies, large tertiary care hospitals, specialty hospitals and outpatient service providers. In the future, we expect to encounter increased competition from companies, like ours, that consolidate hospitals and healthcare companies in specific geographic markets. Continued consolidation in the healthcare industry will be a leading factor contributing to increased competition in our current markets and markets we may enter in the future. Due to the shift to outpatient care and more stringent payer-imposed pre-authorization requirements during the past few years, most hospitals have significant unused capacity resulting in increased competition for patients. Many of our competitors are larger than us and have more financial resources available than we do. Other not-for-profit competitors have endowment and charitable contribution resources available to them and can purchase equipment and other assets on a tax-free basis.

One of the most important factors in the competitive position of a hospital is its location, including its geographic coverage and access to patients. A location convenient to a large population of potential patients or a

wide geographic coverage area through hospital networks can make a hospital significantly more competitive. Another important factor is the scope and quality of services a hospital offers, whether at a single facility or a network of facilities, compared to the services offered by its competitors. A hospital or network of hospitals that offers a broad range of services and has a strong local market presence is more likely to obtain favorable managed care contracts. We intend to evaluate changing circumstances in the geographic areas in which we operate on an ongoing basis to ensure that we offer the services and have the access to patients necessary to compete in these managed care markets and, as appropriate, to form our own, or join with others to form, local hospital networks.

A hospital's competitive position also depends in large measure on the quality and specialties of physicians associated with the hospital. Physicians refer patients to a hospital primarily on the basis of the quality and breadth of services provided by the hospital, the quality of the nursing staff and other professionals affiliated with the hospital, the hospital's location and the availability of modern equipment and facilities. Although physicians may terminate their affiliation with our hospitals, we seek to retain physicians of varied specialties on our medical staffs and to recruit other qualified physicians by maintaining or improving our level of services and providing quality facilities, equipment and nursing care for our patients.

Another major factor in the competitive position of a hospital is the ability of its management to obtain contracts with managed care plans and other group payers. The importance of obtaining managed care contracts has increased in recent years due primarily to consolidations of health plans and is expected to continue to increase as private and government payers increasingly turn to managed care organizations to help control rising healthcare costs. Our markets have experienced significant managed care penetration. The revenues and operating results of our hospitals are significantly affected by our hospitals' ability to negotiate favorable contracts with managed care plans. Health maintenance organizations and preferred provider organizations use managed care contracts to encourage patients to use certain hospitals in exchange for discounts from the hospitals' established charges. Traditional health insurers and large employers also are interested in containing costs through similar contracts with hospitals.

The hospital industry and our hospitals continue to have significant unused capacity. Inpatient utilization, average lengths of stay and average occupancy rates have historically been negatively affected by payer-required pre-admission authorization, utilization review and payer pressure to maximize outpatient and alternative healthcare delivery services for less acutely ill patients. Admissions constraints, payer pressures and increased competition are expected to continue. We expect to meet these challenges first and foremost by our continued focus on our previously discussed quality of care initiatives, which should increase patient, nursing and physician satisfaction. We also may expand our outpatient facilities, strengthen our managed care relationships, upgrade facilities and equipment and offer new or expanded programs and services.

Employees and Medical Staff

As of June 30, 2009, we had approximately 19,200 employees, including approximately 2,100 part-time employees. Approximately 1,600 of our full-time employees at our three Massachusetts hospitals are unionized. Overall, we consider our employee relations to be good. While some of our non-unionized hospitals experience union organizing activity from time to time, we do not currently expect these efforts to materially affect our future operations. Our hospitals, like most hospitals, have experienced labor costs rising faster than the general inflation rate.

While the national nursing shortage has abated somewhat as a result of the weakended U.S. economy, certain pockets of the markets we serve continue to have limited available nursing resources. Nursing shortages often result in our using more contract labor resources to meet increased demand especially during the peak winter months. We expect our nurse leadership and recruiting initiatives to mitigate the impact of the nursing shortage. These initiatives include more involvement with nursing schools, participation in more job fairs, recruiting nurses from abroad, implementing preceptor programs, providing flexible work hours, improving performance leadership training, creating awareness of our quality of care and patient safety initiatives and providing competitive pay and benefits. We anticipate that demand for nurses will continue to exceed supply especially as the baby boomer population reaches the ages where inpatient stays become more frequent. We continue to implement best practices to reduce turnover and to stabilize our nursing workforce over time.

One of our primary nurse recruiting strategies for our San Antonio hospitals is our continued investment in the Baptist Health System School of Health Professions ("SHP"), our nursing school in San Antonio. SHP offers seven different healthcare educational programs with its greatest enrollment in the professional nursing program. SHP trains approximately 450 students each year. The majority of these students have historically chosen permanent employment with our hospitals. We have changed SHP's nursing program from a diploma program to a degree program and may improve other SHP programs in future periods. We completed the necessary steps during fiscal 2009 to make SHP students eligible for participation in the Pell Grant and other federal grant and loan programs. We expect these enhancements will make SHP more attractive to potential students.

Our hospitals grant staff privileges to licensed physicians who may serve on the medical staffs of multiple hospitals, including hospitals not owned by us. A physician who is not an employee can terminate his or her affiliation with our hospital at any time. Although we employ a growing number of physicians, a physician does not have to be our employee to be a member of the medical staff of one of our hospitals. Any licensed physician may apply to be admitted to the medical staff of any of our hospitals, but admission to the staff must be approved by each hospital's medical staff and board of trustees in accordance with established credentialing criteria. Under state laws and other licensing standards, hospital medical staffs are generally self-governing organizations subject to ultimate oversight by the hospital's local governing board. Although we were generally successful in our physician recruiting efforts during fiscal 2009, we face continued challenges in some of our markets to recruit certain types of physician specialists who are in high demand. We expect that our previously described physician recruiting and alignment initiatives will make our hospitals more desirable environments in which more physicians will choose to practice.

Compliance Program

We voluntarily maintain a company-wide compliance program designed to ensure that we maintain high standards of ethics and conduct in the operation of our business and implement policies and procedures so that all our employees act in compliance with all applicable laws, regulations and company policies. The organizational structure of our compliance program includes oversight by our board of directors and a high-level corporate management compliance committee. The board of directors and compliance committee are responsible for ensuring that the compliance program meets its stated goals and remains up-to-date to address the current regulatory environment and other issues affecting the healthcare industry. Our Senior Vice President of Compliance and Ethics reports jointly to our Chairman and Chief Executive Officer and to our board of directors, serves as our Chief Compliance Officer and is charged with direct responsibility for the day-to-day management of our compliance program. Other features of our compliance program include Regional Compliance Officers who report to our Chief Compliance Officer in all four of our operating regions, initial and periodic ethics and compliance training and effectiveness reviews, a toll-free hotline for employees to report, without fear of retaliation, any suspected legal or ethical violations, annual "fraud and abuse" audits to examine all of our payments to physicians and other referral sources and annual "coding audits" to make sure our hospitals bill the proper service codes for reimbursement from the Medicare program.

Our compliance program also oversees the implementation and monitoring of the standards set forth by the Health Insurance Portability and Accountability Act ("HIPAA") for privacy and security. To facilitate reporting of potential HIPAA compliance concerns by patients, family or employees, we established a second toll-free hotline dedicated to HIPAA and other privacy matters. Corporate HIPAA compliance staff monitors all reports to the privacy hotline and each phone call is responded to appropriately. Ongoing HIPAA compliance also includes self-monitoring of HIPAA policy and procedure implementation by each of our healthcare facilities and corporate compliance oversight.

Our Information Systems

We believe that our information systems must cost-effectively meet the needs of our hospital management, medical staff and nurses in the following areas of our business operations:

- patient accounting, including billing and collection of revenues;
- accounting, financial reporting and payroll;
- coding and compliance;
- laboratory, radiology and pharmacy systems;

- medical records and document storage;
- remote physician access to patient data;
- quality indicators;
- materials and asset management; and
- negotiating, pricing and administering our managed care contracts.

During fiscal 2009, we invested significantly in clinical information technology. We believe that the importance of and reliance upon clinical information technology will continue to increase in the future. Accordingly, we expect to make additional significant investments in clinical information technology during fiscal years 2010 and 2011 as part of our business strategy to increase the efficiency and quality of patient care.

Although we map the financial information systems from each of our hospitals to one centralized database, we do not automatically standardize our financial information systems among all of our hospitals. We carefully review the existing systems at the hospitals we acquire. If a particular information system is unable to cost-effectively meet the operational needs of the hospital, we will convert or upgrade the information system at that hospital to one of several standardized information systems that can cost-effectively meet these needs.

Professional and General Liability Insurance

As is typical in the healthcare industry, we are subject to claims and legal actions by patients and others in the ordinary course of business. For claims incurred on or after June 1, 2002 through May 31, 2006, our wholly owned captive insurance subsidiary insured our professional and general liability risks at a $10.0 million retention level. For professional and general liability claims incurred from June 1, 2006 to June 30, 2009, we self-insured the first $9.0 million of each claim, and the captive subsidiary insured the next $1.0 million. We maintain excess coverage from independent third-party carriers for individual claims exceeding $10.0 million per occurrence up to $75.0 million, but limited to total annual payments of $65.0 million in the aggregate. The captive insurance subsidiary funds its portion of claims costs from proceeds of premium payments received from us.

The malpractice insurance environment remains volatile. Some states in which we operate, including Texas and Illinois, have passed in recent years tort reform legislation to place limits on non-economic damages. However, in November 2007 a judge in the Illinois Cook County Circuit Court declared that these Illinois malpractice limits were unconstitutional under state law. While such ruling is being considered in an appeal to the Illinois Supreme Court, we understand that the trial courts are not enforcing the non-economic damages limits under that Illinois tort reform statute. Additionally, in Texas an action has been brought to declare its tort reform legislation unconstitutional under federal law. Thus, while we have taken multiple steps at our facilities to reduce our professional liability exposures, absent significant legislation (not later declared unconstitutional) to curb the size of malpractice judgments in the states in which we operate, our insurance costs may increase in the future.

Sources of Revenues

Hospital revenues depend upon inpatient occupancy levels, the medical and ancillary services ordered by physicians and provided to patients, the volume of outpatient procedures and the charges or payment rates for such services. Charges and reimbursement rates for inpatient services vary significantly depending on the type of payer, the type of service (e.g., acute care, intensive care or subacute) and the geographic location of the hospital. Inpatient occupancy levels fluctuate for various reasons, many of which are beyond our control.

We receive payment for patient services from:

- the federal government, primarily under the Medicare program;
- state Medicaid programs;
- health maintenance organizations, preferred provider organizations, managed Medicare providers, managed Medicaid providers and other private insurers; and
- individual patients

The table below presents the approximate percentage of net patient revenues we received from the following sources for the periods indicated:

	Year ended June 30,		
Payer Source	**2007**	**2008**	**2009**
Medicare	26%	26%	25%
Medicaid	9	8	8
Managed Medicare	13	14	14
Managed Medicaid	7	7	9
Other managed care plans	32	35	35
Self-pay	10	9	8
Commercial	3	1	1
Total	100%	100%	100%

The Medicare program, the nation's largest health insurance program, is administered by CMS. Medicare provides certain hospital and medical insurance benefits to persons age 65 and over, some disabled persons and persons with end-stage renal disease without regard to beneficiary income or assets. Medicaid is a federal-state program, administered by the states, which provides hospital and medical benefits to qualifying individuals who are unable to afford healthcare. All of our general, acute care hospitals located in the United States are certified as healthcare services providers for persons covered under the Medicare and the various state Medicaid programs. Amounts received under these programs are generally significantly less than established hospital gross charges for the services provided.

Our hospitals offer discounts from established charges to certain group purchasers of healthcare services, including private insurance companies, employers, health maintenance organizations, preferred provider organizations and other managed care plans. These discount programs limit our ability to increase net revenues in response to increasing costs. Patients generally are not responsible for any difference between established hospital charges and amounts reimbursed for such services under Medicare, Medicaid and managed care programs, but are generally responsible for exclusions, deductibles and coinsurance features of their coverages. Due to rising healthcare costs, many payers have increased the number of excluded services and the levels of deductibles and coinsurance resulting in a higher portion of the contracted rate due from the individual patients. Collecting amounts due from individual patients is typically more difficult than collecting from governmental or private managed care plans.

Traditional Medicare

One of the ways Medicare beneficiaries can elect to receive their medical benefits is through the traditional Medicare program, which provides reimbursement under a prospective payment fee-for-service system. A general description of the types of payments we receive for services provided to patients enrolled in the traditional Medicare program is provided below. The impact of recent changes to reimbursement for these types of services is included in the section entitled "Annual Medicare Regulatory Update."

Medicare Inpatient Acute Care Reimbursement

Medicare Severity-Adjusted Diagnosis-Related Group Payments. Sections 1886(d) and 1886(g) of the Social Security Act (the "Act") set forth a system of payments for the operating and capital costs of inpatient acute care hospital admissions based on a prospective payment system. Under the inpatient prospective payment system, Medicare payments for hospital inpatient operating services are made at predetermined rates for each hospital discharge. Discharges are classified according to a system of Medicare severity-adjusted diagnosis-related groups ("MS-DRGs"), which categorize patients with similar clinical characteristics that are expected to require similar amounts of hospital resources to treat. CMS assigns to each MS-DRG a relative weight that represents the average resources required to treat cases in that particular MS-DRG, relative to the average resources used to treat cases in all MS-DRGs.

The base payment amount for the operating component of the MS-DRG payment is comprised of an average standardized amount that is divided into a labor-related share and a nonlabor-related share. Both the labor-related share of operating base payments and the base payment amount for capital costs are adjusted for geographic variations in labor and capital costs, respectively. These base payments are multiplied by the relative weight of the MS-DRG assigned to each case. The MS-DRG operating and capital base rates, relative weights and geographic adjustment factors are updated annually, with consideration given to: the increased cost of goods and services purchased by hospitals; the relative costs associated with each MS-DRG; and changes in labor data by geographic area. Although these payments are adjusted for area labor and capital cost differentials, the adjustments do not consider an individual hospital's operating and capital costs. Historically, the average operating and capital costs for our hospitals have exceeded the Medicare rate increases. These annual adjustments are effective for the Medicare fiscal year beginning October 1 of each year and are indicated by the "market basket index" for that year.

Outlier Payments. Outlier payments are additional payments made to hospitals for treating Medicare patients that are costlier to treat than the average patient in the same MS-DRG. To qualify as a cost outlier, a hospital's billed charges, adjusted to cost, must exceed the payment rate for the MS-DRG by a fixed threshold established annually by CMS. The Medicare fiscal intermediary calculates the cost of a claim by multiplying the billed charges by a cost-to-charge ratio that is typically based upon the hospital's most recently filed cost report. Generally, if the computed cost exceeds the sum of the MS-DRG payment plus the fixed threshold, the hospital receives 80% of the difference as an outlier payment.

Under the Act, CMS must project aggregate annual outlier payments to all prospective payment system hospitals to be not less than 5% or more than 6% of total MS-DRG payments. CMS adjusts the fixed threshold on an annual basis to bring the outlier percentage within the 5% to 6% parameters. Changes to the outlier fixed threshold amount can impact a hospital's number of cases that qualify for the additional payment and the amount of reimbursement the hospital receives for those cases that qualify. The most recently filed cost reports for our hospitals as of June 30, 2007, 2008 and 2009 reflected outlier payments of $5.8 million, $4.3 million and $4.2 million, respectively.

Disproportionate Share Hospital Payments. Hospitals that treat a disproportionately large number of low-income patients currently receive additional payments from Medicare in the form of disproportionate share hospital ("DSH") payments. DSH payments are determined annually based upon certain statistical information defined by CMS and are calculated as a percentage add-on to the MS-DRG payments. This percentage varies, depending on several factors that include the percentage of low-income patients served. CMS has recommended certain changes to the DSH formula, including a change that would give greater weight to the amount of uncompensated care provided by a hospital than it would to the number of low-income patients treated. During the years ended June 30, 2008 and 2009, we recognized $59.4 million and $53.4 million of Medicare DSH revenues, respectively.

Direct Graduate and Indirect Medical Education. The Medicare program provides additional reimbursement to approved teaching hospitals for additional expenses incurred by such institutions. This additional reimbursement, which is subject to certain limits, including intern and resident full-time equivalent limits established in 1996, is made in the form of Direct Graduate Medical Education ("GME") and Indirect Medical Education ("IME") payments. During our fiscal year 2009, five of our hospitals were affiliated with academic institutions and received GME or IME payments.

Medicare Outpatient Services Reimbursement

CMS reimburses hospital outpatient services and certain Medicare Part B services furnished to hospital inpatients who have no Part A coverage on a prospective payment system basis. CMS utilizes existing fee schedules to pay for physical, occupational and speech therapies, durable medical equipment, clinical diagnostic laboratory services and nonimplantable orthotics and prosthetics. Freestanding surgery centers and independent diagnostic testing facilities also receive reimbursement from Medicare on a fee schedule basis.

Those hospital outpatient services subject to prospective payment reimbursement are classified into groups called ambulatory payment classifications ("APCs"). Services in each APC are similar clinically and in terms of the resources they require. A payment rate is established for each APC. Depending upon the services provided, a hospital may be paid for more than one APC for a patient visit. CMS periodically updates the APCs and annually

adjusts the rates paid for each APC. As part of a final rule published in November 2007, CMS outlined the requirements for hospitals to submit quality data relating to outpatient care in order to receive the full market basket index increase starting in 2009. This rule required submission of seven quality measures in 2009 or else the market basket index increase would be reduced by two percentage points. We submitted the required quality data for 2009

Rehabilitation Units

CMS reimburses inpatient rehabilitation designated units pursuant to a prospective payment system. Under this prospective payment system, patients are classified into case mix groups based upon impairment, age, comorbidities and functional capability. Inpatient rehabilitation units are paid a predetermined amount per discharge that reflects the patient's case mix group and is adjusted for area wage levels, low-income patients, rural areas and high-cost outliers. As of June 30, 2009, we operated three inpatient rehabilitation units within our acute care hospitals.

Skilled Nursing Units

From July 1998 to June 2002, Medicare phased in a prospective payment system for Medicare skilled nursing units, under which the units are paid a federal per diem rate for virtually all covered services. The effect of this new payment system generally has been to significantly reduce reimbursement for skilled nursing services, which has led many hospitals to close such units. We will monitor closely and evaluate the few remaining skilled nursing units in our hospitals and related facilities to determine whether it is feasible to continue to offer such services under this reimbursement system. As of June 30, 2009, we operated one skilled nursing unit within our acute care hospitals.

Psychiatric Units

Medicare utilizes a prospective payment system to pay inpatient psychiatric hospitals and units. This system is a per diem prospective payment system with adjustments to account for certain patient and facility characteristics. Additionally, this system includes a stop-loss provision, an "outlier" policy authorizing additional payments for extraordinarily costly cases and an adjustment to the base payment if the facility maintains a full-service emergency department which all of our units qualified for. As of June 30, 2009, we operated six even psychiatric units within our acute care hospitals.

Annual Medicare Regulatory Update

The annual Medicare regulatory update published by CMS on August 27, 2009 in the Federal Register provided for the following adjustments in Medicare reimbursement for the Medicare fiscal year 2010 (October 1, 2009 through September 30, 2010):

- A market basket index increase of 2.1% for MS-DRG operating payments for hospitals who reported the 43 patient quality care indicators from 2009 and 0.1% for those who did not (this compares to 3.6% for 2009 and 3.3% for 2008, both of which are subject to a 2.0% reduction for those hospitals who did not report the patient quality care indicators applicable to those years).

- No across-the-board reduction to the to the MS-DRG base payment rate to offset the effect of documentation and/or coding changes or the classification of discharges not related to case mix changes (2009 and 2008 included reductions of 0.9% and 0.6%, respectively). However, CMS will consider phasing in future adjustments over an extended period beginning in fiscal 2011.

- Continuation of the capital indirect medical adjustment to payment rates for teaching hospitals.

- Continuation of a provision of the Deficit Reduction Act of 2005 that precludes hospitals from receiving additional payments to treat costs associated with 10 specifically identified patient hospital-acquired conditions including infections (the same 10 identified conditions as for 2009, but compares to 8 identified conditions for 2008).

- An increase in the inpatient cost outlier threshold to $23,140 from $20,045 in 2009 and $22,185 in 2008.

- An increase in the capital federal MS-DRG rate of 1.4% (compares to a 1.9% increase for federal fiscal year 2009).

- A market basket increase of 2.2% for hospital skilled nursing unit payment rates (this compares to 3.4% for 2009 and 3.3% for 2008).

- A market basket increase of 2.5% for hospital rehabilitation unit payment rates (this compares to 0% for both 2009 and 2008).

We have submitted the required patient care quality indicators for our hospitals to receive the full market basket index increases for the both the inpatient and outpatient prospective payment systems for 2009. We intend to submit the necessary information to realize the full federal fiscal year 2010 inpatient and outpatient increases as well. However, as additional patient quality indicator reporting requirements are added, system limitations or other difficulties could result in CMS deeming our submissions not timely or not complete to qualify for the full market basket index increases. Additionally, Congress has given CMS the ability to continue to evaluate whether the 2008 and 2009 inpatient reductions for documentation and coding adjustments were sufficient to account for payment changes not related to case mix changes. This continuing evaluation could negatively impact MS-DRG payment rates for federal fiscal years 2011 and 2012. Further realignments in the MS-DRG system could also reduce the payments we receive for certain specialties, including cardiology and orthopedics. The more widespread development of specialty hospitals in recent years has caused CMS to focus on payment levels for these specialty services. Changes in the payments for specialty services could adversely impact our revenues. We do not believe that the final Medicare payment updates for federal fiscal year 2010 will have a significant impact on our future financial position, results of operations or cash flows.

Contractor Reform

CMS has a significant initiative underway that could affect the administration of the Medicare program and impact how hospitals bill and receive payment for covered Medicare services. In accordance with the Medicare Modernization Act ("MMA"), CMS has begun implementation of contractor reform whereby CMS will competitively bid the Medicare fiscal intermediary and Medicare carrier functions to 15 Medicare Administrative Contractors ("MACs"). Hospital management companies like Vanguard will have the option to work with the selected MAC in the jurisdiction where a given hospital is located or to use the MAC in the jurisdiction where our home office is located. For hospital management companies, either all hospitals in the system must choose to stay with the MAC chosen for their locality or all hospitals must opt to use the home office MAC. We have filed a request for our single home office MAC to serve all of our hospitals. CMS has now completed the process of awarding contracts for all 15 MAC jurisdictions. Individual MAC jurisdictions are in varying phases of transition. All of these changes could impact claims processing functions and the resulting cash flows; however, we are unable to predict the impact that these changes could have, if any, to our cash flows.

Recovery Audit Contractors

The MMA established the Recovery Audit Contractor ("RAC") three-year demonstration program to detect Medicare overpayments not identified through existing claims review mechanisms. The RAC program relies on private auditing firms to examine Medicare claims filed by healthcare providers. Fees to the RACs are paid on a contingency basis. The RAC program began as a demonstration project in 2005 in three states (New York, California and Florida) which was expanded into the three additional states of Arizona, Massachusetts and South Carolina in July 2007. No RAC audits, however, were initiated at our Arizona or Massachusetts hospitals during the demonstration project. The program was made permanent by the Tax Relief and Health Care Act of 2006 enacted in December 2006. CMS ended the demonstration project in March 2008 and commenced the permanent RAC program in all states beginning in 2009 with plans to have RACs in full operation in all 50 states by 2010.

In a report issued in July 2008, CMS reported that the RACs in the demonstration project corrected over $1 billion of Medicare improper payments from 2005 through March 2008. Roughly 96% of the improper payments ($992.7 million) were overpayments collected from providers, while the remaining 4% ($37.8 million) were underpayments repaid to providers. Of the overpayments, 85% were collected from inpatient hospital providers,

while the other principal collections were 6% from inpatient rehabilitation facilities, and 4% from outpatient hospital providers.

RACs utilize a post-payment targeted review process employing data analysis techniques in order to identify those Medicare claims most likely to contain overpayments, such as incorrectly coded services, incorrect payment amounts, non-covered services and duplicate payments. The RAC review is either "automated", for which a decision can be made without reviewing a medical record, or "complex", for which the RAC must contact the provider in order to procure and review the medical record to make a decision about the payment. CMS has given RACs the authority to look back at claims up to three years old, provided that the claim was paid on or after October 1, 2007. Claims identified as overpayments will be subject to the Medicare appeals process.

As to "automated" reviews where a review of the medical record is not required, RACs make claim determinations using proprietary software designed to detect certain kinds of errors where both of the following conditions must apply. First, there must be certainty that the service is not covered or is coded incorrectly. Second, there must be a written Medicare policy, Medicare article or Medicare-sanctioned coding guideline supporting the determination. For example, an automated review could identify when a provider is billing for more units than allowed on one day. However, the RAC may also use automated review even if such written policies don't exist on certain CMS-approved "clinically unbelievable issues" and when making certain other types of administrative determinations (e.g., duplicate claims, pricing mistakes) when there is certainty that an error exists.

As to "complex" reviews where a review of the medical review is required, RACs make claim determinations when there is a high probability (but not certainty) that a service is not covered, or where no Medicare policy, guidance or Medicare-sanctioned coding guideline exists. It is expected that many complex reviews will be medical necessity audits that assess whether care provided was medically necessary and provided in the appropriate setting. It is currently expected that, while RACs will make complex reviews in calendar year 2009 related to DRG validation and coding, the RACs will not conduct complex reviews for medical necessity cases until calendar year 2010.

RACs are paid a contingency fee based on the overpayments they identify and collect. Therefore, we expect that the RACs will look very closely at claims submitted by our facilities in an attempt to identify possible overpayments. We believe the claims for reimbursement submitted to the Medicare program by our facilities have been accurate. However, we cannot predict, once our facilities are subject to RAC reviews in all subject matters in the future, the results of such reviews. It is reasonably possible that the aggregate payments that our facilities will be required to return to the Medicare program pursuant to these RAC reviews may have a material adverse effect on our financial position, results of operations or cash flows.

Managed Medicare

Managed Medicare plans represent arrangements where a private company contracts with CMS to provide members with Medicare Part A, Part B and Part D benefits. Managed Medicare plans can be structured as health maintenance organizations, preferred provider organizations or private fee-for-service plans. The Medicare program allows beneficiaries to choose enrollment in certain managed Medicare care plans. MMA increased reimbursement to managed Medicare plans and included provisions limiting, to some extent, the financial risk to the companies offering the plans. Following these changes, the number of beneficiaries choosing to receive their Medicare benefits through such plans increased significantly. However, the Medicare Improvement for Patients and Providers Act of 2008 reduced payments to managed Medicare plans, and CMS has recently proposed additional payment cuts to managed Medicare plans. Future changes may result in reduced premium payments to managed Medicare plans and may lead to decreased enrollment in such plans.

Medicaid

Medicaid programs are funded jointly by the federal government and the states and are administered by states under approved plans. Most state Medicaid program payments are made under a prospective payment system or are based on negotiated payment levels with individual hospitals. Medicaid reimbursement is less than Medicare reimbursement for the same services and is often less than a hospital's cost of services. The federal government and many states have recently reduced or are currently considering legislation to reduce the level of Medicaid funding

(including upper payment limits) or program eligibility that could adversely affect future levels of Medicaid reimbursement received by our hospitals. As permitted by law, certain states in which we operate have adopted broad-based provider taxes to fund their Medicaid programs. Since states must operate with balanced budgets and since the Medicaid program is often the state's largest program, states may consider further reductions in their Medicaid expenditures.

As to recent federal action affecting Medicaid, the Deficit Reduction Act of 2005 ("DRA 2005") included Medicaid cuts in federal funding of approximately $4.8 billion over five years. Additionally, on May 29, 2007, CMS published a final rule entitled "Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership" which was estimated to reduce federal Medicaid funding from $12 to $20 billion over five years. Congress enacted two moratoria in respect of this rule that delayed six of the seven proposed Medicaid regulations in this final CMS rule until July 1, 2009. On June 30, 2009, three more of the Medicaid regulations that had been under a congressional moratorium set to expire July 1, 2009 were officially rescinded all or in part by CMS, and CMS also delayed until June 30, 2010 the enforcement of the fourth of the six regulations. As a result of these changes in implementing the final CMS 2007 rule, the impact on us of the final rule can not be quantified.

Disproportionate Share Payments

Certain states in which we operate provide disproportionate share payments to hospitals that treat a disproportionately large number of low-income patients as part of their state Medicaid programs, similar to disproportionate share payments received from Medicare. During the years ended June 30, 2008 and 2009, we recognized revenues of approximately $20.2 million and $26.0 million, respectively, related to Medicaid disproportionate share reimbursement payments. These amounts do not include our revenues recognized from payments related to the Texas UPL program and the Illinois PTA program, which totaled $44.4 million during fiscal 2009, since these programs are separate from DSH. These states continually assess the level of expenditures for disproportionate share reimbursement and may reduce these payments or restructure this portion of their Medicaid programs.

Given the recent budgetary challenges that most states faced (including those in which we operate) for their new fiscal years, it is reasonable to believe that Medicaid payment rates, coverage levels or patient eligibility could be reduced in future periods as new tax collections data is received. Such legislation could also include taxes assessed on hospitals to help fund or expand the states' Medicaid programs or else to balance their general budgets. Future federal or state legislation or other changes in the administration or interpretation of government health programs by the federal government or by the states in which we operate could have a material, adverse effect on our financial position, results of operations and cash flows.

Managed Medicaid

Managed Medicaid programs represent arrangements where states contract with one or more entities for patient enrollment, care management and claims adjudication for enrollees in their state Medicaid programs. The states usually do not give up program responsibilities for financing, eligibility criteria and core benefit plan design. We generally contract directly with one of the designated entities, usually a managed care organization. The provisions of these programs are state-specific.

Annual Cost Reports

All hospitals participating in the Medicare and Medicaid programs are required to meet specific financial reporting requirements. Federal and, where applicable, state regulations require submission of annual cost reports identifying medical costs and expenses associated with the services provided by each hospital to Medicare beneficiaries and Medicaid recipients. Moreover, annual cost reports required under the Medicare and Medicaid programs are subject to routine audits, which may result in adjustments to the amounts ultimately determined to be due to us under these reimbursement programs. The audit process takes several years to reach the final determination of allowable amounts under the programs. Providers also have the right of appeal, and it is common to contest issues raised in audits of prior years' reports.

Many prior year cost reports of our facilities are still open. If any of our facilities are found to have been in violation of federal or state laws relating to preparing and filing of Medicare or Medicaid cost reports, whether prior to or after our ownership of these facilities, we and our facilities could be subject to substantial monetary fines, civil and criminal penalties and exclusion from participation in the Medicare and Medicaid programs. If an allegation is lodged against one of our facilities for a violation occurring during the time period before we acquired the facility, we may have indemnification rights against the seller of the facility to us. In each of our acquisitions, we have negotiated customary indemnification and hold harmless provisions for any damages we may incur in these areas.

Managed Care and Other Private Insurers

Managed care providers, including health maintenance organizations, preferred provider organizations, other private insurance companies and employers, are organizations that provide insurance coverage and a network of healthcare providers to members for a fixed monthly premium. To attract additional volume, most of our hospitals offer discounts from established charges or prospective payment systems to these large group purchasers of healthcare services. These discount programs often limit our ability to increase charges in response to increasing costs. However, as part of our business strategy, we have been able to renegotiate payment rates on many of our managed care contracts to improve our operating margin. While we generally received annual average payment rate increases of 5 to 11 percent from non-governmental managed care payers during fiscal year 2009, there can be no assurance that we will continue to receive increases in the future and that patient volumes from these payers will not be adversely affected by rate negotiations. These contracts often contain exclusions, carve-outs, performance criteria and other provisions and guidelines that require our constant focus and attention. Patients who are members of managed care plans are not required to pay us for their healthcare services except for coinsurance and deductible portions of their plan coverage calculated after managed care discounts have been applied. While the majority of our admissions and revenues are generated from patients covered by managed care plans, the percentage may decrease in the future due to increased Medicare utilization associated with the aging U.S. population. We experienced a slight decrease in managed care utilization of inpatient days as a percentage of total inpatient days during the year ended June 30, 2009 compared to the year ended June 30, 2008.

Self-Pay Patients

Self-pay patients are patients who do not qualify for government programs payments, such as Medicare and Medicaid, who do not qualify for charity care under our guidelines and who do not have some form of private insurance. These patients are responsible for their own medical bills. We also include in our self-pay accounts those unpaid coinsurance and deductible amounts for which payment has been received from the primary payer.

Effective for service dates on or after April 1, 2009, as a result of a state mandate, we implemented a new uninsured discount policy for those patients receiving services in our Illinois hospitals who had no insurance coverage and who did not otherwise qualify for charity care under our guidelines. Under this policy, we apply an uninsured discount (calculated as a standard percentage of gross charges) at the time of patient billing and include this discount as a reduction to patient service revenues. These discounts were approximately $11.7 million for the year ended June 30, 2009. We implemented this policy for most of our remaining facilities effective July 1, 2009 and expect to implement it at all of our facilities by the end of our fiscal year 2010.

A significant portion of our self-pay patients are admitted through our hospitals' emergency departments and often require high-acuity treatment. High-acuity treatment is more costly to provide and, therefore, results in higher billings, which are the least collectible of all accounts. We believe self-pay patient volumes and revenues have been impacted during the last two years due to a combination of broad economic factors, including reductions in state Medicaid budgets, increasing numbers of individuals and employers who choose not to purchase insurance and an increased burden of coinsurance and deductibles to be made by patients instead of insurers.

Self-pay accounts pose significant collectibility problems. At June 30, 2009, approximately 24.5% of our accounts receivable, prior to the allowance for doubtful accounts, contractual allowances and the charity care allowance, was comprised of self-pay accounts. The majority of our provision for doubtful accounts relates to self-pay patients. While our combined allowances for doubtful accounts, uninsured discounts and charity care cover over 96% of our self-pay receivables, we remain vulnerable to further increased self-pay utilization. We are taking multiple actions in an effort to mitigate the effect on us of the high number of uninsured patients and the related

economic impact. These initiatives include conducting detailed reviews of intake procedures in hospitals facing the greatest pressures and applying these intake best practices to all of our hospitals. We developed hospital-specific reports detailing collection rates by type of patient to help the hospital management teams better identify areas of vulnerability and opportunities for improvement. Also, we completely redesigned our self-pay collection workflows, enhanced technology and improved staff training in an effort to increase collections.

We do not pursue collection of amounts due from uninsured patients that qualify for charity care under our guidelines (currently those uninsured patients whose incomes are equal to or less than 200% of the current federal poverty guidelines set forth by the Department of Health and Human Services). We exclude charity care accounts from revenues when we determine that the account meets our charity care guidelines. We provide expanded discounts from billed charges and alternative payment structures for uninsured patients who do not qualify for charity care but meet certain other minimum income guidelines, primarily those uninsured patients with incomes between 200% and 500% of the federal poverty guidelines. During our fiscal years ended June 30, 2007, 2008 and 2009, we deducted $86.1 million, $86.1 million and $91.8 million of charity care from gross charges, respectively.

Other Reimbursement Regulatory and Legislative Changes

Other regulatory and legislative actions that impact or may have a future impact on Medicare or Medicaid reimbursement are set forth below.

- CMS Medicare Value-Based Purchasing Program Report – Congress, through DRA 2005, authorized the Secretary of Health and Human Services to develop a plan to implement value-based purchasing ("VBP"). In November 2007, CMS issued a report to Congress with its plan to implement a VBP program that would transform Medicare from a passive payer of claims to an active purchaser of care. Under this proposal, its VBP program would make a portion of hospital payments contingent on actual performance under specified standards rather than simply on the hospital's reporting data for those measures. We can not predict what action Congress will ultimately take regarding implementation of a VBP program at this time.

- Medicare regulation of serious medical errors – In an effort to encourage hospitals to improve quality of care, the Medicare program and certain state Medicaid programs have taken steps to withhold payments to hospitals for treatment provided to patients whose conditions were caused by serious medical error. Effective October 1, 2008, Medicare will no longer pay hospitals for the additional costs of care resulting from eight medical events such as patient falls, objects left inside patients during surgery, pressure ulcers, and certain types of infections. Certain states have established policies or proposed legislation to prohibit hospitals from charging or receiving payments from their Medicaid programs for highly preventable adverse medical events (often called "never events"), which were developed by the National Quality Forum. Never events include wrong-site surgery, serious medication errors, discharging a baby to the wrong mother, etc.

- SCHIP Extension Act of 2007 – The State Children's Health Insurance Program ("SCHIP") provides health insurance coverage for poor children. SCHIP is jointly funded by the federal government and state governments but is administered and designed by the states. SCHIP provided a capped amount of funds to states on a matching basis through September 30, 2007, when it expired. SCHIP funding was extended through March 31, 2009 by a law signed in December 2007. President Obama signed the State Children's Insurance Program bill in February 2009, which extends SCHIP by 4.5 years and expands the program to an additional 4.5 million children.

- The American Recovery and Reinvestment Act of 2009 – In February 2009, President Obama signed the American Recovery and Reinvestment Act of 2009 into law. The $787 billion economic stimulus plan includes certain measures affecting medical providers including: $21 billion in health insurance assistance that includes COBRA continuation coverage for unemployed workers; a freeze until September 30, 2009 of the final rule phasing out Medicare IME capital payments; $86.7 billion for a temporary (27-month) increase in the rate at which the federal government matches states' Medicaid expenditures and a 2.5% increase in the states' fiscal year 2009 and 2010 DSH payments (with 2010's 2.5% increase being above the new 2009 payment), but will revert to 100% of the annual DSH allotments under current law after 2010; and $31 billion in new spending on health information technology, most of which is for incentive

payments to physicians and hospitals and $2 billion for health information technology grants.

We can not predict what impact these measures will have on our future results of operations or cash flows at this time.

Government Regulation and Other Factors

Overview

All participants in the healthcare industry are required to comply with extensive government regulation at the federal, state and local levels. In addition, these laws, rules and regulations are extremely complex and the healthcare industry has had the benefit of little or no regulatory or judicial interpretation of many of them. Although we believe we are in compliance in all material respects with such laws, rules and regulations, if a determination is made that we were in material violation of such laws, rules or regulations, our business, financial condition or results of operations could be materially adversely affected. If we fail to comply with applicable laws and regulations, we can be subject to criminal penalties and civil sanctions, our hospitals can lose their licenses and their ability to participate in the Medicare and Medicaid programs.

Licensing, Certification and Accreditation

Healthcare facility construction and operation is subject to federal, state and local regulations relating to the adequacy of medical care, equipment, personnel, operating policies and procedures, fire prevention, rate-setting and compliance with building codes and environmental protection laws. Our facilities also are subject to periodic inspection by governmental and other authorities to assure continued compliance with the various standards necessary for licensing and accreditation. We believe that all of our operating healthcare facilities are properly licensed under appropriate state healthcare laws.

All of our operating hospitals are certified under the Medicare program and are accredited by The Joint Commission (formerly, known as The Joint Commission on Accreditation of Healthcare Organizations), the effect of which is to permit the facilities to participate in the Medicare and Medicaid programs. If any facility loses its accreditation by The Joint Commission, or otherwise loses its certification under the Medicare program, then the facility will be unable to receive reimbursement from the Medicare and Medicaid programs. We intend to conduct our operations in compliance with current applicable federal, state, local and independent review body regulations and standards. The requirements for licensure, certification and accreditation are subject to change and, in order to remain qualified, we may need to make changes in our facilities, equipment, personnel and services.

Certificates of Need

In some states, the construction of new facilities, acquisition of existing facilities or addition of new beds or services may be subject to review by state regulatory agencies under a Certificate of Need program. Illinois and Massachusetts are the only states in which we currently operate that require approval under a Certificate of Need program. These laws generally require appropriate state agency determination of public need and approval prior to the addition of beds or services or other capital expenditures. Failure to obtain necessary state approval can result in the inability to expand facilities, add services, acquire a facility or change ownership. Further, violation of such laws may result in the imposition of civil sanctions or the revocation of a facility's license.

Utilization Review

Federal law contains numerous provisions designed to ensure that services rendered by hospitals to Medicare and Medicaid patients meet professionally recognized standards and are medically necessary and that claims for reimbursement are properly filed. These provisions include a requirement that a sampling of admissions of Medicare and Medicaid patients be reviewed by quality improvement organizations that analyze the appropriateness of Medicare and Medicaid patient admissions and discharges, quality of care provided, validity of diagnosis related group classifications and appropriateness of cases of extraordinary length of stay or cost. Quality improvement organizations may deny payment for services provided, assess fines and recommend to the Department of Health and Human Services that a provider not in substantial compliance with the standards of the quality improvement

organization be excluded from participation in the Medicare program. Most non-governmental managed care organizations also require utilization review.

Federal Healthcare Program Statutes and Regulations

Participation in any federal healthcare program, such as the Medicare and Medicaid programs, is regulated heavily by statute and regulation. If a hospital provider fails to substantially comply with the numerous conditions of participation in the Medicare or Medicaid program or performs specific prohibited acts, the hospital's participation in the Medicare program may be terminated or civil or criminal penalties may be imposed upon it under provisions of the Social Security Act and other statutes.

Anti-Kickback Statute

A section of the Social Security Act known as the federal Anti-Kickback Statute prohibits providers and others from soliciting, receiving, offering or paying, directly or indirectly, any remuneration with the intent of generating referrals or orders for services or items covered by a federal healthcare program. Violation of this statute is a felony, including criminal penalties of imprisonment or criminal fines up to $25,000 for each violation, but it also includes civil money penalties of up to $50,000 per violation, damages up to three times the total amount of the improper payment to the referral source and exclusion from participation in Medicare, Medicaid or other federal healthcare programs.

The Office of the Inspector General of the Department of Health and Human Services (the "OIG") has published final safe harbor regulations that outline categories of activities that are deemed protected from prosecution under the Anti-Kickback Statute. Currently there are safe harbors for various activities, including the following: investment interests, space rental, equipment rental, practitioner recruitment, personal services and management contracts, sale of practice, referral services, warranties, discounts, employees, group purchasing organizations, waiver of beneficiary coinsurance and deductible amounts, managed care arrangements, obstetrical malpractice insurance subsidies, investments in group practices, ambulatory surgery centers and referral agreements for specialty services.

The fact that conduct or a business arrangement does not fall within a safe harbor does not automatically render the conduct or business arrangement illegal under the Anti-Kickback Statute. The conduct or business arrangement, however, does increase the risk of scrutiny by government enforcement authorities. We may be less willing than some of our competitors to take actions or enter into business arrangements that do not clearly satisfy the safe harbors. As a result, this unwillingness may put us at a competitive disadvantage.

The OIG, among other regulatory agencies, is responsible for identifying and eliminating fraud, abuse and waste. The OIG carries out this mission through a nationwide program of audits, investigations and inspections. In order to provide guidance to healthcare providers, the OIG has from time to time issued "fraud alerts" that, although they do not have the force of law, identify features of a transaction that may indicate that the transaction could violate the Anti-Kickback Statute or other federal healthcare laws. The OIG has identified several incentive arrangements as potential violations, including:

- payment of any incentive by the hospital when a physician refers a patient to the hospital;
- use of free or significantly discounted office space or equipment for physicians in facilities usually located close to the hospital;
- provision of free or significantly discounted billing, nursing or other staff services;
- free training for a physician's office staff, including management and laboratory techniques;
- guarantees that provide that, if the physician's income fails to reach a predetermined level, the hospital will pay any portion of the remainder;

- low-interest or interest-free loans, or loans which may be forgiven if a physician refers patients to the hospital;

- payment of the costs of a physician's travel and expenses for conferences or a physician's continuing education courses;

- coverage on the hospital's group health insurance plans at an inappropriately low cost to the physician;

- rental of space in physician offices, at other than fair market value terms, by persons or entities to which physicians refer;

- payment of services which require few, if any, substantive duties by the physician, or payment for services in excess of the fair market value of the services rendered; or

- "gain sharing," the practice of giving physicians a share of any reduction in a hospital's costs for patient care attributable in part to the physician's efforts.

Also, the OIG has encouraged persons having information about hospitals who offer the above types of incentives to physicians to report such information to the OIG.

The OIG also issues "Special Advisory Bulletins" as a means of providing guidance to healthcare providers. These bulletins, along with other "fraud alerts", have focused on certain arrangements between physicians and providers that could be subject to heightened scrutiny by government enforcement authorities, including, "suspect" joint ventures where physicians may become investors with the provider in a newly formed joint venture entity where the investors refer their patients to this new entity, and are paid by the entity in the form of "profit distributions." These subject joint ventures may be intended not so much to raise investment capital legitimately to start a business, but to lock up a stream of referrals from the physician investors and to compensate them indirectly for these referrals. Because physician investors can benefit financially from their referrals, unnecessary procedures and tests may be ordered or performed, resulting in unnecessary Medicare expenditures.

Similarly, in a Special Advisory Bulletin issued in April 2003, the OIG focused on "questionable" contractual arrangements where a healthcare provider in one line of business (the "Owner") expands into a related healthcare business by contracting with an existing provider of a related item or service (the "Manager/Supplier") to provide the new item or service to the Owner's existing patient population, including federal healthcare program patients (so called "suspect Contractual Joint Ventures"). The Manager/Supplier not only manages the new line of business, but may also supply it with inventory, employees, space, billing, and other services. In other words, the Owner contracts out substantially the entire operation of the related line of business to the Manager/Supplier – otherwise a potential competitor – receiving in return the profits of the business as remuneration for its federal program referrals. The Bulletin lists the following features of these "questionable" contractual relationships. First, the Owner expands into a related line of business, which is dependent on referrals from, or other business generated by, the Owner's existing business. Second, the Owner neither operates the new business itself nor commits substantial financial, capital or human resources to the venture. Instead, it contracts out substantially all the operations of the new business. The Manager/Supplier typically agrees to provide not only management services, but also a range of other services, such as the inventory necessary to run the business, office and healthcare personnel, billing support, and space. Third, the Manager/Supplier is an established provider of the same services as the Owner's new line of business. In other words, absent the contractual arrangement, the Manager/Supplier would be a competitor of the new line of business, providing items and services in its own right, billing insurers and patients in its own name, and collecting reimbursement. Fourth, the Owner and the Manager/Supplier share in the economic benefit of the Owner's new business. The Manager/Supplier takes its share in the form of payments under the various contracts with the Owner; the Owner receives its share in the form of the residual profit from the new business. Fifth, aggregate payments to the Manager/Supplier typically vary with the value or volume of business generated for the new business by the Owner. We monitor carefully our contracts with other healthcare providers and attempt to not allow our facilities to enter into these suspect Contractual Joint Ventures.

In addition to issuing fraud alerts and Special Advisory Bulletins, the OIG from time to time issues compliance program guidance for certain types of healthcare providers. In January 2005, the OIG published a Supplemental

Compliance Guidance for Hospitals, supplementing its 1998 guidance for the hospital industry. In the supplemental guidance, the OIG identifies a number of risk areas under federal fraud and abuse statutes and regulations. These areas of risk include compensation arrangements with physicians, recruitment arrangements with physicians and joint venture relationships with physicians.

We have a variety of financial relationships with physicians who refer patients to our hospitals. As of June 30, 2009, physicians owned interests in two of our free-standing surgery centers in California and seven of our diagnostic imaging centers in Texas. We may sell ownership interests in certain other of our facilities to physicians and other qualified investors in the future. We also have contracts with physicians providing for a variety of financial arrangements, including employment contracts, leases and professional service agreements. We have provided financial incentives to recruit physicians to relocate to communities served by our hospitals, including income and collection guarantees and reimbursement of relocation costs, and will continue to provide recruitment packages in the future. Although we have established policies and procedures to ensure that our arrangements with physicians comply with current law and applicable regulations, we cannot assure you that regulatory authorities that enforce these laws will not determine that some of these arrangements violate the Anti-Kickback Statute or other applicable laws. An adverse determination could subject us to liabilities under the Social Security Act, including criminal penalties, civil monetary penalties and exclusion from participation in Medicare, Medicaid or other federal healthcare programs, any of which could have a material adverse effect in our business, financial condition or results of operations.

Other Fraud and Abuse Provisions

The Social Security Act also imposes criminal and civil penalties for submitting false claims to Medicare and Medicaid. False claims include, but are not limited to, billing for services not rendered, misrepresenting actual services rendered in order to obtain higher reimbursement and cost report fraud. Like the Anti-Kickback Statute, these provisions are very broad. Further, the Social Security Act contains civil penalties for conduct including improper coding and billing for unnecessary goods and services. Careful and accurate preparation and submission of claims for reimbursement must be performed in order to avoid liability.

The Health Insurance Portability and Accountability Act of 1996 broadened the scope of the fraud and abuse laws by adding several criminal provisions for healthcare fraud offenses that apply to all health benefit programs. This Act also created new enforcement mechanisms to combat fraud and abuse, including the Medicaid Integrity Program and an incentive program under which individuals can receive up to $1,000 for providing information on Medicare fraud and abuse that leads to the recovery of at least $100 of Medicare funds. In addition, federal enforcement officials now have the ability to exclude from Medicare and Medicaid any investors, officers and managing employees associated with business entities that have committed healthcare fraud. Additionally, this Act establishes a violation for the payment of inducements to Medicare or Medicaid beneficiaries in order to influence those beneficiaries to order or receive services from a particular provider or practitioner.

Some of these provisions, including the federal Civil Monetary Penalty Law, require a lower burden of proof than other fraud and abuse laws, including the Anti-kickback Statute. Civil monetary penalties that may be imposed under the federal Civil Monetary Penalty Law range from $10,000 to $50,000 per act, and in some cases may result in penalties of up to three times the remuneration offered, paid, solicited or received. In addition, a violator may be subject to exclusion from federal and state healthcare programs. Federal and state governments increasingly use the federal Civil Monetary Penalty Law, especially where they believe they cannot meet the higher burden of proof requirements under the Anti-kickback Statute.

The Stark Law

The Social Security Act also includes a provision commonly known as the "Stark Law." This law prohibits physicians from referring Medicare and (to an extent) Medicaid patients to entities with which they or any of their immediate family members have a financial relationship for the provision of certain designated health services that are reimbursable by Medicare or Medicaid, including inpatient and outpatient hospital services. The law also prohibits the entity from billing the Medicare program for any items or services that stem from a prohibited referral. Sanctions for violating the Stark Law include denial of payment, refunding amounts received for services provided pursuant to prohibited referrals, civil money penalties up to $15,000 per item or service improperly billed and

exclusion from the federal healthcare programs. The statute also provides for a penalty of up to $100,000 for a circumvention scheme. There are a number of exceptions to the self-referral prohibition, including an exception for a physician's ownership interest in an entire hospital as opposed to an ownership interest in a hospital department although pending legislation in Congress would substantially restrict this "entire hospital" exception. There are also exceptions for many of the customary financial arrangements between physicians and providers, including employment contracts, leases, professional services agreements, non-cash gifts having an annual value of no more than $355 in calendar 2009 and recruitment agreements. Unlike safe harbors under the Anti-kickback Statute with which compliance is voluntary, an arrangement must comply with every requirement of a Stark Law exception or the arrangement is in violation of the Stark Law.

CMS has issued three phases of final regulations implementing the Stark Law, which became effective on January 4, 2002, July 26, 2004 and December 4, 2007, respectively, and which created several additional exceptions and many technical changes and nuanced details. Also, as part of its annual physician fee schedule update, on July 2, 2007, CMS released a number of proposed and potentially far-reaching changes to the Stark Law regulations apparently resulting from CMS's frustration with what it perceived as a growing number of hospital/physician joint venture arrangements that permitted physicians to profit from their referrals of ancillary services, while side-stepping or working around existing Stark Law restrictions. On July 31, 2008, CMS issued the final hospital inpatient prospective payment system rule for federal fiscal year 2009 which, in part, finalized and responded to public comments regarding some of its July 2007 proposed major changes to the Stark Law regulations to undermine many common hospital/physician joint venture models. The most far-reaching of the changes made in this final July 2008 rule will effectively prohibit, as of a delayed effective date of October 1, 2009, both "under arrangements" ventures between a hospital and any of its physicians and unit-of-service-based "per click" compensation and percentage-based compensation in office space and equipment leases between a hospital and its physicians. We have examined all of our "under arrangements" ventures and space and equipment leases with physicians to identify those arrangements which potentially violate these new Stark regulations, and we are in the process of restructuring or terminating non-conforming arrangements so identified prior to October 1, 2009.

Because the Stark Law and its implementing regulations are relatively new, we do not always have the benefit of significant regulatory or judicial interpretation of this law and its regulations. We attempt to structure our relationships to meet an exception to the Stark Law, but the regulations implementing the exceptions are detailed and complex, and we cannot assure that every relationship complies fully with the Stark Law. In addition, in the July 2008 final Stark rule CMS indicated that it will continue to enact further regulations tightening aspects of the Stark Law that it perceives allow for Medicare program abuse, especially those regulations that still permit physicians to profit from their referrals of ancillary services. There can be no assurance that the arrangements entered into by us and our facilities with physicians will be found to be in compliance with the Stark Law, as it ultimately may be implemented or interpreted.

Similar State Laws, etc.

Many of the states in which we operate also have adopted laws that prohibit payments to physicians in exchange for referrals similar to the federal Anti-Kickback Statute or that otherwise prohibit fraud and abuse activities. Many states also have passed self-referral legislation, similar to the Stark Law, prohibiting the referral of patients to entities with which the physician has a financial relationship. Often these state laws are broad in scope and they may apply regardless of the source of payment for care. These statutes typically provide criminal and civil penalties, as well as loss of licensure. Little precedent exists for the interpretation or enforcement of these state laws.

Certain Implications of these Fraud and Abuse Laws or New Laws

Our operations could be adversely affected by the failure of our arrangements to comply with the Anti-Kickback Statute, the Stark Law, billing laws and regulations, current state laws or other legislation or regulations in these areas adopted in the future. We are unable to predict whether other legislation or regulations at the federal or state level in any of these areas will be adopted, what form such legislation or regulations may take or how they may impact our operations. We are continuing to enter into new financial arrangements with physicians and other providers in a manner structured to comply in all material respects with these laws. We cannot assure you, however, that governmental officials responsible for enforcing these laws will not assert that we are in violation of them or

that such statutes or regulations ultimately will be interpreted by the courts in a manner consistent with our interpretation.

The Federal False Claims Act and Similar Laws

Another trend affecting the healthcare industry today is the increased use of the federal False Claims Act, and, in particular, actions being brought by individuals on the government's behalf under the False Claims Act's "*qui tam*" or whistleblower provisions. Whistleblower provisions allow private individuals to bring actions on behalf of the government alleging that the defendant has defrauded the federal government. If the government intervenes in the action and prevails, the party filing the initial complaint may share in any settlement or judgment. If the government does not intervene in the action, the whistleblower plaintiff may pursue the action independently, and may receive a larger share of any settlement or judgment. When a private party brings a *qui tam* action under the False Claims Act, the defendant generally will not be made aware of the lawsuit until the government makes a determination whether it will intervene.

When a defendant is determined by a court of law to be liable under the False Claims Act, the defendant must pay three times the actual damages sustained by the government, plus mandatory civil penalties of between $5,500 to $11,000 for each separate false claim. Settlements entered into prior to litigation usually involve a less severe calculation of damages. There are many potential bases for liability under the False Claims Act. Although liability often arises when an entity knowingly submits a false claim for reimbursement to the federal government, the False Claims Act defines the term "knowingly" broadly. Thus, simple negligence will not give rise to liability under the False Claims Act, but submitting a claim with reckless disregard to its truth or falsity can constitute "knowingly" submitting a false claim and result in liability. In some cases, whistleblowers or the federal government have taken the position that providers who allegedly have violated other statutes, such as the Anti-Kickback Statute or the Stark Law, have thereby submitted false claims under the False Claims Act.

A number of states, including states in which we operate, have adopted their own false claims provisions as well as their own whistleblower provisions whereby a private party may file a civil lawsuit in state court. From time to time, companies in the healthcare industry, including ours, may be subject to actions under the False Claims Act or similar state laws.

Provisions in the Deficit Reduction Act of 2005 ("DRA") that went into effect on January 1, 2007 give states significant financial incentives to enact false claims laws modeled on the federal False Claims Act. Additionally, the DRA requires every entity that receives annual payments of at least $5 million from a state Medicaid plan to establish written policies for its employees that provide detailed information about federal and state false claims statutes and the whistleblower protections that exist under those laws. Both provisions of the DRA are expected to result in increased false claims litigation against health care providers. We have complied with the written policy requirements.

Corporate Practice of Medicine and Fee Splitting

The states in which we operate have laws that prohibit unlicensed persons or business entities, including corporations, from employing physicians or laws that prohibit certain direct or indirect payments or fee-splitting arrangements between physicians and unlicensed persons or business entities. Possible sanctions for violations of these restrictions include loss of a physician's license, civil and criminal penalties and rescission of business arrangements that may violate these restrictions. These statutes vary from state to state, are often vague and seldom have been interpreted by the courts or regulatory agencies. Although we exercise care to structure our arrangements with healthcare providers to comply with the relevant state law, and believe these arrangements comply with applicable laws in all material respects, we cannot assure you that governmental officials responsible for enforcing these laws will not assert that we, or transactions in which we are involved, are in violation of such laws, or that such laws ultimately will be interpreted by the courts in a manner consistent with our interpretations.

The Health Insurance Portability and Accountability Act of 1996

The Administrative Simplification Provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") require the use of uniform electronic data transmission standards for healthcare claims and

payment transactions submitted or received electronically. These provisions are intended to encourage electronic commerce in the healthcare industry. The Department of Health and Human Services ("HHS") has issued regulations implementing the HIPAA Administrative Simplification Provisions and compliance with these regulations is mandatory for our facilities. In January 2009, CMS published a final rule regarding updated standard code sets for certain diagnoses and procedures known as ICD-10 code sets and related changes to the formats used for certain electronic transactions. While use of the ICD-10 code sets is not mandatory until October 1, 2013, we will be modifying our payment systems and processes to prepare for the implementation. In addition, HIPAA requires that each provider use a National Provider Identifier. While use of the ICD-10 code sets will require significant administrative changes, we believe that the cost of compliance with these regulations has not had and is not expected to have a material, adverse effect on our business, financial position or results of operations.

The privacy and security regulations promulgated pursuant to HIPAA extensively regulate the use and disclosure of individually identifiable health information and require covered entities, including our hospitals and health plans, to implement administrative, physical and technical safeguards to protect the security of such information. Recently, the American Recovery and Reinvestment Act of 2009 ("ARRA") broadened the scope of the HIPAA privacy and security regulations. Among other things, the ARRA provides that HHS must issue regulations requiring covered entities to report certain security breaches to individuals affected by the breach and, in some cases, to HHS or to the public via a website. This reporting obligation will apply broadly to breaches involving unsecured protected health information and will become effective 30 days from the date HHS issues these regulations. In addition, the ARRA extends the application of certain provisions of the security and privacy regulations to business associates (entities that handle identifiable health information on behalf of covered entities) and subjects business associates to civil and criminal penalties for violation of the regulations.

Violations of the HIPAA privacy and security regulations may result in civil and criminal penalties, and the ARRA has strengthened the enforcement provisions of HIPAA, which may result in increased enforcement activity. Under the ARRA, HHS is required to conduct periodic compliance audits of covered entities and their business associates. The ARRA broadens the applicability of the criminal penalty provisions to employees of covered entities and requires HHS to impose penalties for violations resulting from willful neglect. The ARRA also significantly increases the amount of the civil penalties, with penalties of up to $50,000 per violation for a maximum civil penalty of $1,500,000 in a calendar year for violations of the same requirement. In addition, the ARRA authorizes state attorneys general to bring civil actions seeking either injunction or damages in response to violations of HIPAA privacy and security regulations that threaten the privacy of state residents.

In addition, we remain subject to any state laws that relate to privacy or the reporting of security breaches that are more restrictive than the regulations issued under HIPAA and the requirements of the ARRA. For example, various state laws and regulations may require us to notify affected individuals in the event of a data breach involving certain individually identifiable health or financial information. In addition, the Federal Trade Commission has issued regulations requiring health providers and health plans to implement by May 1, 2009 written identity theft prevention programs to detect, prevent, and mitigate identity theft in connection with certain accounts. We have complied with these new Federal Trade Commission regulations requiring identity theft prevention programs in all of our hospitals and health plans.

Compliance with these standards has and will continue to require significant commitment and action by us and significant costs. We have appointed members of our management team to direct our compliance with these standards. Implementation has and will continue to require us to engage in extensive preparation and make significant expenditures. At this time we have appointed a corporate privacy officer and a privacy officer at each of our facilities, prepared privacy policies, trained our workforce on these policies and entered into business associate agreements with the appropriate vendors. However, failure by us or third parties on which we rely, including payers, to resolve HIPAA-related implementation or operational issues could have a material adverse effect on our results of operations and our ability to provide healthcare services. Consequently, we can give you no assurance that issues related to the full implementation of, or our operations under, HIPAA will not have a material adverse effect on our financial condition or future results of operations.

Conversion Legislation

Many states have enacted laws affecting the conversion or sale of not-for-profit hospitals. These laws generally include provisions relating to attorney general approval, advance notification and community involvement. In addition, attorneys general in states without specific conversion legislation may exercise authority over these transactions based upon existing law. In many states, there has been an increased interest in the oversight of not-for-profit conversions. The adoption of conversion legislation and the increased review of not-for-profit hospital conversions may increase the cost and difficulty or prevent the completion of transactions with or acquisitions of not-for-profit organizations in various states.

The Emergency Medical Treatment and Active Labor Act

The Federal Emergency Medical Treatment and Active Labor Act ("EMTALA") was adopted by Congress in response to reports of a widespread hospital emergency room practice of "patient dumping." At the time of the enactment, patient dumping was considered to have occurred when a hospital capable of providing the needed care sent a patient to another facility or simply turned the patient away based on such patient's inability to pay for his or her care. The law imposes requirements upon physicians, hospitals and other facilities that provide emergency medical services. Such requirements pertain to what care must be provided to anyone who comes to such facilities seeking care before they may be transferred to another facility or otherwise denied care. The government broadly interprets the law to cover situations in which patients do not actually present to a hospital's emergency department, but present to a hospital-based clinic that treats emergency medical conditions on an urgent basis or are transported in a hospital-owned ambulance, subject to certain exceptions. EMTALA does not generally apply to patients admitted for inpatient services. Sanctions for violations of this statute include termination of a hospital's Medicare provider agreement, exclusion of a physician from participation in Medicare and Medicaid programs and civil monetary penalties. In addition, the law creates private civil remedies that enable an individual who suffers personal harm as a direct result of a violation of the law, and a medical facility that suffers a financial loss as a direct result of another participating hospital's violation of the law, to sue the offending hospital for damages and equitable relief. Although we believe that our practices are in substantial compliance with the law, we cannot assure you that governmental officials responsible for enforcing the law will not assert from time to time that our facilities are in violation of this statute.

Antitrust Laws

The federal government and most states have enacted antitrust laws that prohibit certain types of conduct deemed to be anti-competitive. These laws prohibit price fixing, agreements to fix wages, concerted refusal to deal, market monopolization, price discrimination, tying arrangements, acquisitions of competitors and other practices that have, or may have, an adverse effect on competition. Violations of federal or state antitrust laws can result in various sanctions, including criminal and civil penalties. Antitrust enforcement in the healthcare industry is currently a priority of the Federal Trade Commission. We believe we are in compliance with such federal and state laws, but there can be no assurance that a review of our practices by courts or regulatory authorities will not result in a determination that could adversely affect our operations.

Healthcare Reform

The healthcare industry, as one of the largest industries in the United States, continues to attract much legislative interest and public attention. The Obama administration has stated as its top domestic priority its desire to reform the U.S. healthcare system with the goal of providing affordable, accessible healthcare for all Americans while slowing the growth of healthcare costs. This priority was demonstrated in February 2009, when President Obama released a federal budget proposal to Congress that includes plans to expand coverage to more Americans, but also to reduce Medicare and Medicaid spending over ten years by $316.0 billion in the form of reduced subsidies to Medicare Advantage health plans, cuts in payments to hospitals with high readmission rates and bundled payments for post-acute services during the 30 days following inpatient stays and value-based purchasing savings by linking a portion of Medicare payments to hospitals to performance on specific quality measures. To implement their version of President Obama's reform plans, in July 2009 four of the five Congressional committees working on healthcare reform approved some version of reform legislation. In the House of Representatives, all three committees working on the legislation (the Committees on Ways and Means, Energy and Commerce and Education

and Labor) passed different versions of the same bill under which the principal provisions were as follows: (1) for individuals not currently covered, a new healthcare exchange will be established where they can select from a menu of healthcare options: either a new "public health insurance option" or a plan offered by private insurers; (2) the legislation will provide for portable, secure health care plans, with standardized and comprehensive healthcare benefits, ending denials of care based on pre-existing conditions and capping out-of-pocket expenses; (3) the federal government will provide affordability credits, available on a sliding scale for low- and middle-income individuals and families, to make premiums affordable and reduce cost-sharing; and (4) the legislation imposes both an individual and employer mandate: individuals would be required to obtain and maintain health insurance coverage or be subject to a penalty of 2.5% of modified adjusted gross income above certain specified levels; employers may choose to fund 72.5% of an individual employee's premium cost (65% for families) or contribute an amount ranging from 2% to 8% of the employer's payroll, with small businesses (payroll below $250,000) being exempt from the employer mandate. In the House Energy and Commerce Committee several key provisions of the legislation were changed to reduce its costs, to increase to $500,000 in payroll (from $250,000) the threshold at which small businesses would be required to offer health insurance and to permit providers to negotiate payment rates for the federally-administered "public option" health insurance plan rather than linking payments to Medicare rates. During the Congressional recess in August 2009, the three House committees worked to meld the bills into one final version for consideration by the entire House of Representatives as early as September 2009. In the Senate, its Committee on Health, Education, Labor and Pensions approved its version of healthcare reform legislation on July 15, 2009 which is similar to, but less extensive in benefits than, the House version. Meanwhile, during August 2009 the Senate Committee on Finance continued its efforts to negotiate a bipartisan agreement on healthcare reform legislation and that committee is not expected to vote upon its healthcare reform bill until at least September 2009, when Congress returns from its August recess. One of the most significant differences in the legislation produced by the Senate Finance Committee is likely to be the establishment of state and/or regional health insurance cooperatives in lieu of a federally-administered "public option" to compete with private health insurance plans. The health cooperatives would be privately-administered, non-profit entities managed by a board of directors comprised of cooperative members. The Senate Finance Committee is also developing additional tax proposals such as taxing healthcare benefits under the most generous plans, as well as Medicare and Medicaid reductions, to offset the cost of the legislation. Furthermore, unlike the proposals passed by the four other House and Senate committees, it is anticipated that the Senate Finance Committee package will likely not include a requirement that employers must offer health insurance coverage to employees and their families. Once passed by the Senate Finance Committee, the two Senate committees will need to merge the two bills into one final version for consideration by the entire Senate, potentially in September or October 2009.

Also, many states have enacted or are considering enacting measures designed to reduce their Medicaid expenditures. States have also adopted, or are considering, legislation designed to reduce coverage and program eligibility and/or impose additional taxes on hospitals to help finance or expand states' Medicaid systems. Also, many states, including the states in which we operate, have applied for and been granted federal waivers from current Medicaid regulations to allow them to serve some or all of their Medicaid participants through managed care providers.

We are unable to predict the future course of federal or state healthcare legislation. Further changes in the law or regulatory framework that reduce our revenues or increase our costs could have a material adverse effect on our business, financial condition or results of operations.

Healthcare Industry Investigations

Significant media and public attention has focused in recent years on the hospital industry. In recent years, increased attention has been paid to hospitals with high Medicare outlier payments and to recruitment arrangements with physicians. Further, there are numerous ongoing federal and state investigations regarding multiple issues. These investigations have targeted hospital companies as well as their executives and managers. Like other hospital companies, we have substantial Medicare, Medicaid and other governmental billings and we engage in various arrangements with physicians, which could result in scrutiny of our operations. We continue to monitor these and all other aspects of our business and have developed a compliance program to assist us in gaining comfort that our business practices are consistent with both legal principles and current industry standards. However, because the law in this area is complex and constantly evolving, we cannot assure you that government investigations will not result in interpretations that are inconsistent with industry practices, including ours. In public statements surrounding

current investigations, governmental authorities have taken positions on a number of issues, including some for which little official interpretation previously has been available, that appear to be inconsistent with practices that have been common within the industry and that previously have not been challenged in this manner. In some instances, government investigations that have in the past been conducted under the civil provisions of federal law may now be conducted as criminal investigations.

Many current healthcare investigations are national initiatives in which federal agencies target an entire segment of the healthcare industry. One example is the federal government's initiative regarding hospital providers' improper requests for separate payments for services rendered to a patient on an outpatient basis within three days prior to the patient's admission to the hospital, where reimbursement for such services is included as part of the reimbursement for services furnished during an inpatient stay. In particular, the government has targeted all hospital providers to ensure conformity with this reimbursement rule. The federal government also has undertaken a national investigative initiative targeting the billing of claims for inpatient services related to bacterial pneumonia, as the government has found that many hospital providers have attempted to bill for pneumonia cases under more complex and higher reimbursed diagnosis related groups codes. Further, the federal government continues to investigate Medicare overpayments to prospective payment hospitals that incorrectly report transfers of patients to other prospective payment system hospitals as discharges. We are aware that prior to our acquisition of them, several of our hospitals were contacted in relation to certain government investigations relating to their operations. Although we take the position that, under the terms of the acquisition agreements, the prior owners of these hospitals retained any liability resulting from these government investigations, we cannot assure you that the prior owners' resolution of these matters or failure to resolve these matters, in the event that any resolution was deemed necessary, will not have a material adverse effect on our operations. Further, under the federal False Claims Act, private parties have the right to bring *"qui tam"* whistleblower lawsuits against companies that submit false claims for payments to the government. Some states have adopted similar state whistleblower and false claims provisions.

In addition to national enforcement initiatives, federal and state investigations commonly relate to a wide variety of routine healthcare operations such as: cost reporting and billing practices; financial arrangements with referral sources; physician recruitment activities; physician joint ventures; and hospital charges and collection practices for self-pay patients. We engage in many of these routine healthcare operations and other activities that could be the subject of governmental investigations or inquiries from time to time. For example, we have significant Medicare and Medicaid billings, we have numerous financial arrangements with physicians who are referral sources to our hospitals and we have joint venture arrangements involving physician investors.

While we are not currently aware of any material investigation of us under federal or state health care laws or regulations, it is possible that governmental entities may conduct investigations at facilities operated by us and that such investigations could result in significant penalties to us, as well as adverse publicity. It is also possible that our executives and managers, many of whom have worked at other healthcare companies that are or may become the subject of federal and state investigations and private litigation, could be included in governmental investigations or named as defendants in private litigation. The positions taken by authorities in any future investigations of us, our executives or managers or other healthcare providers and the liabilities or penalties that may be imposed could have a material adverse effect on our business, financial condition and results of operations.

Health Plan Regulatory Matters

Our health plans are subject to state and federal laws and regulations. CMS has the right to audit our health plans to determine the plans' compliance with such standards. In addition, AHCCCS has the right to audit PHP to determine PHP's compliance with such standards. Also, PHP is required to file periodic reports with AHCCCS, meet certain financial viability standards, provide its enrollees with certain mandated benefits and meet certain quality assurance and improvement requirements. Our health plans also have to comply with the standardized formats for electronic transmissions and privacy and security standards set forth in the Administrative Simplifications Provisions of HIPAA. Our health plans have implemented the necessary policies and procedures to comply with the final federal regulations on these matters and were in compliance with them by their deadlines.

The Anti-Kickback Statute has been interpreted to prohibit the payment, solicitation, offering or receipt of any form of remuneration in return for the referral of federal health program patients or any item or service that is reimbursed, in whole or in part, by any federal healthcare program. Similar statutes have been adopted in Illinois and

Arizona that apply regardless of the source of reimbursement. The Department of Health and Human Services has adopted safe harbor regulations specifying certain relationships and activities that are deemed not to violate the Anti-Kickback Statute which specifically relate to managed care including:

- waivers by health maintenance organizations of Medicare and Medicaid beneficiaries' obligations to pay cost-sharing amounts or to provide other incentives in order to attract Medicare and Medicaid enrollees;
- certain discounts offered to prepaid health plans by contracting providers;
- certain price reductions offered to eligible managed care organizations; and
- certain price reductions offered by contractors with substantial financial risk to managed care organizations.

We believe that the incentives offered by our health plans to their enrollees and the discounts they receive contracting with healthcare providers satisfy the requirements of the safe harbor regulations. However, the failure to satisfy each criterion of the applicable safe harbor does not mean that the arrangement constitutes a violation of the law; rather, the safe harbor regulations provide that an arrangement which does not fit within a safe harbor must be analyzed on the basis of its specific facts and circumstances. We believe that our health plans' arrangements comply in all material respects with the federal Anti-Kickback Statute and similar state statutes.

Environmental Matters

We are subject to various federal, state and local laws and regulations relating to environmental protection. Our hospitals are not highly regulated under environmental laws because we do not engage in any industrial activities at those locations. The principal environmental requirements and concerns applicable to our operations relate to:

- the proper handling and disposal of hazardous and low level medical radioactive waste;
- ownership or historical use of underground and above-ground storage tanks;
- management of impacts from leaks of hydraulic fluid or oil associated with elevators, chiller units or incinerators;
- appropriate management of asbestos-containing materials present or likely to be present at some locations; and
- the potential acquisition of, or maintenance of air emission permits for, boilers or other equipment.

We do not expect our compliance with environmental laws and regulations to have a material effect on us. We may also be subject to requirements related to the remediation of substances that have been released into the environment at properties owned or operated by us or at properties where substances were sent for off-site treatment or disposal. These remediation requirements may be imposed without regard to fault and whether or not we owned or operated the property at the time that the relevant releases or discharges occurred. Liability for environmental remediation can be substantial.

Item 1A. Risk Factors.

If any of the following events discussed in the following risks were to occur, our business, results of operations, financial condition, cash flows or prospects could be materially adversely affected. Additional risks and uncertainties not presently known, or currently deemed immaterial by us, may also constrain our business and operations.

Risks Relating to our Capital Structure

Our high level of debt and significant leverage may adversely affect our operations and our ability to grow and otherwise execute our business strategy.

We have a substantial amount of debt. As of June 30, 2009, we had $1,551.6 million of outstanding debt, excluding letters of credit and guarantees. This represented 72.5% of our total capitalization as of June 30, 2009. The amount of our outstanding indebtedness is large compared to the net book value of our assets, and we have significant repayment obligations under our outstanding indebtedness.

Our substantial indebtedness could:

- limit our ability to obtain additional financing to fund future capital expenditures, working capital, acquisitions or other needs;
- increase our vulnerability to general adverse economic, market and industry conditions and limit our flexibility in planning for, or reacting to, these conditions;
- make us vulnerable to increases in interest rates since $316.4 million (as of September 1, 2009) and an additional $450.0 million (after the expiration of our interest rate swap agreement on March 31, 2010) of our borrowings under our senior credit facilities are, and additional borrowings may be, at variable interest rates;
- our flexibility to adjust to changing market conditions and ability to withstand competitive pressures could be limited, and we may be more vulnerable to a downturn in general economic or industry conditions or be unable to carry out capital spending that is necessary or important to our growth strategy and our efforts to improve operating margins;
- limit our ability to use operating cash in other areas of our business because we must use a substantial portion of these funds to make principal and interest payments; and
- limit our ability to compete with others who are not as highly-leveraged.

Our ability to make scheduled payments of principal and interest or to satisfy our other debt obligations, to refinance our indebtedness or to fund capital expenditures will depend on our future operating performance. Prevailing economic conditions (including interest rates) and financial, business and other factors, many of which are beyond our control, will also affect our ability to meet these needs. We may not be able to generate sufficient cash flows from operations or realize anticipated revenue growth or operating improvements, or obtain future borrowings in an amount sufficient to enable us to pay our debt, or to fund our other liquidity needs. We may need to refinance all or a portion of our debt on or before maturity. We may not be able to refinance any of our debt when needed on commercially reasonable terms or at all.

Despite our current significant leverage, we may still be able to incur substantially more debt. This could further exacerbate the risks that we and our subsidiaries face.

We and our subsidiaries may be able to incur substantial additional indebtedness in the future. The terms of the indentures and the senior credit facilities do not fully prohibit us or our subsidiaries from doing so. Our revolving credit facility provides commitments of up to $250.0 million (not giving effect to any outstanding letters of credit, which would reduce the amount available under our revolving credit facility), of which $218.8 million was available for future borrowings as of September 1, 2009. In addition, upon the occurrence of certain events, we may request an incremental term loan facility or facilities be added to our current senior credit facilities in an amount not to exceed $300.0 million in the aggregate, subject to receipt of commitments by existing lenders or other financing institutions and to the satisfaction of certain other conditions. We may in the future borrow all available amounts under the revolving credit facility, under the incremental term loan facility and in addition, we may borrow substantial additional indebtedness in the future under new debt agreements. If new debt is added to our current debt levels, the related risks that we and our subsidiaries now face could intensify.

Operating and financial restrictions in our debt agreements limit our operational and financial flexibility.

The senior credit facilities and the indentures under which $575.0 million aggregate principal amount of our 9.0% senior subordinated notes due 2014 and $216.0 million aggregate principal amount of our 11.25% senior discount notes due 2015 were issued (collectively, the "Public Notes") contain a number of significant covenants that, among other things, restrict our ability to:

- incur additional indebtedness or issue preferred stock;
- pay dividends on or make other distributions or repurchase our capital stock or make other restricted payments;
- make investments;
- enter into certain transactions with affiliates;
- limit dividends or other payments by restricted subsidiaries to our restricted subsidiaries;
- create liens on *pari passu* or subordinated indebtedness without securing the Public Notes;
- designate our subsidiaries as unrestricted subsidiaries; and
- sell certain assets or merge with or into other companies or otherwise dispose of all or substantially all of our assets.

In addition, under the senior credit facilities, we are required to satisfy and maintain specified financial ratios and tests. Events beyond our control may affect our ability to comply with those provisions, and we may not be able to meet those ratios and tests. The breach of any of these covenants would result in a default under the senior credit facilities. In the event of default, the lenders could elect to declare all amounts borrowed under the senior credit facilities, together with accrued interest, to be due and payable and could proceed against the collateral securing that indebtedness. Borrowings under the senior credit facilities are senior in right of payment to the Public Notes. If any of our indebtedness were to be accelerated, our assets may not be sufficient to repay in full that indebtedness and the Public Notes.

Our capital expenditure and acquisition strategies require substantial capital resources. The building of new hospitals and the operations of our existing hospitals and newly acquired hospitals require ongoing capital expenditures for construction, renovation, expansion and the addition of medical equipment and technology. More specifically, we may in the future be contractually obligated to make significant capital expenditures relating to the facilities we acquire. Also, construction costs to build new hospitals are substantial and continue to increase. Our debt agreements may restrict our ability to incur additional indebtedness to fund these expenditures.

A breach of any of the restrictions or covenants in our debt agreements could cause a cross-default under other debt agreements. A significant portion of our indebtedness then may become immediately due and payable. We are not certain whether we would have, or be able to obtain, sufficient funds to make these accelerated payments. If any senior debt is accelerated, our assets may not be sufficient to repay in full such indebtedness and our other indebtedness.

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

Our ability to make scheduled payments or to refinance our debt obligations depends on our financial and operating performance, which is subject to prevailing economic and competitive conditions and to certain financial, business and other factors beyond our control. We may not be able to maintain a level of cash flows from operating activities sufficient to permit us to pay the principal, premium, if any, and interest on our indebtedness. In addition, the indentures governing the Public Notes allow us to make significant dividend payments, investments and other restricted payments. Our making these payments could decrease available cash and adversely affect our ability to make principal and interest payments on our indebtedness.

If our cash flows and capital resources are insufficient to fund our debt service obligations, we may be forced to reduce or delay capital expenditures, seek additional capital or seek to restructure or refinance our indebtedness. These alternative measures may not be successful and may not permit us to meet our scheduled debt service obligations. In the absence of such operating results and resources, we could face substantial liquidity problems and might be required to sell material assets or operations to attempt to meet our debt service and other obligations. The

senior credit facilities and the indentures restrict our ability to use the proceeds from asset sales. We may not be able to consummate those asset sales to raise capital or sell assets at prices that we believe are fair and proceeds that we do receive may not be adequate to meet any debt service obligations then due.

Tightened credit markets and continued economic deterioration may prevent us from servicing our current debt or refinancing, replacing or otherwise obtaining a new revolving loan facility to replace our facility expiring in September 2010 or obtaining the necessary funds to repay a significant portion of our debt that will mature during September 2011.

We are a highly leveraged company. As of June 30, 2009, we had $1,551.6 million of outstanding indebtedness. Of this amount, $766.4 million of term loans mature in September 2011. Additionally, we have a $250.0 million ($218.8 million net of borrowing capacity reductions for our outstanding letters of credit) revolving loan facility that expires in September 2010. The tightened credit markets have especially impacted the ability of highly leveraged companies, like us, to access sources of liquidity on similar terms or pricing as currently in place, or at all. Our inability to replace our revolving credit facility in September 2010 may limit our ability to competitively manage our current operations, make capital expenditures, make required principal and interest repayments under our debt agreements or complete acquisitions to grow our business. If prevailing instability in the credit and financial markets continues, we may be unable to refinance or repay our outstanding $766.4 million term debt due in September 2011. We also make significant cash interest payments on our outstanding $575.0 million 9.0% senior subordinated notes and will be required to make cash interest payments on our $216.0 million 11.25% senior discount notes beginning in April 2010. Should current economic conditions worsen, our operating cash flows may be materially adversely impacted, which could make it more difficult for us to make these cash interest payments. If we were unable to make scheduled interest or principal payments on our debt, we would be in default and, as a result:

- Our debt holders could declare all outstanding principal and interest to be due and payable;
- Our secured debt lenders could terminate their commitments and commence foreclosure proceedings against our assets; and
- We could be forced into bankruptcy or liquidation.

We also face the risk of non-compliance with the debt covenants under our senior secured credit agreement, including the total leverage ratio limit, which decreased to 4.50x from 5.00x for the test period ending March 31, 2009. While we are currently in compliance with all of our debt covenants, future violations of any of these covenants without cure would result in a debt default as described above.

An increase in interest rates would increase the cost of servicing our debt and could reduce our profitability.

A significant portion of the borrowings under our Senior Credit Facilities bear interest at variable rates. As a result, an increase in interest rates, whether because of an increase in market interest rates or an increase in our own cost of borrowing, would increase the cost of servicing our debt and could materially reduce our profitability. The impact of such an increase would be more significant than it would be for some other companies because of our substantial debt. For a discussion of how we manage our exposure to changes in interest rates through the use of interest rate swap agreements on certain portions of our outstanding debt, see "Item 7A. – Quantitave and Qualitative Disclosure About Market Risks."

We are controlled by a small number of stockholders and they may have conflicts of interest with us in the future.

We are controlled by our principal equity sponsors, and they have the ability to control our policies and operations. The interests of our principal equity sponsors may not in all cases be aligned with our interests. For example, our principal equity sponsors could cause us to make acquisitions, divestitures and other transactions that, in their judgment, could enhance their equity investment in us, even though such transactions might reduce cash flows or capital reserves available to fund our debt service obligations. Additionally, our controlling shareholders are in the business of making investments in companies and may from time to time acquire and hold interests in businesses that compete directly or indirectly with us. Accordingly, our principal equity sponsors may also pursue

acquisitions that may be complementary to our business, and as a result, those acquisition opportunities may not be available to us. So long as our principal equity sponsors continue to own a significant amount of our equity interests, even if such amount is less than 50%, they will continue to be able to strongly influence or effectively control our decisions.

Risks Related to our Business

If we are unable to enter into favorable contracts with managed care plans, our operating revenues may be reduced.

Our ability to negotiate favorable contracts with health maintenance organizations, insurers offering preferred provider arrangements and other managed care plans significantly affects the revenues and operating results of our hospitals. Revenues derived from health maintenance organizations, insurers offering preferred provider arrangements and other managed care plans, including managed Medicare and managed Medicaid plans, accounted for approximately 58% of our net patient revenues for the year ended June 30, 2009. Managed care organizations offering prepaid and discounted medical services packages represent an increasing portion of our admissions, a general trend in the industry which has limited hospital revenue growth nationwide and a trend that may continue. In addition, private payers are increasingly attempting to control healthcare costs through direct contracting with hospitals to provide services on a discounted basis, increased utilization review and greater enrollment in managed care programs such as health maintenance organizations and preferred provider organizations. Additionally, the trend towards consolidation among private managed care payers tends to increase their bargaining prices over fee structures. In most cases, we negotiate our managed care contracts annually as they come up for renewal at various times during the year. Our future success will depend, in part, on our ability to renew existing managed care contracts and enter into new managed care contracts on terms favorable to us. Other healthcare companies, including some with greater financial resources, greater geographic coverage or a wider range of services, may compete with us for these opportunities. If we are unable to contain costs through increased operational efficiencies or to obtain higher reimbursements and payments from managed care payers, our results of operations and cash flows will be materially adversely affected.

Our revenues may decline if federal or state programs reduce our Medicare or Medicaid payments or managed care companies reduce our reimbursements.

Approximately 56% of our net patient revenues for the year ended June 30, 2009 came from the Medicare and Medicaid programs, including Medicare and Medicaid managed plans. In recent years, federal and state governments have made significant changes in the Medicare and Medicaid programs. Some of those changes adversely affect the reimbursement we receive for certain services. In addition, due to budget deficits in many states, significant decreases in state funding for Medicaid programs have occurred or are being proposed.

On August 22, 2007, CMS issued a final rule for federal fiscal year 2008 for the hospital inpatient prospective payment system. This rule adopted a two-year implementation of MS-DRGs, a severity-adjusted DRG system. This change represented a refinement to the DRG system, and its impact on our revenues has not been significant. Realignments in the DRG system could impact the margins we receive for certain services.

DRG rates are updated and MS-DRG weights are recalibrated each federal fiscal year. The index used to update the market basket gives consideration to the inflation experienced by hospitals and entities outside the healthcare industry in purchasing goods and services. The annual Medicare regulatory update for federal fiscal year 2010 provides for a 2.1% market basket update for hospitals that submit certain quality patient care indicators and a 0.1% update for hospitals that do not submit this data. While we will endeavor to comply with all quality data submission requirements, our submissions may not be deemed timely or sufficient to entitle us to the full market basket adjustment for all our hospitals. Medicare payments to hospitals in federal fiscal year 2009 were reduced by 0.9% to eliminate what CMS estimates will be the effect of coding or classification changes as a result of hospitals implementing the MS-DRG system. After earlier proposing an increase in the "documentation and coding adjustment" to 1.9% for federal fiscal year 2010, on July 31, 2009 CMS announced that it had decided not to make any adjustment in federal fiscal year 2010 since it did not know whether federal fiscal year 2009 spending from documentation and coding is more or less than earlier projected. However, Congress has given CMS the ability to continue to retrospectively determine if the documentation and coding adjustment levels for federal fiscal years 2008

and 2009 were adequate to account for changes in payments not related to changes in case mix. If the levels are found to have been inadequate, CMS could impose an adjustment to payments for federal fiscal years 2011 and 2012. This evaluation of changes in case-mix based on actual claims data may yield a higher documentation and coding adjustment thereby potentially reducing our revenues and impacting our results of operations in ways that cannot be quantified at this time. Additionally, Medicare payments to hospitals are subject to a number of other adjustments, and the actual impact on payments to specific hospitals may vary. In some cases, commercial third-party payers and other payers such as some state Medicaid programs rely on all or portions of the Medicare DRG system to determine payment rates. The change from traditional Medicare DRGs to MS-DRGs could adversely impact those payment rates if any other payers adopt MS-DRGs.

The federal government and many states have recently adopted or are currently considering reducing the level of Medicaid funding (including upper payment limits) or program eligibility that could adversely affect future levels of Medicaid reimbursement received by our hospitals. Since states must operate with balanced budgets and since the Medicaid program is often a state's largest program, a number of states have adopted, or are considering adopting, legislation designed to reduce their Medicaid expenditures. DRA 2005 includes federal Medicaid cuts of approximately $4.8 billion over five years. Additionally, on May 29, 2007, CMS published a final rule entitled "Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership" which is estimated to reduce federal Medicaid funding from $12 to $20 billion over five years. Congress enacted two moratoria in respect of this rule that delayed six of seven proposed Medicaid regulations in this final CMS rule until July 1, 2009. On June 30, 2009, three more of the Medicaid regulations that had been under a congressional moratorium set to expire July 1, 2009 were officially rescinded all or in part by CMS, and CMS also delayed until June 30, 2010 the enforcement of the fourth of the six regulations. As a result of these changes in implementing the final rule, the impact on us of the final rule can not be quantified. States have also adopted, or are considering adopting, legislation designed to reduce coverage and program eligibility, enroll Medicaid recipients in managed care programs and/or impose additional taxes on hospitals to help finance or expand the states' Medicaid systems. Future legislation or other changes in the administration or interpretation of government health programs could have a material adverse effect on our financial position and results of operations.

Our ability to negotiate favorable contracts with managed care plans significantly affects the revenues and operating results of most of our hospitals. Managed care payers increasingly are demanding discounted fee structures, and the trend toward consolidation among managed care plans tends to increase their bargaining power over fee structures. Reductions in price increases or the amounts received from managed care plans could have a material adverse effect on our financial position and results of operations.

In recent years, both the Medicare program and several large managed care companies have changed our reimbursement to link some of their payments, especially their annual increases in payments, to performance of quality of care measures. We expect this trend to "pay-for-performance" to increase in the future. If we are unable to meet these performance measures, our results of operations and cash flow will be materially adversely affected.

We conduct business in a heavily regulated industry, and changes in regulations or violations of regulations may result in increased costs or sanctions that could reduce our revenues and profitability.

The healthcare industry is subject to extensive federal, state and local laws and regulations relating to licensing, the conduct of operations, the ownership of facilities, the addition of facilities and services, financial arrangements with physicians and other referral sources, confidentiality, maintenance and security issues associated with medical records, billing for services and prices for services. If a determination were made that we were in material violation of such laws or regulations, our operations and financial results could be materially adversely affected.

In many instances, the industry does not have the benefit of significant regulatory or judicial interpretations of these laws and regulations. This is particularly true in the case of Medicare and Medicaid statute codified under section 1128B(b) of the Social Security Act and known as the "Anti-Kickback Statute." This law prohibits providers and other person or entities from soliciting, receiving, offering or paying, directly or indirectly, any remuneration with the intent to generate referrals of orders for services or items reimbursable under Medicare, Medicaid and other federal healthcare programs. As authorized by Congress, the United States Department of Health and Human Services has issued regulations which describe some of the conduct and business relationships immune from prosecution under the Anti-Kickback Statute. The fact that a given business arrangement does not fall within one of

these "safe harbor" provisions does not render the arrangement illegal, but business arrangements of healthcare service providers that fail to satisfy the applicable safe harbor criteria risk increased scrutiny by enforcement authorities.

Some of the financial arrangements that our facilities maintain with physicians do not meet all of the requirements for safe harbor protection. The regulatory authorities that enforce the Anti-Kickback Statute may in the future determine that one or more of these arrangements violate the Anti-Kickback Statute or other federal or state laws. A determination that a facility has violated the Anti-Kickback Statute or other federal laws could subject us to liability under the Social Security Act, including criminal and civil penalties, as well as exclusion of the facility from participation in government programs such as Medicare and Medicaid or other federal healthcare programs.

In addition, the portion of the Social Security Act commonly known as the "Stark Law" prohibits physicians from referring Medicare and (to an extent) Medicaid patients to providers of certain "designated health services" if the physician or a member of his or her immediate family has an ownership or investment interest in, or compensation arrangement with, that provider. In addition, the provider in such arrangements is prohibited from billing for all of the designated health services referred by the physician. Many of the services furnished by our facilities are "designated health services" for Stark Law purposes. There are multiple exceptions to the Stark Law, among others, for physicians maintaining an ownership interest in an entire hospital or having a compensation relationship with the facility as a result of employment agreements, leases, physician recruitment and certain other arrangements. However, each of these exceptions applies only if detailed conditions are met. An arrangement subject to the Stark Law must qualify for an exception in order for the services to be lawfully referred by the physician and billed by the provider.

CMS has issued three phases of final regulations implementing the Stark Law. Phases I and II became effective in January 2002 and July 2004, respectively, and Phase III became effective in December 2007. While these regulations help clarify the requirements of the exceptions to the Stark Law, it is unclear how the government will interpret many of these exceptions for enforcement purposes. In addition, in July 2007 CMS proposed far-reaching changes to the regulations implementing the Stark Law that would further restrict the types of arrangements that hospitals and physicians may enter, including additional restrictions on certain leases, percentage compensation arrangements, and agreements under which a hospital purchases services under arrangements. On July 31, 2008, CMS issued a final rule which, in part, finalized and responded to public comments regarding some of its July 2007 proposed major changes to the Stark Law regulations to undermine many common hospital/physician joint venture models. The most far-reaching of the changes made in this final July 2008 rule will effectively prohibit, as of a delayed effective date of October 1, 2009, both "under arrangements" ventures between a hospital and any of its physicians and unit-of-service-based "per click" compensation and percentage-based compensation in office space and equipment leases between a hospital and its physicians. We have examined all of our "under arrangements" ventures and space and equipment leases with physicians to identify those arrangements which potentially violate these new Stark regulations, and we are in the process of restructuring or terminating non-conforming arrangements so identified prior to October 1, 2009. Because the Stark Law and its implementing regulations are relatively new, we do not always have the benefit of significant regulatory or judicial interpretation of this law and its regulations. We attempt to structure our relationships to meet an exception to the Stark Law, but the regulations implementing the exceptions are detailed and complex, and we cannot assure that every relationship complies fully with the Stark Law. In addition, in the July 2008 final Stark rule CMS indicated that it will continue to enact further regulations tightening aspects of the Stark Law that it perceives allow for Medicare program abuse, especially those regulations that still permit physicians to profit from their referrals of ancillary services. We cannot assure you that the arrangements entered into by our hospitals with physicians will be found to be in compliance with the Stark Law, as it ultimately may be implemented or interpreted.

Additionally, if we violate the Anti-kickback Statute or Stark Law, or if we improperly bill for our services, we may be found to violate the False Claims Act, either under a suit brought by the government or by a private person under a *qui tam*, or "whistleblower," suit.

If we fail to comply with the Anti-kickback Statute, the Stark Law, the False Claims Act or other applicable laws and regulations, or if we fail to maintain an effective corporate compliance program, we could be subjected to liabilities, including civil penalties (including the loss of our licenses to operate one or more facilities), exclusion of one or more facilities from participation in the Medicare, Medicaid and other federal and state health care programs

and, for violations of certain laws and regulations, criminal penalties. See Item 1, "Business — Governmental Regulation and Other Factors."

All of the states in which we operate have adopted or have considered adopting similar anti-kickback and physician self-referral legislation, some of which extends beyond the scope of the federal law to prohibit the payment or receipt of remuneration for the referral of patients and physician self-referrals, regardless of the source of payment for the care. Little precedent exists for the interpretation or enforcement of these laws. Both federal and state government agencies have announced heightened and coordinated civil and criminal enforcement efforts.

Government officials responsible for enforcing healthcare laws could assert that one or more of our facilities, or any of the transactions in which we are involved, are in violation of the Anti-Kickback Statute or the Stark Law and related state law exceptions. It is also possible that the courts could ultimately interpret these laws in a manner that is different from our interpretations. Moreover, other healthcare companies, alleged to have violated these laws, have paid significant sums to settle such allegations and entered into "corporate integrity agreements" because of concern that the government might exercise its authority to exclude those providers from governmental payment programs (Medicare, Medicaid, TRICARE). A determination that one or more of our facilities has violated these laws, or the public announcement that we are being investigated for possible violations of these laws, could have a material adverse effect on our business, financial condition, results of operations or prospects, and our business reputation could suffer significantly.

Illinois and Massachusetts require governmental determinations of need ("Certificates of Need") prior to the purchase of major medical equipment or the construction, expansion, closure, sale or change of control of healthcare facilities. We believe our facilities have obtained appropriate certificates wherever applicable. However, if a determination were made that we were in material violation of such laws, our operations and financial results could be materially adversely affected. The governmental determinations, embodied in Certificates of Need, can also affect our facilities' ability to add bed capacity or important services. We cannot predict whether we will be able to obtain required Certificates of Need in the future. A failure to obtain any required Certificates of Need may impair our ability to operate the affected facility profitably.

The laws, rules and regulations described above are complex and subject to interpretation. If we are in violation of any of these laws, rules or regulations, or if further changes in the regulatory framework occur, our results of operations could be significantly harmed. For a more detailed discussion of the laws, rules and regulations described above, see Item 1, "Business – Government Regulation and Other Factors."

Some of our hospitals will be required to submit to CMS information on their relationships with physicians and this submission could subject such hospitals and us to liability.

CMS announced in 2007 that it intends to collect information on ownership, investment and compensation arrangements with physicians from 500 (pre-selected) hospitals by requiring these hospitals to submit to CMS Disclosure of Financial Relationship Reports ("DFRR") from each selected hospital. CMS also indicated that at least 10 of our hospitals will be among these 500 hospitals required to submit a DFRR because these 10 hospitals did not respond to CMS' voluntary survey instrument on this topic purportedly submitted to these hospitals via email by CMS in 2006. CMS intends to use this data to determine whether these hospitals were in compliance with the Stark Law and implementing regulations during the reporting period (currently expected to be the cost reporting periods of these hospitals ending in 2006), and CMS has indicated it may share this information with other government agencies and with Congressional committees. Many of these agencies have not previously analyzed this information and have the authority to bring enforcement actions against the hospitals. However, in July 2008 CMS announced that, based on its further review and expected further public comments on this matter, CMS may decide in the future to decrease (but not increase) the number of hospitals to which it will send the DFRR below the 500 hospitals originally designated.

Once a hospital receives this request for a DFRR, the hospital will have 60 days to compile a significant amount of information relating to its financial relationships with physicians. The hospital may be subject to civil monetary penalties of up to $10,000 per day if it is unable to assemble and report this information within the required timeframe or if CMS or any other government agency determines that the submission is inaccurate or incomplete.

The hospital may be the subject of investigations or enforcement actions if a government agency determines that any of the information indicates a potential violation of law.

Also, while in 2007 CMS had announced that it was contemplating proposing a regular financial disclosure process that would apply in the future to all Medicare participating hospitals, in July 2008 CMS announced that, based upon public comments previously received, it was not adopting a regular reporting or disclosure process at that time, and, thus, CMS said the DFRR will initially be used as a one-time collection effort. However, CMS also said in July 2008 that, depending on the information received from the initial DFRR process and other factors, it may propose future rulemaking to use the DFRR or some other instrument as a periodic or regular collection instrument. Thus, even if one of our hospitals does not receive the DFRR survey as part of the initial up to 500 selected hospitals, we expect that all of our hospitals will possibly have to report similar information to CMS in the future.

The DFRR and its supporting documentation are currently under review by the Office of Management and Budget and have not yet been released. Depending on the final format of the DFRR, responding hospitals may be subject to substantial penalties as a result of enforcement actions brought by government agencies and whistleblowers acting pursuant to the False Claims Act and similar state laws, based on such allegations like failure to respond within required deadlines, that the response is inaccurate or contains incomplete information or that the response indicates a potential violation of the Stark Law or other requirements.

Any governmental investigation or enforcement action which results from the DFRR process could materially adversely affect the results of our operations.

Providers in the healthcare industry have been the subject of federal and state investigations, whistleblower lawsuits and class action litigation, and we may become subject to investigations, whistleblower lawsuits or class action litigation in the future.

Both federal and state government agencies have heightened and coordinated civil and criminal enforcement efforts as part of numerous ongoing investigations of hospital companies, as well as their executives and managers. These investigations relate to a wide variety of topics, including:

- cost reporting and billing practices;
- laboratory and home healthcare services;
- physician ownership of, and joint ventures with, hospitals;
- physician recruitment activities; and
- other financial arrangements with referral sources

In addition, the federal False Claims Act permits private parties to bring *qui tam*, or whistleblower, lawsuits against companies. Whistleblower provisions allow private individuals to bring actions on behalf of the government alleging that the defendant has defrauded the federal government. Because *qui tam* lawsuits are filed under seal, we could be named in one or more such lawsuits of which we are not aware. Defendants determined to be liable under the False Claims Act may be required to pay three times the actual damages sustained by the government, plus mandatory civil penalties of between $5,500 and $11,000 for each separate false claim. Typically, each fraudulent bill submitted by a provider is considered a separate false claim, and thus the penalties under false claims may be substantial. Liability arises when an entity knowingly submits a false claim for reimbursement to the federal government. In some cases, whistleblowers or the federal government have taken the position that providers who allegedly have violated other statutes and have submitted claims to a governmental payer during the time period they allegedly violated these other statutes, have thereby submitted false claims under the False Claims Act. Some states have adopted similar whistleblower and false claims provisions.

The Office of the Inspector General of the Department of Health and Human Services and the Department of Justice have, from time to time, established national enforcement initiatives that focus on specific billing practices or other suspected areas of abuse. Initiatives include a focus on hospital billing for outpatient charges associated with inpatient services, as well as hospital laboratory billing practices. As a result of these regulations and initiatives, some of our activities could become the subject of governmental investigations or inquiries. For example, we have significant Medicare and Medicaid billings, we provide some durable medical equipment and home healthcare

services, and we have joint venture arrangements involving physician investors. We also have a variety of other financial arrangements with physicians and other potential referral sources including recruitment arrangements and leases. In addition, our executives and managers, many of whom have worked at other healthcare companies that are or may become the subject of federal and state investigations and private litigation, could be included in governmental investigations or named as defendants in private litigation. We are aware that several of our hospitals or their related healthcare operations were and may still be under investigation in connection with activities conducted prior to our acquisition of them. Under the terms of our various acquisition agreements, the prior owners of our hospitals are responsible for any liabilities arising from pre-closing violations. The prior owners' resolution of these matters or failure to resolve these matters, in the event that any resolution was deemed necessary, may have a material adverse effect on our business, financial condition or results of operations. Any investigations of us, our executives, managers, facilities or operations could result in significant liabilities or penalties to us, as well as adverse publicity.

We maintain a voluntary compliance program to address health regulatory and other compliance requirements. This program includes initial and periodic ethics and compliance training and effectiveness reviews, a toll-free hotline for employees to report, without fear of retaliation, any suspected legal or ethical violations, annual "fraud and abuse" audits to look at all of our financial relationships with physicians and other referral sources and annual "coding audits" to make sure our hospitals bill the proper service codes in respect of obtaining payment from the Medicare and Medicaid programs.

As an element of our corporate compliance program and our internal compliance audits, from time to time we make voluntary disclosures and repayments to the Medicare and Medicaid programs and/or to the federal and/or state regulators for these programs in the ordinary course of business. At the current time, we know of no active investigations by any of these programs or regulators in respect of our disclosures or repayments. All of these voluntary actions on our part could lead to an investigation by the regulators to determine whether any of our facilities have violated the Stark Law, the Anti-Kickback Statute, the False Claims Act or similar state law. Either an investigation or initiation of administrative or judicial actions could result in a public announcement of possible violations of the Stark Law, the Anti-Kickback Statute or the False Claims Act or similar state law. Such determination or announcements could have a material adverse effect on our business, financial condition, results of operations or prospects, and our business reputation could suffer significantly.

Additionally, several hospital companies have in recent years been named defendants in class action litigation alleging, among other things, that their charge structures are fraudulent and, under state law, unfair or deceptive practices, insofar as those hospitals charge insurers lower rates than those charged to uninsured patients. We cannot assure you that we will not be named as a defendant in litigation of this type. Furthermore, the outcome of these suits may affect the industry standard for charity care policies and any response we take may have a material adverse effect on our financial results.

In June 2006 we and two other hospital systems operating in San Antonio, Texas had a putative class action lawsuit brought against all of us alleging that we and the other defendants has conspired with each other and with other unidentified San Antonio area hospitals to depress the compensation levels of registered nurses employed at the competing hospitals within the San Antonio area by engaging in certain activities that violated the federal antitrust laws. See "Item 3- Legal Proceedings" for further discussion of this litigation. On the same day that this litigation was brought against us and two other hospital systems in San Antonio, substantially similar class action litigation was brought against multiple hospitals in three other cities.

Competition from other hospitals or healthcare providers (especially specialty hospitals) may reduce our patient volumes and profitability.

The healthcare business is highly competitive and competition among hospitals and other healthcare providers for patients has intensified in recent years. Generally, other hospitals in the local communities served by most of our hospitals provide services similar to those offered by our hospitals. In addition, we believe the number of freestanding specialty hospitals and surgery and diagnostic centers in the geographic areas in which we operate has increased significantly in recent years. As a result, most of our hospitals operate in an increasingly competitive environment. Some of the hospitals that compete with our hospitals are owned by governmental agencies or not-for-profit corporations supported by endowments and charitable contributions and can finance capital expenditures and

operations on a tax-exempt basis. Increasingly, we are facing competition from physician-owned specialty hospitals and freestanding surgery centers that compete for market share in high margin services and for quality physicians and personnel. If ambulatory surgery centers are better able to compete in this environment than our hospitals, our hospitals may experience a decline in patient volume, and we may experience a decrease in margin, even if those patients use our ambulatory surgery centers. Further, if our competitors are better able to attract patients, recruit physicians, expand services or obtain favorable managed care contracts at their facilities than our hospitals and ambulatory surgery centers, we may experience an overall decline in patient volume. See Item 1, "Business - Competition."

In 2005, CMS began making public performance data related to 10 quality measures that hospitals submit in connection with their Medicare reimbursement. In February 2006, federal legislation was enacted to expand and provide for the future expansion of the number of quality measures that must be reported. During federal fiscal year 2008, CMS required hospitals to report 30 measures of inpatient quality of care to avoid a 2% point reduction in their market basket update. During federal fiscal year 2009, CMS requires hospitals to report 43 inpatient quality measures to avoid a 2% point reduction in their market basket update. For federal fiscal year 2010, CMS will require hospitals to report 47 inpatient quality measures to avoid a 2% reduction in their market basket update. If any of our hospitals achieve poor results (or results that are lower than our competitors) on these quality measures, patient volumes could decline. Also, the additional quality measures and future trends toward clinical transparency may have an unanticipated impact on our competitive position and patient volumes.

PHP also faces competition within the Arizona markets that it serves. As in the case of our hospitals, some of our competitors in these markets are owned by governmental agencies or not-for-profit corporations that have greater financial resources than we do. The revenues we derive from PHP could significantly decrease if new plans operating under AHCCCS enter these markets or other existing AHCCCS plans increase their number of enrollees. Moreover, a failure to attract future enrollees may negatively impact our ability to maintain our profitability in these markets.

We may be subject to liabilities from claims brought against our facilities.

We operate in a highly regulated and litigious industry. As a result, various lawsuits, claims and legal and regulatory proceedings have been instituted or asserted against us, including those outside of the ordinary course of business like class actions and those in the ordinary course of business like malpractice lawsuits. Some of these actions may involve large claims as well as significant defense costs. (See "Item 3, "Legal Proceedings.")

We maintain professional and general liability insurance in amounts we believe are sufficient to cover claims arising out of the operations of our facilities. Some of the claims could exceed the scope of the coverage in effect or coverage of particular claims or damages could be denied.

The relatively high cost of professional liability insurance and, in some cases, the lack of availability of such insurance coverage, for physicians with privileges at our hospitals increases our risk of vicarious liability in cases where both our hospital and the uninsured or underinsured physician are named as co-defendants. As a result, we are subject to greater self-insured risk and may be required to fund claims out of our operating cash flows to a greater extent than during fiscal year 2009. We cannot assure you that we will be able to continue to obtain insurance coverage in the future or that such insurance coverage, if it is available, will be available on acceptable terms.

While we cannot predict the likelihood of future claims or inquiries, we expect that new matters may be initiated against us from time to time. Moreover, the results of current claims, lawsuits and investigations cannot be predicted, and it is possible that the ultimate resolution of these matters, individually or in the aggregate, may have a material adverse effect on our business (both in the near and long term), financial position, results of operations or cash flows.

Our hospitals face a growth in uncompensated care as the result of the inability of uninsured patients to pay for healthcare services and difficulties in collecting patient portions of insured accounts.

Like others in the hospital industry, we have experienced an increase in uncompensated care. Our combined provision for doubtful accounts and charity care deductions as a percentage of patient service revenues increased

from 12.0% during fiscal 2007 to 12.5% during fiscal 2008 and decreased to 12.0% during fiscal 2009. Our self pay discharges as a percentage of total discharges have not fluctuated significantly during our past three fiscal years. Our hospitals remain at risk for increases in uncompensated care as a result of price increases, the continuing trend of increases in coinsurance and deductible portions of managed care accounts and increases in uninsured patients as a result of potential state Medicaid funding cuts or general economic weakness. Although we continue to seek ways of improving point of service collection efforts and implementing appropriate payment plans with our patients, if we continue to experience growth in self-pay volumes and revenues, our results of operations could be materially adversely affected. Further, our ability to improve collections for self-pay patients may be limited by regulatory and investigatory initiatives, including private lawsuits directed at hospital charges and collection practices for uninsured and underinsured patients.

Our performance depends on our ability to recruit and retain quality physicians.

Physicians generally direct the majority of hospital admissions. Thus, the success of our hospitals depends in part on the following factors:

- the number and quality of the physicians on the medical staffs of our hospitals;
- the admitting practices of those physicians; and
- the maintenance of good relations with those physicians.

Most physicians at our hospitals also have admitting privileges at other hospitals. Our efforts to attract and retain physicians are affected by our managed care contracting relationships, national shortages in some specialties, such as anesthesiology and radiology, the adequacy of our support personnel, the condition of our facilities and medical equipment, the availability of suitable medical office space and federal and state laws and regulations prohibiting financial relationships that may have the effect of inducing patient referrals. If facilities are not staffed with adequate support personnel or technologically advanced equipment that meets the needs of patients, physicians may be discouraged from referring patients to our facilities, which could adversely affect our profitability.

In an effort to meet community needs in the markets in which we operate, we have implemented a strategy to employ physicians both in primary care and in certain specialties. As of June 30, 2009, we employed approximately 290 practicing physicians, excluding residents. The deployment of a physician employment strategy includes increased salary costs, physician integration risks and difficulties associated with physician practice management. While we believe this strategy is consistent with industry trends, we cannot be assured of the long-term success of such a strategy.

We may be unable to achieve our acquisition and growth strategies and we may have difficulty acquiring not-for-profit hospitals due to regulatory scrutiny.

An important element of our business strategy is expansion by acquiring hospitals in our existing and in new urban and suburban markets and by entering into partnerships or affiliations with other healthcare service providers. The competition to acquire hospitals is significant, including competition from healthcare companies with greater financial resources than ours. We may not be able to make suitable acquisitions on favorable terms. We may have difficulty obtaining financing, if necessary, for such acquisitions on satisfactory terms. We sometimes agree not to sell an acquired hospital for some period of time (currently no longer than 10 years) after purchasing it and/or grant the seller a right of first refusal to purchase the hospital if we agree to sell it to a third party. In addition, we may not be able to effectively integrate any acquired facilities with our operations. Even if we continue to acquire additional facilities and/or enter into partnerships or affiliations with other healthcare service providers, federal and state regulatory agencies may constrain our ability to grow.

Additionally, many states, including some where we have hospitals and others where we may in the future attempt to acquire hospitals, have adopted legislation regarding the sale or other disposition of hospitals operated by not-for-profit entities. In other states that do not have specific legislation, the attorneys general have demonstrated an interest in these transactions under their general obligations to protect charitable assets from waste. These legislative and administrative efforts focus primarily on the appropriate valuation of the assets divested and the use of the sale proceeds by the not-for-profit seller. These review and approval processes can add time to the consummation of an acquisition of a not-for profit hospital, and future actions on the state level could seriously

delay or even prevent future acquisitions of not-for-profit hospitals. Furthermore, as a condition to approving an acquisition, the attorney general of the state in which the hospital is located may require us to maintain specific services, such as emergency departments, or to continue to provide specific levels of charity care, which may affect our decision to acquire or the terms upon which we acquire one of these hospitals.

Difficulties with integrating our acquisitions may disrupt our ongoing operations.

We may not be able to profitably or effectively integrate the operations of, or otherwise achieve the intended benefits from, any acquisitions we make or partnerships or affiliations we may form. The process of integrating acquired hospitals may require a disproportionate amount of management's time and attention, potentially distracting management from its day-to-day responsibilities. This process may be even more difficult in the case of hospitals we may acquire out of bankruptcy or otherwise in financial distress. In addition, poor integration of acquired facilities could cause interruptions to our business activities, including those of the acquired facilities. As a result, we may incur significant costs related to acquiring or integrating these facilities and may not realize the anticipated benefits.

Moreover, acquired businesses may have unknown or contingent liabilities, including liabilities for failure to comply with healthcare laws and regulations. We could in the future become liable for past activities of acquired businesses and these liabilities could be material.

The cost of our malpractice insurance and the malpractice insurance of physicians who practice at our facilities remains volatile. Successful malpractice or tort claims asserted against us, our physicians or our employees could materially adversely affect our financial condition and profitability.

Physicians, hospitals and other healthcare providers are subject to legal actions alleging malpractice, product liability or related legal theories. Many of these actions involve large monetary claims and significant defense costs. Hospitals and physicians have typically maintained a special type of insurance (commonly called malpractice or professional liability insurance) to protect against the costs of these types of legal actions. We created a captive insurance subsidiary on June 1, 2002, to assume a substantial portion of the professional and general liability risks of our facilities. For claims incurred during the period June 1, 2002 to May 31, 2006, we maintained all of our professional and general liability insurance through this captive insurance subsidiary in respect of losses up to $10.0 million per occurrence. For claims incurred from June 1, 2006 to June 30, 2009, we self-insured the first $9.0 million per occurrence, and our captive subsidiary insured the next $1.0 million per occurrence. We have also purchased an umbrella excess policy for professional and general liability insurance for the period July 1, 2009 to June 30, 2010 with unrelated commercial carriers. This policy covers losses in excess of $10.0 million per occurrence up to $75.0 million, but is limited to total annual payments of $65.0 million in the aggregate. While our premium prices have declined during the past few years, the total cost of professional and general liability insurance remains sensitive to the volume and severity of cases reported. There is no guarantee that excess insurance coverage will continue to be available in the future at a cost allowing us to maintain adequate levels of such insurance. Moreover, due to the increased retention limits insured by us and our captive subsidiary, if actual payments of claims materially exceed our projected estimates of malpractice claims, our financial condition could be materially adversely affected.

Physicians' professional liability insurance costs in certain markets have dramatically increased to the point where some physicians are either choosing to retire early or leave those markets. If physician professional liability insurance costs continue to escalate in markets in which we operate, some physicians may choose not to practice at our facilities, which could reduce our patient volumes and revenues. Our hospitals may also incur a greater percentage of the amounts paid to claimants if physicians are unable to obtain adequate malpractice coverage since we are often sued in the same malpractice suits brought against physicians on our medical staffs who are not employed by us.

We anticipate employing over 160 additional physicians during our fiscal year 2010. Such a significant increase in employed physicians could significantly increase our professional and general liability risks and related costs in future periods since for employed physicians there is no insurance coverage from unaffiliated insurance companies.

We are subject to uncertainties regarding healthcare reform that could materially and adversely affect our business.

In recent years, an increasing number of legislative initiatives have been introduced or proposed in Congress and in state legislatures that would result in major changes in the healthcare system, either nationally or at the state level. Among the proposals that have been introduced in recent years are price controls on hospitals, insurance market reforms to increase the availability of group health insurance to small businesses, requirements that all businesses offer health insurance coverage to their employees and the creation of a government health insurance plan or plans that would cover all citizens and increase payments by beneficiaries. Also, the Obama administration has stated as its top domestic priority its desire to reform the U.S. healthcare system with the goal of providing affordable, accessible healthcare for all Americans. In July 2009 four of the five Congressional committees working on healthcare reform approved some version of reform legislation. In the House of Representatives, all three committees working on the legislation (the Committees on Ways and Means, Energy and Commerce and Education and Labor) passed different versions of the same extensive reform bill under which, for individuals not currently covered, a new healthcare exchange will be established where they can select either a new "public health insurance option" or a plan offered by private insurers. During the Congressional recess in August 2009, the three House committees worked to meld the bills into one final version for consideration by the entire House of Representatives as early as September 2009. In the Senate, its Committee on Health, Education, Labor and Pensions approved its version of healthcare reform legislation on July 15, 2009 which is similar to, but less extensive in benefits than, the House version. Meanwhile, during August 2009 the Senate Committee on Finance continued its efforts to negotiate a bipartisan agreement on healthcare reform legislation and that committee is not expected to vote upon its healthcare reform bill until at least September 2009. One of the most significant differences in the legislation produced by the Senate Finance Committee is likely to be the establishment of state and/or regional health insurance cooperatives in lieu of a federally-administered "public option" to compete with private health insurance plans. Once passed by the Senate Finance Committee, the two Senate committees will need to merge the two bills into one final version for consideration by the entire Senate, potentially in September or October 2009. Also, many states have enacted or are considering enacting measures designed to reduce their Medicaid expenditures. States have also adopted, or are considering, legislation designed to reduce coverage and program eligibility, enroll Medicaid recipients in managed care programs and/or impose additional taxes on hospitals to help finance or expand states' Medicaid systems. We cannot predict whether any of the above proposals or any other proposals will be adopted, and if adopted, we cannot assure you that the implementation of these reforms will not have a material adverse effect on our business, financial position or results of operations.

Our facilities are concentrated in a small number of regions. If any one of the regions in which we operate experiences a regulatory change, economic downturn or other material change, our overall business results may suffer.

Among our operations as of June 30, 2009, five hospitals and various related healthcare businesses were located in San Antonio, Texas; five hospitals and related healthcare businesses were located in metropolitan Phoenix, Arizona; two hospitals and related healthcare businesses were located in metropolitan Chicago, Illinois; and three hospitals and related healthcare businesses were located in Massachusetts.

For the year ended June 30, 2009, our total revenues were generated as follows:

	Year Ended June 30, 2009
San Antonio	29.6 %
Phoenix Health Plan and Abrazo Advantage Health Plan	19.3
Massachusetts	18.3
Metropolitan Phoenix, excluding Phoenix Health Plan and Abrazo Advantage Health Plan	17.9
Metropolitan Chicago (1)	14.6
Other	0.3
	100.0 %

(1) Includes MacNeal Health Providers.

Any material change in the current demographic, economic, competitive or regulatory conditions in any of these regions could adversely affect our overall business results because of the significance of our operations in each of these regions to our overall operating performance. Moreover, due to the concentration of our revenues in only four regions, our business is less diversified and, accordingly, is subject to greater regional risk than that of some of our larger competitors.

If we are unable to control our healthcare costs at Phoenix Health Plan and Abrazo Advantage Health Plan, if the health plans should lose their governmental contracts or if budgetary cuts reduce the scope of Medicaid or dual-eligibility coverage, our profitability may be adversely affected.

For the year ended June 30, 2009, PHP generated approximately 18.1% of our total revenues. PHP derives substantially all of its revenues through a contract with AHCCCS. AHCCCS pays capitated rates to PHP, and PHP subcontracts with physicians, hospitals and other healthcare providers to provide services to its enrollees. If we fail to effectively manage our healthcare costs, these costs may exceed the payments we receive. Many factors can cause actual healthcare costs to exceed the capitated rates paid by AHCCCS, including:

- our ability to contract with cost-effective healthcare providers;
- the increased cost of individual healthcare services;
- the type and number of individual healthcare services delivered; and
- the occurrence of catastrophes, epidemics or other unforeseen occurrences

Our current contract with AHCCCS began October 1, 2008 and expires September 30, 2011. This contract is terminable without cause on 90 days' written notice from AHCCCS or for cause upon written notice from AHCCCS if we fail to comply with any term or condition of the contract or fail to take corrective action as required to comply with the terms of the contract. AHCCCS may also terminate the contract with PHP in the event of unavailability of state or federal funding. If our AHCCCS contract is terminated, our profitability would be adversely affected by the loss of these revenues and cash flows. Also, should the scope of the Medicaid program be reduced as a result of state budgetary cuts or other political factors, our results of operations could be adversely affected.

For the year ended June 30, 2009, AAHP generated 1.2% of our total revenues. AAHP began providing healthcare coverage to Medicare and Medicaid dual-eligible enrollees on January 1, 2006. Most of AAHP's members were formerly enrolled in PHP. AAHP's contract with CMS went into effect on January 1, 2006, for a term of one year, with a provision for successive one year renewals, and has currently been renewed through December 31, 2009. If we fail to effectively manage AAHP's healthcare costs, these costs may exceed the payments we receive.

We are dependent on our senior management team and local management personnel, and the loss of the services of one or more of our senior management team or key local management personnel could have a material adverse effect on our business.

The success of our business is largely dependent upon the services and management experience of our senior management team, which includes Charles N. Martin, Jr., our Chairman and Chief Executive Officer; Kent H. Wallace, our President and Chief Operating Officer; Keith B. Pitts, our Vice Chairman, Phillip W. Roe, our Executive Vice President, Chief Financial Officer and Treasurer; and Joseph D. Moore, Executive Vice President. In addition, we depend on our ability to attract and retain local managers at our hospitals and related facilities, on the ability of our senior officers and key employees to manage growth successfully and on our ability to attract and retain skilled employees. We do not maintain key man life insurance policies on any of our officers. If we were to lose any of our senior management team or members of our local management teams, or if we are unable to attract other necessary personnel in the future, it could have a material adverse effect on our business, financial condition and results of operations. If we were to lose the services of one or more members of our senior management team or a significant portion of our hospital management staff at one or more of our hospitals, we would likely experience a significant disruption in our operations and failure of the affected hospitals to adhere to their respective business plans.

Controls designed to reduce inpatient services may reduce our revenues.

Controls imposed by Medicare and commercial third-party payers designed to reduce admissions and lengths of stay, commonly referred to as "utilization review," have affected and are expected to continue to affect our facilities. Utilization review entails the review of the admission and course of treatment of a patient by managed care plans. Inpatient utilization, average lengths of stay and occupancy rates continue to be negatively affected by payer-required preadmission authorization and utilization review and by payer pressures to maximize outpatient and alternative healthcare delivery services for less acutely ill patients. Efforts to impose more stringent cost controls are expected to continue. Although we are unable to predict the effect these changes will have on our operations, significant limits on the scope of services reimbursed and on reimbursement rates and fees could have a material, adverse effect on our business, financial position and results of operations.

If we fail to continually enhance our hospitals with the most recent technological advances in diagnostic and surgical equipment, our ability to maintain and expand our markets will be adversely affected.

Technological advances with respect to computed axial tomography (CT), magnetic resonance imaging (MRI) and positron emission tomography (PET) equipment, as well as other equipment used in our facilities, are continually evolving. In an effort to compete with other healthcare providers, we must constantly evaluate our equipment needs and upgrade equipment as a result of technological improvements. Such equipment costs typically range from $1.0 million to $3.0 million, exclusive of construction or build-out costs.

Our hospitals face competition for staffing especially as a result of the national shortage of nurses and the increased imposition on us of nurse-staffing ratios, which has in the past and may in the future increase our labor costs and materially reduce our profitability.

We compete with other healthcare providers in recruiting and retaining qualified management and staff personnel responsible for the day-to-day operations of each of our hospitals, including most significantly nurses and other non-physician healthcare professionals. In the healthcare industry generally, including in our markets, the national shortage of nurses and other medical support personnel has become a significant operating issue. This shortage has caused us in the past and may require us in the future to increase wages and benefits to recruit and retain nurses and other medical support personnel or to hire more expensive temporary personnel. We have voluntarily raised on several occasions in the past, and expect to raise in the future, wages for our nurses and other medical support personnel.

In addition, union-mandated or state-mandated nurse-staffing ratios significantly affect not only labor costs, but may also cause us to limit patient admissions with a corresponding adverse effect on revenues if we are unable to hire the appropriate number of nurses to meet the required ratios. While we do not currently operate in any states with mandated nurse-staffing ratios, the states in which we operate could adopt mandatory nurse-staffing ratios at any time. In those instances where our nurses are unionized, it is our experience that new union contracts often impose significant new additional staffing ratios by contract on our hospitals. This was the case with the increased staffing ratios imposed on us in our union contract with our nurses at Saint Vincent Hospital in Worcester, Massachusetts negotiated in 2007.

Congress is currently considering a bill called the Employee Free Choice Act of 2009 ("EFCA") which organized labor, a major supporter of the Obama administration, has called its number one legislative objective. EFCA would amend the National Labor Relations Act to establish a procedure whereby the National Labor Relations Board would certify a union as the bargaining representative of employees, without a NLRB-supervised secret ballot election, if a majority of unit employees signs valid union authorization cards (the "card-check provision"). Additionally, under EFCA, parties that are unable to reach a first contract within 90 days of collective bargaining could refer the dispute to mediation by the Federal Mediation and Conciliation Service. If the Service is unable to bring the parties to agreement within 30 days, the dispute then would be referred to binding arbitration. Also, the bill would provide for increased penalties for labor law violations by employers. In July 2009, due to intense opposition from the business community, alternative draft legislation became public dropping the card-check provision, but putting in its place new provisions making it easier for employees to organize including provisions to require shorter unionization campaigns, faster elections and limitations on employer-sponsored anti-unionization

meetings which employees are required to attend. This legislation, if passed, would make it easier for our nurses or other groups of hospital employees to unionize, which could materially increase our labor costs.

If our labor costs continue to increase, we may not be able to raise our payer reimbursement levels to offset these increased costs, including the significantly increased costs that we will incur for wage increases and nurse-staffing ratios under our new union contract with our nurses at Saint Vincent Hospital. Because substantially all of our net patient revenues consist of payments based on fixed or negotiated rates, our ability to pass along increased labor costs is materially constrained. Our failure to recruit and retain qualified management, nurses and other medical support personnel, or to control our labor costs, could have a material adverse effect on our profitability.

The current economic recession, along with difficult and volatile conditions in the capital and credit markets, could materially adversely affect our financial position, results of operations or cash flows, and we are unsure whether these conditions will improve in the near future.

The United States economy is currently in a period of recession and global credit markets remain volatile. Declining consumer confidence and increased unemployment have increased concerns of prolonged economic weakness. While certain healthcare spending is considered non-discretionary and may not be significantly impacted by economic downturns, other types of healthcare spending may be significantly adversely impacted by such conditions. When patients are experiencing personal financial difficulties or have concerns about general economic conditions, they may choose to defer or forego elective surgeries and other non-emergent procedures, which are generally more profitable lines of business for hospitals. We are unable to determine the specific impact of the current economic conditions on our business at this time, but we believe that further deterioration or a prolonged period of recession will have an adverse impact on our operations. Other risk factors discussed in this report describe some significant risks that may be magnified by the current economic conditions such as the following:

- Our concentration of operations in a small number of regions, and the impact of economic downturns in those communities. To the extent the communities in and around San Antonio, Texas; Phoenix, Arizona; Chicago, Illinois or certain communities in Massachusetts experience a greater degree of economic weakness than average, the adverse impact on our operations could be magnified.

- Our revenues may decline if federal or state programs reduce our Medicare or Medicaid payments or managed care companies (including managed Medicare and managed Medicaid payers) reduce our reimbursement. Current economic conditions have accelerated and increased the budget deficits for most states, including those in which we operate. These budgetary pressures may result in healthcare payment reductions under state Medicaid plans or reduced benefits to participants in those plans. Also, governmental, managed Medicare or managed Medicaid payers may defer payments to us to conserve cash. Managed care companies may also seek to reduce payment rates or limit payment rate increases to hospitals in response to reductions in enrolled participants.

- Our hospitals face a growth in uncompensated care as the result of the inability of uninsured patients to pay for healthcare services and difficulties in collecting patient portions of insured accounts. Higher unemployment, Medicaid benefit reductions and employer efforts to reduce employee healthcare costs may increase our exposure to uncollectible accounts for uninsured patients or those patients with higher co-pay and deductible limits.

- We believe our operating cash and remaining borrowing capacity is sufficient to run our business and fund our growth initiatives. However, under extreme market conditions, there can be no assurance that such funds will be available to us on favorable terms or at all. Most of our cash and borrowing capacity under our revolving credit facility is held with a limited number of financial institutions, which could increase our liquidity risk if one or more of those institutions become financially strained or are no longer able to operate.

We are unable to predict if the condition of the United States economy, the local economies in the communities we serve or global credit conditions will improve in the near future or when such improvements may occur.

Compliance with section 404 of the Sarbanes-Oxley Act may negatively impact our results of operations and failure to comply may subject us to regulatory scrutiny and a loss of investors' confidence in our internal control over financial reporting.

Section 404 of the Sarbanes-Oxley Act of 2002 (the "404 Act") requires us to perform an evaluation of our internal control over financial reporting and file management's attestation with our annual report. The 404 Act also requires our independent auditors to opine on our internal control over financial reporting beginning with our fiscal year ending June 30, 2010. We have evaluated, tested and implemented internal controls over financial reporting to enable management to report on such internal controls under the 404 Act. However, we can not assure you that the conclusions reached in our June 30, 2010 management report will be the same as those reached by our independent auditors in its report. Failure on our part to comply with the 404 Act may subject us to regulatory scrutiny and a loss of public confidence in our internal control over financial reporting.

A failure of our information systems would adversely affect our ability to properly manage our operations.

We rely on our advanced information systems and our ability to successfully use these systems in our operations. These systems are essential to the following areas of our business operations, among others:

- patient accounting, including billing and collection of patient service revenues;
- financial, accounting, reporting and payroll;
- coding and compliance;
- laboratory, radiology and pharmacy systems;
- remote physician access to patient data;
- negotiating, pricing and administering managed care contracts; and
- monitoring quality of care.

If we are unable to use these systems effectively, we may experience delays in collection of patient service revenues and may not be able to properly manage our operations or oversee the compliance with laws or regulations.

Difficulties with current construction projects or new construction projects such as additional hospitals or major expansion projects may involve significant capital expenditures that could have an adverse impact on our liquidity.

We may decide to construct an additional hospital or hospitals in the future or construct additional major expansion projects to existing hospitals in order to achieve our growth objectives. Our ability to complete construction of new hospitals or new expansion projects on budget and on schedule would depend on a number of factors, including, but not limited to:

- our ability to control construction costs;
- the failure of general contractors or subcontractors to perform under their contracts;
- adverse weather conditions;
- shortages of labor or materials;
- our ability to obtain necessary licensing and other required governmental authorizations; and
- other unforeseen problems and delays.

As a result of these and other factors, we cannot assure you that we will not experience increased construction costs on our construction projects or that we will be able to construct our current or any future construction projects as originally planned. In addition, our current and any future major construction projects would involve a significant commitment of capital with no revenues associated with the projects during construction, which also could have a future adverse impact on our liquidity.

If the costs for construction materials and labor continue to rise, such increased costs could have an adverse impact on the return on investment relating to our expansion projects.

The cost of construction materials and labor has significantly increased over the past years as a result of global and domestic events. We have experienced significant increases in the cost of steel due to the demand in China for

such materials and an increase in the cost of lumber due to multiple factors. Increases in oil and gas prices have increased costs for oil-based products and for transporting materials to job sites. As we continue to invest in modern technologies, emergency rooms and operating room expansions, we expend large sums of cash generated from operating activities. We evaluate the financial viability of such projects based on whether the projected cash flow return on investment exceeds our cost of capital. Such returns may not be achieved if the cost of construction continues to rise significantly or anticipated volumes do not materialize.

State efforts to regulate the construction or expansion of hospitals could impair our ability to operate and expand our operations.

Some states require healthcare providers to obtain prior approval, known as certificates of need, for:

- the purchase, construction or expansion of healthcare facilities;
- capital expenditures exceeding a prescribed amount; or
- changes in services or bed capacity.

In giving approval, these states consider the need for additional or expanded healthcare facilities or services. Illinois and Massachusetts are the only states in which we currently own hospitals that have certificate of need laws. The failure to obtain any required certificate of need could impair our ability to operate or expand operations in these states.

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

Blackstone acquired our predecessor company during fiscal 2005. We recorded a significant portion of the purchase price as goodwill. At June 30, 2009, we had approximately $692.1 million of goodwill recorded on our financial statements. We expect to recover the carrying value of this goodwill through our future cash flows. On an ongoing basis, we evaluate, based on the fair value of our reporting units, whether the carrying value of our goodwill is impaired. During fiscal 2007, we recorded a $123.8 million ($110.5 million, net of tax benefit) impairment charge to goodwill to reduce the carrying values of our Chicago hospitals to their fair values. If the carrying value of our goodwill is further impaired, we may incur an additional material non-cash charge to earnings.

Additional Risk Factors

See the additional risks related to our business in "Item 7 – Management's Discussion and Analysis of Financial Conditions and Results of Operations – General Trends" which are incorporated by reference in this Item 1A as if fully set forth herein.

Available Information

We currently voluntarily file certain reports with the Securities and Exchange Commission ("SEC"), including annual reports on Form 10-K and quarterly reports on Form 10-Q. The public may read and copy any materials we file with the SEC at the SEC's Public Reference Room at 100 F Street, N.E., Washington, DC 20549. The public may obtain information on the operation of the Public Reference Room by calling the SEC at 1-800-SEC-0330. We are an electronic filer and the SEC maintains an Internet site at http://www.sec.gov that contains the reports and other information we file electronically. Our Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q, Current Reports on Form 8-K and amendments to those reports are also available free of charge on our internet website at www.vanguardhealth.com under "Investor Relations-SEC Filings-SEC Filings on the Edgar Database" as soon as reasonably practicable after such reports are electronically filed with or furnished to the SEC. Please note that our website address is provided as an inactive textual reference only. Also, the information provided on our website is not part of this report, and is therefore not incorporated by reference unless such information is specifically referenced elsewhere in this report.

Item 1B. Unresolved Staff Comments.

Not applicable.

Item 2. Properties.

A listing of our owned acute hospitals is included in Item 1 of this report under the caption "Business-Our Facilities". We also own or lease space for outpatient service facilities complementary to our hospitals and own and operate a limited number of medical office buildings (some of which are joint ventures) associated with our hospitals that are occupied primarily by physicians who practice at our hospitals. The most significant of these complementary outpatient healthcare facilities are two surgery centers in Orange County, California, five diagnostic imaging centers in metropolitan Phoenix, Arizona and a 50% interest in seven diagnostic imaging centers in San Antonio, Texas. Most of these outpatient facilities are in leased facilities, and the diagnostic imaging centers in San Antonio are owned and operated in joint ventures where we have minority partners.

As of June 30, 2009, we leased approximately 53,200 square feet of office space at 20 Burton Hills Boulevard, Nashville, Tennessee, for our corporate headquarters.

Our headquarters, hospitals and other facilities are suitable for their respective uses and are, in general, adequate for our present needs. Our obligations under our senior credit facilities are secured by a pledge of substantially all of our assets, including first priority mortgages on each of our hospitals. Also, our properties are subject to various federal, state and local statutes and ordinances regulating their operation. Management does not believe that compliance with such statutes and ordinances will materially affect our financial position or results from operations.

Item 3. Legal Proceedings.

We operate in a highly regulated and litigious industry. As a result, various lawsuits, claims and legal and regulatory proceedings have been instituted or asserted against us. While we cannot predict the likelihood of future claims or inquiries, we expect that new matters may be initiated against us from time to time. The results of claims, lawsuits and investigations cannot be predicted, and it is possible that the ultimate resolution of these matters, individually or in the aggregate, may have a material adverse effect on our business (both in the near and long term), financial position, results of operations or cash flows. We recognize that, where appropriate, our interests may be best served by resolving certain matters without litigation. If non-litigated resolution is not possible or appropriate with respect to a particular matter, we will continue to defend ourselves vigorously.

Currently pending and recently settled legal proceedings and investigations that are not in the ordinary course of business are set forth below. Where specific amounts are sought in any pending legal proceeding, those amounts are disclosed. For all other matters, where the possible loss or range of loss is reasonably estimable, an estimate is provided. Where no estimate is provided, the possible amount of loss is not reasonably estimable at this time. We record reserves for claims and lawsuits when they are probable and reasonably estimable. For matters where the likelihood or extent of a loss is not probable or cannot be reasonably estimated, we have not recognized in our consolidated financial statements all potential liabilities that may result. We undertake no obligation to update the following disclosures for any new developments.

Sherman Act Antitrust Class Action Litigation – Maderazo, et al v. VHS San Antonio Partners, L.P. d/b/a Baptist Health Systems, et al, Case No. 5:06cv00535 (United States District Court, Western District of Texas, San Antonio Division, filed June 20, 2006 and amended August 29, 2006)

On June 20, 2006, a federal antitrust class action suit was filed in San Antonio, Texas against our Baptist Health System subsidiary in San Antonio, Texas and two other large hospital systems in San Antonio. In the complaint, plaintiffs allege that the three hospital system defendants conspired with each other and with other unidentified San Antonio area hospitals to depress the compensation levels of registered nurses employed at the conspiring hospitals within the San Antonio area by engaging in certain activities that violated the federal antitrust laws. The complaint alleges two separate claims. The first count asserts that the defendant hospitals violated Section 1 of the federal Sherman Act, which prohibits agreements that unreasonably restrain competition, by conspiring to depress nurses' compensation. The second count alleges that the defendant hospital systems also violated Section 1 of the Sherman Act by participating in wage, salary and benefits surveys for the purpose, and having the effect, of depressing registered nurses' compensation or limiting competition for nurses based on their compensation. The class on whose behalf the plaintiffs filed the complaint is alleged to comprise all registered nurses employed by the defendant hospitals since June 20, 2002. The suit seeks unspecified damages, trebling of this damage amount pursuant to

federal law, interest, costs and attorneys fees. From 2006 through April 2008 we and the plaintiffs worked on producing documents to each other relating to, and supplying legal briefs to the court in respect of, the issue of whether the court will certify a class in this suit. In April 2008 the case was stayed by the judge pending his ruling on plaintiffs' motion for class certification. We believe that the allegations contained within this putative class action suit are without merit, and we have vigorously worked to defeat class certification. If a class is certified, we will continue to defend vigorously against the litigation.

On the same date that this suit was filed against us in federal district court in San Antonio, the same attorneys filed three other substantially similar putative class action lawsuits in federal district courts in Chicago, Illinois, Albany, New York and Memphis, Tennessee against some of the hospitals in those cities (none of such hospitals being owned by us). The attorneys representing the plaintiffs in all four of these cases said in June 2006 that they may file similar complaints in other jurisdictions and in December 2006 they brought a substantially similar class action lawsuit against various hospitals in the Detroit, Michigan metropolitan area. Since representatives of the Service Employees International Union joined plaintiffs' attorneys in announcing the filing of all four complaints on June 20, 2006, and as has been reported in the media, we believe that SEIU's involvement in these actions appears to be part of a corporate campaign to attempt to organize nurses in these cities, including San Antonio. The nurses in our hospitals in San Antonio are currently not members of any union.

Claims in the ordinary course of business.

We are also subject to claims and lawsuits arising in the ordinary course of business, including potential claims related to care and treatment provided at our hospitals and outpatient services facilities. Although the results of these claims and lawsuits cannot be predicted with certainty, we believe that the ultimate resolution of these ordinary course claims and lawsuits will not have a material adverse effect on our business, financial condition or results of operations.

Item 4. Submission of Matters to a Vote of Security Holders.

No matters were submitted to a vote of stockholders during the fourth quarter ended June 30, 2009, except that the holders of 100% of our outstanding common stock approved Amendment 6 to our 2004 Stock Incentive Plan pursuant to a written consent dated May 5, 2009. This Amendment increased the total number of our shares which may be issued under the Plan from 101,117 to 105,611.

PART II

Item 5. Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities.

There is no established public trading market for our common stock. At September 1, 2009, there were five holders of record of our common stock. These holders are VHS Holdings LLC and four investment funds affiliated with Blackstone.

We have not declared or paid any dividends on our common stock in our two most recent fiscal years. We intend to retain all current and foreseeable future earnings to support operations and finance expansion. Our senior secured credit facility and the indentures governing our long-term indebtedness restrict our ability to pay cash dividends on our common stock.

There were no unregistered sales of our equity securities during the quarter ended June 30, 2009.

Information regarding our equity compensation plans is set forth in this report under "Item 12 – Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters – Equity Compensation Plan Information", which information is incorporated herein by reference.

Item 6. Selected Financial Data.

The following table sets forth our selected historical financial and operating data for, or as of the end of, each of the five years ended June 30, 2009 (including the predecessor and successor periods). The selected historical financial data as of and for the combined predecessor and successor year ended June 30, 2005 and the years ended June 30, 2006, 2007, 2008 and 2009 were derived from our audited consolidated financial statements that have been audited by Ernst & Young LLP, an independent registered public accounting firm. Dispositions completed during fiscal 2007 have been excluded from all periods presented. See "Executive Overview" included in "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations." This table should be read in conjunction with the consolidated financial statements and notes thereto.

	Combined Basis Year Ended June 30, 2005	Year Ended June 30, 2006	Year Ended June 30, 2007	Year ended June 30, 2008	Year ended June 30, 2009	Predecessor July 1, 2004 through September 22, 2004	Successor September 23, 2004 through June 30, 2005
			(Dollars in millions, except Operating Data)				
Statement of Operations Data:							
Total revenues	$ 2,037.3	$ 2,418.6	$ 2,580.7	$ 2,790.7	$ 3,199.7	$ 397.9	$ 1,639.4
Costs and expenses:							
Salaries and benefits (includes stock compensation of $97.4, $1.7, $1.2, $2.5, $4.4, $96.7 and $0.7, respectively)	909.2	991.4	1,067.9	1,152.7	1,240.1	248.2	661.0
Supplies	336.8	394.1	421.8	434.5	456.3	63.7	273.1
Health plan claims expense	237.2	270.3	297.0	328.2	525.6	55.0	182.2
Provision for doubtful accounts	133.0	156.8	175.2	205.6	210.8	27.8	105.2
Other operating expenses	288.8	353.0	375.0	405.8	468.9	57.3	231.5
Depreciation and amortization	75.7	100.3	118.6	131.0	130.6	16.0	59.7
Interest, net	82.3	103.8	123.8	122.1	111.6	9.0	73.3
Debt extinguishment costs	62.2	0.1	—	—	—	62.2	—
Minority interests	(0.3)	2.6	2.6	3.0	3.2	(0.5)	0.2
Merger expenses	23.3	—	—	—	—	23.1	0.2
Impairment loss	—	—	123.8	—	6.2	—	—
Other expenses	3.6	6.5	0.2	6.5	2.7	0.4	3.2
Subtotal	2,151.8	2,378.9	2,705.9	2,789.4	3,156.0	562.2	1,589.6
Income (loss) from continuing operations before income taxes	(114.5)	39.7	(125.2)	1.3	43.7	(164.3)	49.8
Income tax expense (benefit)	(34.7)	17.8	(11.6)	1.7	16.0	(52.2)	17.5
Income (loss) from continuing operations	(79.8)	21.9	(113.6)	(0.4)	27.7	(112.1)	32.3
Income (loss) from discontinued operations, net of taxes	1.7	(9.0)	(19.1)	(0.3)	0.9	1.4	0.3
Net income (loss)	(78.1)	12.9	(132.7)	(0.7)	28.6	(110.7)	32.6
Preferred dividends	(1.0)	—	—	—	—	(1.0)	—
Net income (loss) attributable to common stockholders	$ (79.1)	$ 12.9	$ (132.7)	$ (0.7)	$ 28.6	$ (111.7)	$ 32.6
Balance Sheet Data:							
Assets	$ 2,471.7	$ 2,650.5	$ 2,538.1	$ 2,582.3	$ 2,731.1		$ 2,471.7
Long-term debt, including current portion	1,357.1	1,519.2	1,528.7	1,537.5	1,551.6		1,357.1
Working capital	77.7	193.0	156.4	217.8	251.6		77.7
Other Financial Data:							
Capital expenditures	$ 224.2	$ 275.5	$ 164.3	$ 121.6	$ 132.1	$ 27.1	$ 197.1
Cash provided by operating activities	201.8	149.3	123.3	173.1	308.2	78.8	123.0
Cash used in investing activities	(324.3)	(245.4)	(118.5)	(143.8)	(133.6)	(50.0)	(274.3)
Cash provided by (used in) financing activities	151.6	140.5	(8.3)	(7.8)	(8.0)	(20.0)	171.6
Operating Data-continuing operations: (unaudited)							
Number of hospitals at end of period	15	15	15	15	15		
Number of licensed beds at end of period (a)	3,907	3,937	4,143	4,181	4,135		
Discharges (b)	147,798	162,446	166,873	169,668	167,880		
Adjusted discharges - hospitals (c)	231,322	261,056	264,698	270,076	274,767		
Adjusted discharges (d)	278,255	303,696	278,820	284,680	289,997		
Net revenue per adjusted discharge – hospitals (e)	$ 6,859	$ 7,319	$ 7,766	$ 8,110	$ 8,623		
Net revenue per adjusted discharge (f)	$ 6,817	$ 7,353	$ 7,690	$ 8,059	$ 8,517		
Patient days (g)	623,333	701,307	721,832	734,838	709,952		
Average length of stay (days) (h)	4.2	4.3	4.3	4.3	4.2		
Inpatient surgeries (i)	33,424	36,606	37,227	37,538	37,970		
Outpatient surgeries (j)	67,944	76,437	76,606	73,339	76,378		
Emergency room visits (k)	504,172	554,250	572,946	588,246	605,729		
Occupancy rate (l)	48.5%	49.2%	48.2%	48.0%	47.0%		
Average daily census (m)	1,708	1,921	1,978	2,008	1,945		
Member lives (n)	146,700	146,200	145,600	149,600	218,700		
Health plan claims expense percentage (o)	71.1%	72.1%	74.0%	72.9%	77.5%		

(a) Licensed beds are those beds for which a facility has been granted approval to operate from the applicable state licensing agency.

(b) Discharges represent the total number of patients discharged (in the facility for a period in excess of 23 hours) from our hospitals and is used by management and certain investors as a general measure of inpatient volumes.

(c) Adjusted discharges-hospitals is used by management and certain investors as a general measure of combined hospital inpatient and outpatient volumes. Adjusted discharges-hospitals is computed by multiplying discharges by the sum of gross hospital inpatient and gross hospital outpatient revenues and then dividing the result by gross hospital inpatient revenues. This computation enables management to assess hospital volumes by a combined measure of hospital inpatient and outpatient utilization.

(d) Adjusted discharges is used by management and certain investors as a general measure of consolidated inpatient and outpatient volumes. Adjusted discharges is computed by multiplying discharges by the sum of gross inpatient revenues and gross outpatient revenues and then dividing the result by gross inpatient revenues.

(e) Net revenue per adjusted discharge-hospitals is calculated by dividing hospital net patient revenues by adjusted discharges-hospitals and measures the average net payment expected to be received for a patient's stay in the hospital.

(f) Net revenue per adjusted discharge is calculated by dividing net patient revenues by adjusted discharges and measures the average net payment expected to be received for an episode of service provided to a patient.

(g) Patient days represent the number of days (calculated as overnight stays) our beds were occupied by patients during the periods.

(h) Average length of stay represents the average number of days an admitted patient stays in our hospitals.

(i) Inpatient surgeries represent the number of surgeries performed in our hospitals where overnight stays are necessary.

(j) Outpatient surgeries represent the number of surgeries performed at hospitals or ambulatory surgery centers on an outpatient basis (patient overnight stay not necessary).

(k) Emergency room visits represent the number of patient visits to a hospital or freestanding emergency room where treatment is received, regardless of whether an overnight stay is subsequently required.

(l) Occupancy rate represents the percentage of hospital licensed beds occupied by patients. Occupancy rate provides a measure of the utilization of inpatient rooms.

(m) Average daily census represents the average number of patients in our hospitals each day during our ownership.

(n) Member lives represent the total number of enrollees in PHP, AAHP and MHP as of the end of the respective period.

(o) Health plan claims expense percentage is calculated by dividing health plan claims expense by premium revenues.

Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations.

You should read the following discussion together with our historical financial statements and related notes included elsewhere herein and the information set forth under "Item 6. Selected Financial Data." The discussion contains forward-looking statements that involve risks and uncertainties. For additional information regarding some of the risks and uncertainties that affect our business and the industry in which we operate, please read "Item 1A. - Risk Factors" included elsewhere herein. Our actual results may differ materially from those estimated or projected in any of these forward-looking statements.

Executive Overview

As of June 30, 2009, we owned and operated 15 hospitals with a total of 4,135 licensed beds, and related outpatient service facilities complementary to the hospitals in San Antonio, Texas; metropolitan Phoenix, Arizona; metropolitan Chicago, Illinois; and Massachusetts, and two surgery centers in Orange County, California. As of June 30, 2009, we also owned three health plans as set forth in the following table.

Health Plan	Location	Membership
Phoenix Health Plan ("PHP") – managed Medicaid	Arizona	176,200
Abrazo Advantage Health Plan ("AAHP") – managed Medicare and Dual Eligible	Arizona	2,800
MacNeal Health Providers ("MHP") – capitated outpatient and physician services	Illinois	39,700
		218,700

Our objective is to help communities achieve health for life by delivering an ideal patient-centered experience in a highly reliable environment of care. We plan to grow our business by improving quality of care, expanding services and strengthening the financial performance of our existing operations and selectively acquiring other hospitals where we see an opportunity to improve operating performance and profitability.

Operating Environment

We believe that the operating environment for hospital operators continues to evolve, which presents both challenges and opportunities for us. In order to remain competitive in the markets we serve, we must transform our operating strategies to not only accommodate changing environmental factors but to make them operating advantages for us relative to our peers. These factors will require continued focus on quality of care initiatives. As consumers become more involved in their healthcare decisions, we believe perceived quality of care will become an even greater factor in determining where physicians choose to practice and where patients choose to receive care. In the following paragraphs we discuss both current challenges and future challenges that we face and our strategies to proactively address them.

Pay for Performance Reimbursement

Many payers, including Medicare and several large managed care organizations, currently require hospital providers to report certain quality measures in order to receive the full amount of payment increases that were awarded automatically in the past. For federal fiscal year 2010, Medicare expanded the number of quality measures to be reported to 47 compared to 43 during federal fiscal year 2009. Many large managed care organizations have developed quality measurement criteria that are similar to or even more stringent than these Medicare requirements. While current Medicare guidelines and contracts with most managed care payers provide for reimbursement based upon the reporting of quality measures, we believe it is only a matter of time until all significant payers utilize the quality measures themselves to determine reimbursement rates for hospital services. In order to meet these requirements, we must deliver an ideal patient-centered experience. This will require us to engage our nurses and partner with physicians to drive our quality of care strategies, invest in and to upgrade our information technology systems to monitor clinical quality indicators and to make all of our processes more efficient.

Physician Alignment

Our ability to attract skilled physicians to our hospitals is critical to our success. Coordination of care and alignment of care strategies between hospitals and physicians will become more critical as reimbursement becomes more episode-based. We have adopted several significant physician recruitment goals with primary emphasis on recruiting physicians specializing in family practice, internal medicine, obstetrics and gynecology, cardiology, neurology, orthopedics and inpatient hospital care (hospitalists). To provide our patients access to the appropriate physician resources, we recruited approximately 150 physicians to the communities served by our hospitals during the year ended June 30, 2009 through employment agreements, relocation agreements or physician practice acquisitions. We have invested heavily in the infrastructure necessary to coordinate our physician alignment strategies and manage our physician operations. Our hospitalist strategy is a key element in coordination of patient-centered care. The costs associated with recruiting, integrating and managing such a large number of new physicians will have a negative impact on our operating results and cash flows in the short term. However, we expect to realize improved clinical quality and service expansion capabilities from this initiative that will positively impact our operating results over the long-term.

Cost pressures

In order to demonstrate a highly reliable environment of care, we must hire and retain nurses who share our ideals and beliefs and who have access to the training necessary to implement our clinical quality initiatives. While the national nursing shortage has abated somewhat during the past year, the nursing workforce remains volatile. As a result, we expect continuing pressures on nursing salaries and benefits. These pressures include higher than normal base wage increases, demands for flexible working hours and other increased benefits and higher nurse to patient ratios necessary to improve quality of care. Inflationary pressures and technological advancements continue to drive supplies costs higher. We have implemented multiple supply chain initiatives including consolidation of low-priced vendors, establishment of value analysis teams and coordination of care efforts with physicians to reduce physician preference items.

Potential Healthcare Reform

The increase in the number of individuals and families without healthcare coverage has heightened debate about whether and how to implement comprehensive reform of the United States healthcare system. The Obama administration has made healthcare reform its primary domestic agenda item, and Congress is currently considering multiple plans on how to change the healthcare system and how to fund those changes. Generally, President Obama and most members of Congress believe that the current healthcare system is too inefficient and leaves too many individuals without healthcare coverage. Much of the current healthcare reform debate includes the following considerations: whether a public insurance option should be established; the impact to private insurance companies; the impact to consumer choice of healthcare services; the impact to small businesses; and the impact of funding alternatives including personal tax rate increases, business surcharges, service provider assessments and increasing the federal deficit. We are not able to predict whether healthcare reform will be implemented, what provisions a potential reform plan may include or what impact these developments may have on our future operating results or cash flows at this time.

Implementation of our Clinical Quality Initiatives

The integral component of each of the challenge areas previously discussed is quality of care. We have implemented many of our expanded clinical quality initiatives and are in the process of implementing several others. These initiatives include monthly review of the current 43 CMS quality indicators, rapid response teams, mock Joint Commission surveys, hourly nursing rounds, our nurse leadership professional practice model, alignment of hospital management incentive compensation with quality performance indicators and the formation of Physician Advisory Councils at our hospitals to align the quality goals of our hospitals with those of the physicians who practice in our hospitals.

Revenue/Volume Trends

Our revenues depend upon inpatient occupancy levels, outpatient procedures performed at our facilities, the ancillary services and therapy programs ordered by physicians and provided to patients and our ability to successfully negotiate appropriate payment rates for these services with third party payers.

Sources of Revenues

The primary sources of our revenues include various managed care payers including managed Medicare and managed Medicaid programs, the traditional Medicare program, various state Medicaid programs, commercial health plans and the patients themselves. We are typically paid much less than our gross charges regardless of the payer source. Refer to "Item 1. Business – "Sources of Revenues" section of this report for a comprehensive discussion of these payers, how they reimburse us for our services provided and the risks we face with regard to potential reimbursement changes.

The following table sets forth the percentages of net patient revenues by payer for the years ended June 30, 2007, 2008 and 2009.

	Year ended June 30,		
	2007	2008	2009
Medicare	26.4%	26.2%	25.3%
Medicaid	8.6%	7.6%	7.8%
Managed Medicare	12.8%	14.0%	14.1%
Managed Medicaid	7.5%	7.5%	8.9%
Managed care	32.0%	35.0%	34.8%
Self pay	9.7%	8.6%	8.2%
Other	3.0%	1.1%	0.9%
Total	100.0%	100.0%	100.0%

Volumes by Payer

During the year ended June 30, 2009, we experienced a 1.1% decrease in discharges compared to the prior year. During the year ended June 30, 2009, we experienced a 1.7% increase in hospital adjusted discharges compared to the prior year. The following table provides details of discharges by payer for the years ended June 30, 2007, 2008 and 2009.

	Year ended June 30,					
	2007		2008		2009	
Medicare	46,452	27.8%	47,040	27.7%	45,516	27.1%
Medicaid	22,518	13.5%	20,195	11.9%	17,068	10.2%
Managed Medicare	23,339	14.0%	26,040	15.3%	26,925	16.0%
Managed Medicaid	18,579	11.1%	19,893	11.7%	23,185	13.8%
Managed care	48,481	29.1%	50,040	29.5%	48,977	29.2%
Self pay	6,181	3.7%	5,854	3.5%	5,650	3.4%
Other	1,323	0.8%	606	0.4%	559	0.3%
Total	166,873	100.0%	169,668	100.0%	167,880	100.0%

Impact of Current Economic Environment

We continue to experience limited volume growth due to stagnant demand for inpatient healthcare services and increased competition for available patients. The current economic recession has negatively impacted many industries. While many healthcare services are considered non-discretionary in nature, certain services including elective procedures and other non-emergent services may be deferred or canceled by patients when they are suffering personal financial hardship or have a negative outlook on the general economy. Increases in unemployment often result in a higher number of uninsured patients, and employer cost reduction programs may result in a higher level of co-pays and deductible limits for patients. Governmental payers and managed care payers may reduce reimbursement paid to hospitals and other healthcare providers to address budget shortfalls or enrollment declines. We are unable to determine the specific impact of the economic recession on our results of operations and cash flows, but we believe a prolonged or more severe economic recession during the remainder of 2009 and into 2010 will have an adverse impact on our revenues whether in the form of payer mix shifts from managed care to uninsured or Medicaid, additional charity care, lower patient volumes, lower collection rates of patient co-pay and deductible balances or a combination of such factors. We expect our volumes to improve more significantly over the long-term as a result of our quality of care and service expansion initiatives and other market-specific strategies, especially as more individuals in the markets we serve reach ages where hospital services become more prevalent. However, we have no way to estimate when the economy may improve or when we will realize the benefits of our long-term strategies.

Payer Reimbursement Trends

In addition to the volume factors described above, patient mix, acuity factors and pricing trends affect our patient service revenues. Net patient revenue per adjusted hospital discharge was $8,110 and $8,623 for the years ended June 30, 2008 and 2009, respectively. This increase reflects improved reimbursement for services provided under negotiated managed care contracts and increased revenues earned from the Texas upper payment limit ("UPL") program and the Illinois provider tax assessment ("PTA") program further described below. However, due to consolidation of managed care plans and federal and state efforts to decrease Medicare and Medicaid spending, our ability to recognize improved reimbursement above or equal to rates recognized in previous periods is becoming more difficult. We cannot assure you that future reimbursement rates, even if improved, will sufficiently cover potential increases in the cost of providing healthcare services to our patients.

During fiscal 2007 we were approved to receive payments under the Bexar County, Texas UPL Medicaid program. UPL programs allow private hospitals to enter into indigent care affiliation agreements with governmental entities. Within the parameters of these programs, private hospitals expand charity care services to indigent patients and alleviate expenses for the governmental entity. The governmental entity is then able to utilize its tax revenue to fund the Medicaid program for private hospitals. CMS began reviewing the operations of this private hospital UPL program after the State of Texas made the first payments in April 2007. It is customary for CMS to review Medicaid UPL payment programs. In October 2007, the State of Texas halted all funding of its private hospital UPL programs due to the deferral by CMS of certain federal Medicaid payments to the State of Texas. In August 2008, CMS completed its review and the state lifted its moratorium on payments under this UPL program. Payments received under the Texas UPL program increased income before taxes by $0.2 million and $19.5 million during the years ended June 30, 2008 and 2009, respectively.

During our third quarter of fiscal 2009, the federal government approved federal matching funds for the Illinois PTA program. This program enables the state of Illinois to increase funding for its state Medicaid plan. Hospitals providing services to Medicaid enrollees receive funds directly from the state and then repay a portion of these proceeds to the state in the form of a provider tax assessment. We received $24.9 million of cash from this program during the year ended June 30, 2009, all of which increased revenues and $13.4 million of which was subsequently paid to the state in the form of a provider tax assessment and is included in non-income taxes in our consolidated statement of operations for the year ended June 30, 2009. The PTA program increased income before taxes by $11.5 million during the year ended June 30, 2009.

Accounts Receivable Collection Risks Leading to Increased Bad Debts

Similar to others in the hospital industry, we have a significant amount of self-pay receivables (including self-pay after primary), and collecting these receivables is difficult and may become more difficult if economic conditions worsen. The following table provides a summary of our accounts receivable payer class mix as of June 30, 2007, 2008 and 2009.

June 30, 2007	0-90 days	91-180 days	Over 180 days	Total
Medicare	15.0%	0.6%	0.6%	16.2%
Medicaid	7.5%	2.0%	1.0%	10.5%
Managed Medicare	7.6%	0.7%	0.6%	8.9%
Managed Medicaid	5.3%	0.6%	0.7%	6.6%
Managed Care	25.1%	2.7%	1.6%	29.4%
Self-Pay[1]	10.2%	8.0%	1.7%	19.9%
Self-Pay after primary[2]	1.8%	2.8%	1.1%	5.7%
Other	1.8%	0.6%	0.4%	2.8%
Total	74.3%	18.0%	7.7%	100.0%

June 30, 2008	0-90 days	91-180 days	Over 180 days	Total
Medicare	15.3%	0.6%	0.4%	16.3%
Medicaid	8.0%	2.2%	1.3%	11.5%
Managed Medicare	8.5%	0.6%	0.5%	9.6%
Managed Medicaid	5.6%	0.4%	0.3%	6.3%
Managed Care	25.8%	2.6%	1.9%	30.3%
Self-Pay[1]	9.3%	7.6%	1.1%	18.0%
Self-Pay after primary[2]	1.9%	2.6%	1.0%	5.5%
Other	1.6%	0.5%	0.4%	2.5%
Total	76.0%	17.1%	6.9%	100.0%

June 30, 2009	0-90 days	91-180 days	Over 180 days	Total
Medicare	15.6%	0.3%	0.3%	16.2%
Medicaid	6.7%	0.9%	1.0%	8.6%
Managed Medicare	10.0%	0.5%	0.3%	10.8%
Managed Medicaid	7.1%	0.5%	0.5%	8.1%
Managed Care	25.1%	2.3%	1.5%	28.9%
Self-Pay[1]	9.7%	8.1%	0.8%	18.6%
Self-Pay after primary[2]	2.1%	2.9%	0.9%	5.9%
Other	1.8%	0.6%	0.5%	2.9%
Total	78.1%	16.1%	5.8%	100.0%

(1) Includes uninsured only.
(2) Includes patient co-insurance and deductible amounts after payment has been received from the primary payer.

Our combined allowances for doubtful accounts, self-pay discounts and charity care covered 96.3% and 96.5% of combined self-pay and self-pay after primary accounts receivable as of June 30, 2008 and 2009, respectively.

The volume of self-pay accounts receivable remains sensitive to a combination of factors including price increases, acuity of services, higher levels of patient deductibles and co-insurance under managed care plans, economic factors and the increased difficulties of uninsured patients who do not qualify for charity care programs to pay for escalating healthcare costs. We have implemented policies and procedures designed to expedite upfront cash collections and promote repayment plans from our patients. However, we believe bad debts will remain a significant risk for us and the rest of the hospital industry in the near term.

Governmental and Managed Care Payer Reimbursement

Healthcare spending comprises a significant portion of total spending in the United States and has been growing at annual rates that exceed inflation, wage growth and gross national product. There is considerable pressure on governmental payers, managed Medicare/Medicaid payers and commercial managed care payers to control costs by either reducing or limiting increases in reimbursement to healthcare providers or limiting benefits to enrollees. The current economic recession has magnified these pressures. Lower than expected tax collections due to higher unemployment and depressed consumer spending have resulted in budget shortfalls for most states, including those in which we operate. Additionally, the demand for Medicaid coverage has increased due to job losses that have left many individuals without health insurance. To balance their budgets, many states, either directly or through their managed Medicaid programs, may enact healthcare spending cuts or defer cash payments to healthcare providers, since raising taxes is not a popular option during recessionary cycles. Further, the tightened credit markets have complicated the states' efforts to issue additional bonds to raise cash. During the year ended June 30, 2009, Medicaid and managed Medicaid programs accounted for approximately 17% of our net patient revenues. Managed care payers also face economic pressures during periods of economic weakness due to lower enrollment resulting from higher unemployment rates and the inability of individuals to afford private insurance coverage. These payers may respond to these challenges by reducing or limiting increases to healthcare provider reimbursement rates or reducing benefits to enrollees. During the year ended June 30, 2009, we recognized approximately 35% of our net patient revenues from managed care payers. If we do not receive increased payer reimbursement rates from governmental or managed care payers that cover the increasing cost of providing healthcare services to our patients or if governmental payers defer payments to our hospitals, our financial position, results of operations and cash flows could be materially adversely impacted.

Increased Costs of Compliance in a Heavily Regulated Industry

We conduct business in a heavily regulated industry. Accordingly, we maintain a comprehensive, company-wide compliance program to address healthcare regulatory and other compliance requirements. This compliance program includes, among other things, initial and periodic ethics and compliance training, a toll-free reporting hotline for employees, annual fraud and abuse audits and annual coding audits. The organizational structure of our compliance program includes oversight by our board of directors and a high-level corporate management compliance committee. Our Senior Vice President of Compliance and Ethics reports jointly to our Chairman and Chief Executive Officer and to our board of directors, serves as our Chief Compliance Officer and is charged with direct responsibility for the day-to-day management of our compliance program. We also have regional compliance officers in our markets that are 100% dedicated to compliance duties. The financial resources necessary for program oversight, internal enforcement and periodic improvements to our program continue to grow, especially when we add new features to our program or engage external resources to assist with these highly complex matters.

Premium Revenues

We recognize premium revenues from our three health plans, PHP, AAHP and MHP. PHP's membership increased to approximately 176,200 at June 30, 2009 compared to approximately 103,400 at June 30, 2008 primarily due to a new contract with Arizona Health Care Cost Containment System ("AHCCCS") that went into effect on October 1, 2008, as discussed below. Premium revenues from these three plans increased $227.8 million or 50.6% during the year ended June 30, 2009 compared to the prior year period.

In May 2008, PHP was awarded a new contract with AHCCCS effective for the three-year period beginning October 1, 2008 and ending September 30, 2011. AHCCCS has the option to renew the new contract, in whole or in part, for two additional one-year periods commencing on October 1, 2011 and on October 1, 2012. The new contract covers the three counties covered under the previous contract (Gila, Maricopa and Pinal) plus an additional six Arizona counties: Apache, Coconino, Mohave, Navajo, Pima and Yavapai. We experienced a significant increase in PHP membership and premium revenues during our second, third and fourth quarters of our fiscal year ended June 30, 2009 as a result of this new contract. The new contract utilizes a national episodic/diagnostic risk adjustment factor for non-reconciled enrollee risk groups, the calculation of which AHCCCS expects to finalize by September 30, 2009 and then apply retroactively to October 1, 2008, that was not part of PHP's previous AHCCCS contract. Our financial statements include an estimated reserve for the impact of this risk adjustment factor, and we will adjust the reserve as necessary once the calculation is finalized by AHCCCS. Given the State of Arizona's recent budget crisis and continued concerns about economic indicators during its 2010 fiscal year, AHCCCS could cut reimbursement rates, reduce enrollment, defer capitation payments, reduce or limit covered services or take other steps to reduce program expenditures including cancelling PHP's contract. Any of these actions could materially adversely impact our future results of operations, financial position or cash flows.

Critical Accounting Policies

Our consolidated financial statements have been prepared in accordance with accounting principles generally accepted in the United States. In preparing these financial statements, we make estimates and assumptions that affect the reported amounts of assets, liabilities, revenues and expenses included in the financial statements. Management bases its estimates on historical experience and other available information, the results of which form the basis of the estimates and assumptions. We consider the following accounting policies to be critical because they involve highly subjective and complex assumptions and assessments, are subject to a great degree of fluctuation period over period and are the most critical to our operating performance.

Revenues and Revenue Deductions

We recognize patient service revenues during the period the healthcare services are provided based upon estimated amounts due from payers. We record contractual adjustments to our gross charges to reflect expected reimbursement negotiated with or prescribed by third party payers. We estimate contractual adjustments and allowances based upon payment terms set forth in managed care health plan contracts and by federal and state regulations. For the majority of our patient service revenues, we apply contractual adjustments to patient accounts at the time of billing using specific payer contract terms entered into the accounts receivable systems, but in some cases we record an estimated allowance until payment is received. If our estimated contractual adjustments as a percentage of gross revenues were 1% higher for all insured accounts, our net revenues would have been reduced by approximately $79.0 million for the year ended June 30, 2009. We derive most of our patient service revenues from healthcare services provided to patients with Medicare (including managed Medicare plans) or managed care insurance coverage.

Services provided to Medicare patients are generally reimbursed at prospectively determined rates per diagnosis ("PPS"), while services provided to managed care patients are generally reimbursed based upon predetermined rates per diagnosis, per diem rates or discounted fee-for-service rates. Medicaid reimbursements vary by state. Other than Medicare, no individual payer represents more than 10% of our patient service revenues.

Medicare regulations and many of our managed care contracts are often complex and may include multiple reimbursement mechanisms for different types of services provided in our healthcare facilities. To obtain reimbursement for certain services under the Medicare program, we must submit annual cost reports and record estimates of amounts owed to or receivable from Medicare. These cost reports include complex calculations and estimates related to indirect medical education, disproportionate share payments, reimbursable Medicare bad debts and other items that are often subject to interpretation that could result in payments that differ from recorded estimates. We estimate amounts owed to or receivable from the Medicare program using the best information available and our interpretation of the applicable Medicare regulations. We include differences between original estimates and subsequent revisions to those estimates (including final cost report settlements) in our consolidated statements of operations in the period in which the revisions are made. Net adjustments for final third party settlements increased patient service revenues and income from continuing operations before income taxes by $6.3

million, $7.9 million and $8.0 million during the years ended June 30, 2007, 2008 and 2009, respectively. Additionally, updated regulations and contract negotiations with payers occur frequently, which necessitates continual review of revenue estimation processes by management. Management believes that future adjustments to its current third party settlement estimates will not materially impact our results of operations, cash flows or financial position.

Effective for service dates on or after April 1, 2009, as a result of a state mandate, we implemented a new uninsured discount policy for those patients receiving services in our Illinois hospitals who had no insurance coverage and who did not otherwise qualify for charity care under our guidelines. Under this policy, we apply an uninsured discount (calculated as a standard percentage of gross charges) at the time of patient billing and include this discount as a reduction to patient service revenues. These discounts were approximately $11.7 million for the year ended June 30, 2009. We implemented this policy for most of our remaining facilities effective July 1, 2009 and expect to implement it at all of our facilities by the end of our fiscal year 2010.

We do not pursue collection of amounts due from uninsured patients that qualify for charity care under our guidelines (currently those uninsured patients whose incomes are equal to or less than 200% of the current federal poverty guidelines set forth by the Department of Health and Human Services). We deduct charity care accounts from revenues when we determine that the account meets our charity care guidelines. We also provide discounts from billed charges and alternative payment structures for uninsured patients who do not qualify for charity care but meet certain other minimum income guidelines, primarily those uninsured patients with incomes between 200% and 500% of the federal poverty guidelines. During the past three fiscal years, a significant percentage of our charity care deductions represented services provided to undocumented aliens under the Section 1011 border funding reimbursement program. Border funding qualification has ended in Texas, and we expect that qualification will end sometime during our fiscal 2010 in Arizona and Illinois when funds appropriated to those states have been exhausted.

The following table provides a breakdown of our charity care deductions during the years ending June 30, 2007, 2008 and 2009, respectively (in millions).

	Year ended June 30,		
	2007	2008	2009
Total charity care deductions	$ 86.1	$ 86.1	$ 91.8
Border funding charity deductions, net of payments received	$ 19.4	$ 29.6	$ 34.9
Payments received for border funding accounts	$ 2.0	$ 3.8	$ 4.6

We record revenues related to the Illinois PTA program, as previously described, when the receipt of payment from the state entity is assured. For the Texas UPL program, as previously described, we recognize revenues that offset the expenses associated with the provision of charity care when the services are provided. We recognize federal match revenues under the Texas UPL program when payments are assured.

We earned premium revenues of $401.4 million, $450.2 million and $678.0 million during the years ended June 30, 2007, 2008 and 2009, respectively, from our health plans. Our health plans, PHP, AAHP and MHP, have agreements with AHCCCS, CMS and various health maintenance organizations ("HMOs"), respectively, to contract to provide medical services to subscribing participants. Under these agreements, our health plans receive monthly payments based on the number of HMO participants in MHP or the number and coverage type of enrollees in PHP and AAHP. Our health plans recognize the payments as revenues in the month in which members are entitled to healthcare services with the exception of AAHP Medicare Part D reinsurance premiums and low income subsidy cost sharing premiums that are recorded as a liability to fund future healthcare costs or else repaid to CMS.

Allowance for Doubtful Accounts and Provision for Doubtful Accounts

Our ability to collect the self-pay portions of our receivables is critical to our operating performance and cash flows. Our allowance for doubtful accounts was approximately 28.1% and 30.6% of accounts receivable, net of contractual discounts, as of June 30, 2008 and 2009, respectively. The primary collection risk relates to uninsured

patient accounts and patient accounts for which primary insurance has paid but patient deductibles or co-insurance portions remain outstanding.

We estimate our allowance for doubtful accounts using a standard policy that reserves all accounts aged greater than 365 days subsequent to discharge date plus percentages of uninsured accounts and self-pay after primary accounts less than 365 days old. We test our allowance for doubtful accounts policy quarterly using a hindsight calculation that utilizes write-off data for all payer classes during the previous twelve-month period to estimate the allowance for doubtful accounts at a point in time. We also supplement our analysis by comparing cash collections to net patient revenues and monitoring self-pay utilization. We adjust the standard percentages in our allowance for doubtful accounts reserve policy as necessary given changes in trends from these analyses. We most recently adjusted this reserve policy when we implemented our uninsured discount policy in Illinois. If our uninsured accounts receivable as of June 30, 2009 were 1% higher, our provision for doubtful accounts would have increased by $1.0 million. Significant changes in payer mix, business office operations, general economic conditions and healthcare coverage provided by federal or state governments or private insurers may have a significant impact on our estimates and significantly affect our liquidity, results of operations and cash flows.

Prior to the implementation of our new uninsured discount policy, we classified accounts pending Medicaid approval as Medicaid accounts in our accounts receivable aging report and recorded a contractual allowance for these accounts equal to the average Medicaid reimbursement rate for that specific state until qualification was confirmed at which time the account was netted in the aging. In the event an account did not successfully qualify for Medicaid coverage and did not meet our charity guidelines, the previously recorded Medicaid contractual adjustment remained a revenue deduction (similar to a self-pay discount), and the remaining net account balance was reclassified to uninsured status and subjected to our allowance for doubtful accounts policy. If accounts did not qualify for Medicaid coverage but did qualify as charity care, the contractual adjustments were reversed and the gross account balances was recorded as charity deductions.

Upon the implementation of our new uninsured discount policy, all uninsured accounts (including those pending Medicaid qualification) that do not qualify for charity care receive the standard uninsured discount. The balance of these accounts are subject to our allowance for doubtful accounts policy. For those accounts that subsequently qualify for Medicaid coverage, the uninsured discount is reversed and the account is reclassified to Medicaid accounts receivable with the appropriate contractual discount applied. Thus, the contractual allowance for Medicaid pending accounts is no longer necessary for those accounts subject to the uninsured discount policy. The following table provides the value of accounts pending Medicaid qualification, the balance successfully qualified for Medicaid coverage, the balance not qualified and transferred to uninsured status, the balance not qualified and transferred to charity and the percentage successfully qualified for Medicaid coverage during the respective fiscal years (dollars in millions).

	Fiscal Year June 30, 2008			Fiscal Year June 30, 2009		
	Accounts prior to uninsured discount policy	Accounts subject to uninsured discount policy	Total	Accounts prior to uninsured discount policy	Accounts subject to uninsured discount policy	Total
Medicaid pending accounts receivable balance	$ 12.5	$ –	$ 12.5	$ 12.5	$ 3.3	$ 15.8
Medicaid pending accounts successfully qualified	$ 22.5	$ –	$ 22.5	$ 23.5	$ –	$ 23.5
Medicaid pending accounts not qualified (uninsured)	$ 25.1	$ –	$ 25.1	$ 29.4	$ 0.2	$ 29.6
Medicaid pending accounts not qualified (charity)	$ 7.2	$ –	$ 7.2	$ 8.0	$ –	$ 8.0
Medicaid pending qualification success percentage			41%			39%

Because we require patient verification of coverage at the time of admission, reclassifications of Medicare or managed care accounts to self-pay, other than patient coinsurance or deductible amounts, occur infrequently and are not material to our financial statements. Additionally, the impact of these classification changes is further limited by our ability to identify any necessary classification changes prior to patient discharge or soon thereafter. Due to information system limitations, we are unable to quantify patient deductible and co-insurance receivables that are included in the primary payer classification in the accounts receivable aging report at any given point in time. When classification changes occur, the account balance remains aged from the patient discharge date.

Insurance Reserves

As of June 30, 2008, we maintained a self-insured medical plan for a limited number of our employees. Claims were accrued under the self-insured plan as the incidents that gave rise to them occurred. Unpaid claims accruals were based on the estimated ultimate cost of settlement, including claim settlement expenses, in accordance with an average lag time and historical experience. Effective July 1, 2008, we began covering all of our employees under a self-insured medical plan, which subjected us to significantly higher risks and reserve levels.

Due to the nature of our operating environment, we are subject to professional and general liability and workers compensation claims and related lawsuits in the ordinary course of business. For professional and general liability claims incurred from June 1, 2002 to May 31, 2006, our wholly owned captive subsidiary insured our professional and general liability risks at a $10.0 million retention level. For professional and general liability claims incurred subsequent to May 31, 2006 through June 30, 2009, we self-insured the first $9.0 million per claim, and the captive subsidiary insured the next $1.0 million per claim. We maintain excess coverage from independent third party insurers on a claims-made basis for individual claims exceeding $10.0 million up to $75.0 million, but limited to total annual payments of $65.0 million in the aggregate.

We insure our excess professional and general liability coverage under a retrospectively rated policy, and premiums under this policy are recorded at the minimum premium amount unless our claims experience leads us to believe that a higher premium applies. We self-insure our workers compensation claims up to $1.0 million per claim and purchase excess insurance coverage for claims exceeding $1.0 million.

The following tables summarize our employee health, professional and general liability and workers compensation reserve balances (including the current portions of such reserves) as of June 30, 2008 and 2009 and claims loss and claims payment information during the years ended June 30, 2007, 2008 and 2009.

	Employee Health	Professional and General Liability	Workers Compensation
		(in millions)	
Reserve balance:			
June 30, 2006	$ 1.6	$ 58.8	$ 15.3
June 30, 2007	$ 1.2	$ 64.6	$ 18.5
June 30, 2008	$ 1.5	$ 74.3	$ 18.8
June 30, 2009	$ 13.4	$ 92.9	$ 18.2
Current year provision for claims losses:			
Fiscal year 2007	$ 6.8	$ 24.7	$ 9.4
Fiscal year 2008	$ 7.3	$ 22.4	$ 7.6
Fiscal year 2009	$ 93.2	$ 22.2	$ 7.8
Adjustments to prior year claims losses:			
Fiscal year 2007	$ –	$ (4.5)	$ –
Fiscal year 2008	$ –	$ (0.6)	$ (2.3)
Fiscal year 2009	$ (0.6)	$ 13.4	$ (3.8)
Claims paid related to current year:			
Fiscal year 2007	$ 6.0	$ 0.2	$ 1.3
Fiscal year 2008	$ 5.8	$ 0.1	$ 1.0
Fiscal year 2009	$ 79.8	$ 0.3	$ 1.6
Claims paid related to prior years:			
Fiscal year 2007	$ 1.2	$ 14.2	$ 4.9
Fiscal year 2008	$ 1.2	$ 12.0	$ 4.0
Fiscal year 2009	$ 0.9	$ 16.7	$ 3.0

In developing our estimates of our reserves for employee health, professional and general liability and workers compensation claims, we utilize actuarial and certain case-specific information. Each reserve is comprised of

estimated indemnity and expense payments related to: 1) reported events ("case reserves") and 2) incurred but not reported ("IBNR") events as of the end of the period. Management uses information from its human resource and risk managers and its best judgment to estimate case reserves. Actuarial IBNR estimates are dependent on multiple variables including our risk exposures, our self-insurance limits, geographic locations in which we operate, the severity of our historical losses compared to industry averages and the reporting pattern of our historical losses compared to industry averages, among others. Most of these variables require judgment, and changes in these variables could result in significant period over period fluctuations in our estimates. We discount our workers compensation reserve using actuarial estimates of projected cash payments in future periods (approximately 5.0% for each of the past three fiscal years). We do not discount our professional and general liability reserve. We adjust these reserves from time to time as we receive updated information.

In April 2009, a jury awarded damages to the plaintiff in a professional liability case against one of our hospitals in the amount of approximately $14.9 million, which exceeded our captive subsidiary's $10.0 million self insured limit. Based upon this verdict, we increased our professional and general liability reserve by the excess of the verdict amount over our previously established case reserve estimate and recorded a receivable from our captive subsidiary's third party excess carrier for that portion exceeding $10.0 million. We then reduced this receivable by the additional premium due to the excess carrier under our retrospectively rated insurance policy for that particular policy year. These developments resulted in an increase to insurance expense of approximately $11.9 million during the year ended June 30, 2009. We appealed this verdict since most of the verdict represented non-economic damages like pain and suffering, but we can not predict whether or not the verdict will be reduced at this time.

Our best estimate of professional and general liability and workers compensation IBNR utilizes statistical confidence levels that are below 75%. Using a higher statistical confidence level, while not permitted under United States generally accepted accounting principles, would increase the estimated reserve. The following table illustrates the sensitivity of the reserve estimates at 75% and 90% confidence levels.

	Professional and General Liability	Workers Compensation
	(in millions)	
June 30, 2008 reserve:		
As reported	$ 74.3	$ 18.8
With 75% Confidence Level	$ 85.7	$ 21.5
With 90% Confidence Level	$ 97.2	$ 23.8
June 30, 2009 reserve:		
As reported	$ 92.9	$ 18.2
With 75% Confidence Level	$ 104.9	$ 21.2
With 90% Confidence Level	$ 116.9	$ 23.8

Our best estimate of employee health claims IBNR relies primarily upon payment lag data. If our estimate of the number of unpaid days of employee health claims expense changed by 5 days, our employee health IBNR estimate would change by approximately $1.3 million.

Health Plan Claims Reserves

During the years ended June 30, 2007, 2008 and 2009, medical claims expense was $297.0 million, $328.2 million and $525.6 million, respectively, primarily representing medical claims of PHP. Vanguard estimates PHP's reserve for medical claims using historical claims experience (including cost per member and payment lag time) and other actuarial data including number of enrollees and certain enrollee demographic information. The following table provides the health plan reserve balances as of June 30, 2008 and 2009 and health plan claims and payment information during the years ended June 30, 2007, 2008 and 2009, respectively (in millions).

	Year ended June 30,		
	2007	2008	2009
Health plan reserves, beginning of year	$ 46.6	$ 61.4	$ 51.1
Current year provision for health plan claims	293.9	329.7	525.5
Current year adjustments to prior year health plan claims	3.1	(1.5)	0.1
Program settlement, capitation and other activity	(9.7)	(24.2)	19.3
Claims paid related to current year	(231.2)	(268.4)	(424.6)
Claims paid related to prior years	(41.3)	(45.9)	(53.8)
Health plan reserves, end of year	$ 61.4	$ 51.1	$ 117.6

The increases in reserves, claims losses and claims payments from 2008 to 2009 were primarily due to the significant increase in enrollees during the current year period as a result of the new AHCCCS contract that went into effect on October 1, 2008. While management believes that its estimation methodology effectively captures trends in medical claims costs, actual payments could differ significantly from its estimates given changes in the healthcare cost structure or adverse experience. During the years ended June 30, 2007, 2008 and 2009, approximately $34.2 million, $31.2 million and $34.0 million, respectively, of accrued and paid claims for services provided to our health plan enrollees by our hospitals and our other healthcare facilities were eliminated in consolidation. Our operating results and cash flows could be materially affected by increased or decreased utilization of our healthcare facilities by enrollees in our health plans.

Income Taxes

We believe that our income tax provisions are accurate and supportable, but certain tax matters require interpretations of tax law that may be subject to future challenge and may not be upheld under tax audit. To reflect the possibility that all of our tax positions may not be sustained, we maintain tax reserves that are subject to adjustment as updated information becomes available or as circumstances change. We record the impact of tax reserve changes to our income tax provision in the period in which the additional information, including the progress of tax audits, is obtained.

We assess the realization of our deferred tax assets to determine whether an income tax valuation allowance is required. Based on all available evidence, both positive and negative, and the weight of that evidence to the extent such evidence can be objectively verified, we determine whether it is more likely than not that all or a portion of the deferred tax assets will be realized. The factors used in this determination include the following:

- Cumulative losses in recent years
- Income/losses expected in future years
- Unsettled circumstances that, if favorably resolved, would adversely affect future operations
- Availability, or lack thereof, of taxable income in prior carryback periods that would limit realization of tax benefits
- Carryforward period associated with the deferred tax assets and liabilities
- Prudent and feasible tax planning strategies

In addition, financial forecasts used in determining the need for or amount of federal and state valuation allowances are subject to changes in underlying assumptions and fluctuations in market conditions that could significantly alter our recoverability analysis and thus have a material adverse effect on our consolidated financial condition, results of operations or cash flows. Effective July 1, 2007, we adopted the provisions of FASB Interpretation No. 48, *Accounting for Uncertainty in Income Taxes – An Interpretation of FASB Statement No. 109* ("FIN 48"). The following table provides the detail comprising our FIN 48 net liability from the date of adoption through June 30, 2009 (in millions).

Reclassification from income taxes payable	$	0.3
Increase to non-current deferred tax assets		2.7
Cumulative impact of change recorded to retained earnings		(2.6)
Opening balance at July 1, 2007	$	0.4
Additions for tax provisions of prior years		0.2
Balance at June 30, 2008	$	0.6
Additions for tax positions of prior years		2.9
Reductions for tax positions of prior years		(0.3)
Balance at June 30, 2009	$	3.2

The provisions of FIN 48 allow for the classification election of interest on an underpayment of income taxes, when the tax law requires interest to be paid, and penalties, when a tax position does not meet the minimum statutory threshold to avoid payment of penalties, in income taxes, interest expense or another appropriate expense classification based on the accounting policy election of the entity. We elected to continue our historical practice of classifying interest and penalties as a component of income tax expense. All $3.2 million of the unrecognized tax benefits, if recognized, would impact the effective tax rate.

Long-Lived Assets and Goodwill

Long-lived assets, including property, plant and equipment and amortizable intangible assets, comprise a significant portion of our total assets. We evaluate the carrying value of long-lived assets when impairment indicators are present or when circumstances indicate that impairment may exist under the provisions of SFAS 144, *Accounting for the Impairment or Disposal of Long-Lived Assets*. When management believes impairment indicators may exist, projections of the undiscounted future cash flows associated with the use of and eventual disposition of long-lived assets held for use are prepared. If the projections indicate that the carrying values of the long-lived assets are not recoverable, we reduce the carrying values to fair value. In May 2009, we recorded a $6.2 million ($3.8 million net of taxes) impairment charge to write-down the value of a building that we currently lease to other healthcare service providers to fair value. For long-lived assets held for sale, we compare the carrying values to an estimate of fair value less selling costs to determine potential impairment. We test for impairment of long-lived assets at the lowest level for which cash flows are measurable. These impairment tests are heavily influenced by assumptions and estimates that are subject to change as additional information becomes available. Given the relatively few number of hospitals we own and the significant amounts of long-lived assets attributable to those hospitals, an impairment of the long-lived assets for even a single hospital could materially adversely impact our operating results or financial position.

Goodwill also represents a significant portion of our total assets. We review goodwill for impairment annually during our fourth fiscal quarter or more frequently if certain impairment indicators arise under the provisions of SFAS 142, *Goodwill and Other Intangible Assets*. We review goodwill at the reporting level unit, which is one level below an operating segment. We review the carrying value of the net assets of each reporting unit to the net present value of estimated discounted future cash flows of the reporting unit. If the carrying value exceeds the net present value of estimated discounted future cash flows, an impairment indicator exists and an estimate of the impairment loss is calculated. The fair value calculation includes multiple assumptions and estimates, including the projected cash flows and discount rates applied. Changes in these assumptions and estimates could result in goodwill impairment that could materially adversely impact our financial position or results of operations. In December 2006, we recorded a goodwill impairment charge in the amount of $123.8 million ($110.5 million, net of tax benefit) related to our Chicago hospitals.

We completed our annual goodwill impairment test during the fourth quarter of fiscal 2009 noting no impairment. However, we will continue to closely monitor the operations of our Chicago hospitals reporting unit, which has goodwill of approximately $43.0 million, due to the sensitivity of the projected operating results of this reporting unit to the goodwill impairment analysis. If projected future cash flows become less favorable than those

projected by management, an additional impairment charge relating to our Chicago hospitals may become necessary that could have a material adverse impact on our financial position and results of operations.

Selected Operating Statistics

The following table sets forth certain operating statistics for the periods indicated below.

	Year Ended June 30,		
	2007	2008	2009
Number of hospitals at end of period	15	15	15
Number of licensed beds at end of period	4,143	4,181	4,135
Discharges (a)	166,873	169,668	167,880
Adjusted discharges - hospitals (b)	264,698	270,076	274,767
Adjusted discharges (c)	278,820	284,680	289,997
Net revenue per adjusted discharge-hospitals (d)	$ 7,766	$ 8,110	$ 8,623
Net revenue per adjusted discharge (e)	$ 7,690	$ 8,059	$ 8,517
Patient days (f)	721,832	734,838	709,952
Average length of stay (days) (g)	4.3	4.3	4.2
Inpatient surgeries (h)	37,227	37,538	37,970
Outpatient surgeries (i)	76,606	73,339	76,378
Emergency room visits (j)	572,946	588,246	605,729
Occupancy rate (k)	48.2%	48.0%	47.0%
Member lives (l)	145,600	149,600	218,700
Health plan claims expense percentage (m)	74.0%	72.9%	77.5%

(a) Discharges represent the total number of patients discharged (in the facility for a period in excess of 23 hours) from our hospitals and is used by management and certain investors as a general measure of inpatient volumes.

(b) Adjusted discharges-hospitals is used by management and certain investors as a general measure of combined hospital inpatient and hospital outpatient volumes. Adjusted discharges-hospitals is computed by multiplying discharges by the sum of gross hospital inpatient revenues and gross hospital outpatient revenues and then dividing the result by gross hospital inpatient revenues.

(c) Adjusted discharges is used by management and certain investors as a general measure of consolidated inpatient and outpatient volumes. Adjusted discharges is computed by multiplying discharges by the sum of gross inpatient revenues and gross outpatient revenues and then dividing the result by gross inpatient revenues.

(d) Net revenue per adjusted discharge-hospitals is calculated by dividing net hospital patient revenues by adjusted discharge-hospitals and measures the average net payment expected to be received for a patient's stay in the hospital.

(e) Net revenue per adjusted discharge is calculated by dividing net patient revenues by adjusted discharges and measures the average net payment expected to be received for an episode of service provided to a patient.

(f) Patient days represent the number of days (calculated as overnight stays) our beds were occupied by patients during the periods.

(g) Average length of stay represents the average number of days an admitted patient stays in our hospitals.

(h) Inpatient surgeries represent the number of surgeries performed in our hospitals where overnight stays are necessary.

(i) Outpatient surgeries represent the number of surgeries performed at hospitals or ambulatory surgery centers on an outpatient basis (patient overnight stay not necessary).

(j) Emergency room visits represent the number of patient visits to a hospital emergency room where treatment is received, regardless of whether an overnight stay is subsequently required.

(k) Occupancy rate represents the percentage of hospital licensed beds occupied by patients. Occupancy rate provides a measure of the utilization of inpatient beds.

(l) Member lives represent the total number of enrollees in PHP, AAHP and MHP as of the end of the respective period.

(m) Health plan claims expense percentage is calculated by dividing health plan claims expense by premium revenues.

Results of Operations

The following tables present a summary of our operating results for the respective periods shown.

	Year Ended June 30,					
	2007		2008		2009	
	Amount	%	Amount	%	Amount	%
	(Dollars in millions)					
Patient service revenues	$ 2,179.3	84.4%	$ 2,340.5	83.9%	$ 2,521.7	78.8%
Premium revenues	401.4	15.6	450.2	16.1	678.0	21.2
Total revenues	2,580.7	100.0	2,790.7	100.0	3,199.7	100.0
Salaries and benefits (includes stock compensation of $1.2, $2.5 and $4.4 respectively)	1,067.9	41.4	1,152.7	41.3	1,240.1	38.7
Health plan claims expense	297.0	11.5	328.2	11.8	525.6	16.4
Supplies	421.8	16.4	434.5	15.5	456.3	14.3
Provision for doubtful accounts	175.2	6.8	205.6	7.4	210.8	6.6
Other operating expenses	375.0	14.5	405.8	14.5	468.9	14.6
Depreciation and amortization	118.6	4.6	131.0	4.7	130.6	4.1
Interest, net	123.8	4.8	122.1	4.4	111.6	3.5
Impairment loss	123.8	4.8	–	0.0	6.2	0.2
Other expenses	2.8	0.1	9.5	0.3	5.9	0.2
Income (loss) from continuing operations before income taxes	(125.2)	(4.9)	1.3	0.1	43.7	1.4
Income tax expense (benefit)	(11.6)	(0.5)	1.7	0.1	16.0	0.5
Income (loss) from continuing operations	(113.6)	(4.4)	(0.4)	0.0	27.7	0.9
Income (loss) from discontinued operations, net of taxes	(19.1)	(0.7)	(0.3)	0.0	0.9	0.0
Net income (loss)	$ (132.7)	(5.1)%	$ (0.7)	0.0%	$ 28.6	0.9%

Year Ended June 30, 2009 Compared to the Year Ended June 30, 2008

Revenues. Patient service revenues increased 7.7% year over year primarily as a result of a 5.7% increase in patient revenues per adjusted discharge and a 1.9% increase in adjusted discharges. Total outpatient volumes increased year over year, including a 3.0% and 4.1% increase in emergency room visits and outpatient surgeries, respectively. Our volumes by payer remained relatively consistent during both years. However, our combined Medicaid and managed Medicaid net revenues as a percentage of total net revenues increased to 16.7% during the current year compared to 15.1% during the prior year, primarily as a result of the increase in Texas UPL and Illinois PTA revenues previously discussed. The acuity level of our patients also increased year over year. However, during the current year, we continued to generate most of our admissions from emergency room visits and experienced lower elective admissions. Patients often elect to defer elective procedures when general economic conditions are weak. We also face continued intense competition from other hospitals to recruit and retain the best physicians to practice in our facilities. Further improvement in our operating results will depend on our ability to increase elective inpatient and outpatient business to maintain a favorable payer mix. We believe our quality initiatives will be the catalyst for long-term revenue growth, especially given the forecasted population growth for most of the markets in which we operate. However, environmental factors outside our control, including patient demand, potential healthcare reform, deterioration of general economic conditions, payer pressures and increased competition could limit our future revenue growth.

Premium revenues increased $227.8 million or 50.6% during the current year as a result of higher enrollment at PHP compared to the prior year. PHP's new contract with AHCCCS began on October 1, 2008, and average enrollment increased from 101,435 during the prior year to 150,468 during the current year. PHP was awarded six new counties under the new contract in addition to the three counties served under the prior AHCCCS contract.

We continue to implement our quality of care initiatives and streamline our processes from admission to discharge to provide our patients effective healthcare solutions in an efficient manner. Part of this process includes identifying the optimal service line mix that both meets the needs of our patients and improves our operating results. The success of these objectives depends on our ability to engage our nursing workforce, recruit and retain physicians

who share our commitment to quality, strengthen the primary care infrastructure for our hospitals and complete capital improvements projects including advanced clinical systems in a timely manner.

Costs and Expenses. Total costs and expenses from continuing operations, exclusive of income taxes, were $3,156.0 million or 98.6% of total revenues during the current year, compared to 99.9% during the prior year. Salaries and benefits, supplies, health plan claims and provision for doubtful accounts represent the most significant of our normal costs and expenses and those typically subject to the greatest level of fluctuation period over period.

- **Salaries and benefits**. Salaries and benefits as a percentage of total revenues decreased to 38.7% during the current year from 41.3% during the prior year. This ratio was positively impacted by the significant increase in premium revenues, which utilize a much lower rate of salaries and benefits than acute care services, during the current year compared to the prior year and by the increase in Texas UPL and Illinois PTA revenues during the current year compared to the prior year. Salaries and benefits as a percentage of acute care segment revenues were 47.2% during the current year compared to 47.8% during the prior year, which improvement was primarily attributable to the Texas UPL and Illinois PTA revenues growth during the current year.

  These ratios were adversely impacted during the current year by our investments in physician services and quality initiatives. We continue to employ more physicians to support the communities our hospitals serve and have added significant corporate resources during the past year to manage and oversee the physician growth. Implementation of our quality initiatives have also resulted in additional labor costs associated with training staff to utilize new clinical quality systems and additional hospital and corporate resources to monitor and manage quality indicators. As of June 30, 2009, we had approximately 19,200 full-time and part-time employees compared to 18,500 as of June 30, 2008. Our contract labor expense as a percentage of patient service revenues decreased to 2.6% for the current year compared to 3.5% for the prior year. We have been successful in our nurse recruiting and retention initiatives during the current year, much of which we attribute to our commitment to delivering quality patient care. While the national nursing shortage has abated to some degree during the current year as a result of weakened economic conditions, shortages in certain pockets of the communities we serve still exist. We expect that our nurse leadership program will help mitigate this risk.

- **Supplies**. Supplies as a percentage of total revenues decreased to 14.3% during the current year compared to 15.5% during the prior year. Supplies as a percentage of patient service revenues decreased to 18.1% during the current year quarter compared to 18.6% during the prior year. The increase in Texas UPL and Illinois PTA revenues during the current year quarter accounted for approximately half of this improvement. Although the acuity of our services provided increased during the current year compared to the prior year, we were successful in limiting the ratio of supplies to patient service revenues by further implementing certain supply chain initiatives such as increased use of our group purchasing contract and pharmacy formulary management. Because our growth strategies include expansion of higher acuity services and due to inflationary pressures on medical supplies and pharmaceuticals, our ability to reduce this ratio in future periods may be limited.

- **Health plan claims**. Health plan claims expense as a percentage of premium revenues increased to 77.5% during the current year compared to 72.9% during the prior year. The new PHP contract resulted in a significant change in the mix of our AHCCCS enrollees with a significant increase in enrollees in geographic areas not previously served by PHP. As a result of the bid process for these new areas, the rates paid to providers in those six new counties and capitated payment rates received from AHCCCS for those counties were not necessarily the same as those applicable to the three counties previously served by PHP. Also, the additional PHP revenues diluted the impact of the third party administrator revenues at MHP that have no corresponding medical claims expense. We could experience changes in this ratio during upcoming quarters as we receive more PHP historical claims payment information, especially for the new counties where service began on October 1, 2008. During fiscal 2009, we accrued for the estimated amount payable to AHCCCS for the risk adjustment factor payment methodology that will be retroactively applied to October 1, 2008, which also caused the health plan claims expense as a percentage of premium revenues to increase during the current year.

Health plan claims expense represents the amounts paid by the health plans for healthcare services provided to their members, including an estimate of incurred but not yet reported claims that is determined based upon lag data and other actuarial assumptions. Revenues and expenses between the health plans and our hospitals and related outpatient service providers of approximately $34.0 million, or 6.1% of gross health plan claims expense, were eliminated in consolidation during the current year.

- **Provision for doubtful accounts**. The provision for doubtful accounts as a percentage of patient service revenues decreased to 8.4% during the current year from 8.8% during the prior year. On a combined basis, the provision for doubtful accounts, uninsured discounts and charity care deductions as a percentage of patient service revenues was 12.0% for both the current year and prior year periods. During the current year, our self-pay revenues as a percentage of net patient revenues decreased to 8.2% compared to 8.6% during the prior year. We have also experienced improved upfront cash collections and success in qualifying patients for coverage under Medicaid or similar programs. We utilized hindsight testing analysis, cash collections data and other metrics to conclude that our policies adequately provided for uncompensated care during the year ended June 30, 2009. Our combined allowances for doubtful accounts, uninsured discounts and charity care as of June 30, 2009 represented 96.5% of total self-pay accounts receivable compared to 96.3% as of June 30, 2008. We expect our bad debts ratios to remain sensitive to environmental factors including deteriorating economic conditions that could result in a greater number of uninsured patients and increased difficulty for patients to pay their co-payment and deductible balances.

Other operating expenses. Other operating expenses include, among others, purchased services, insurance, non-income taxes, rents and leases, repairs and maintenance and utilities. Other operating expenses as a percentage of total revenues increased to 14.6% during the current year compared to 14.5% during the prior year. Other operating expenses as a percentage of patient service revenues increased to 18.6% during the current year compared to 17.3% during the prior year. In April 2009, a jury awarded damages to the plaintiff in a professional liability case against one of our hospitals in the amount of approximately $14.9 million, which exceeded our captive insurance subsidiary's $10.0 million self-insured limit. Based upon this verdict, we recognized additional insurance expense of $11.9 million during the current year representing the amount necessary to reach our captive's self-insured limit plus additional premiums due to the third party excess coverage carrier under our retrospectively rated insurance policy with that carrier. Also, non-income taxes increased by $23.9 million during the current year primarily as a result of $13.4 million of Illinois PTA program cash receipts that were subsequently paid to the state in the form of a provider tax and higher premiums taxes related to the significant enrollment growth at PHP.

Other. Depreciation and amortization was flat year over year. Net interest decreased by $10.5 million during the current year primarily due to lower interest rates on the variable portion of our term debt. We incurred an impairment loss of $6.2 million ($3.8 million, net of taxes) during the current year resulting from the write-down of a non-hospital building to fair value.

Income taxes. Our effective tax rate was approximately 36.6% during the current year. Income taxes during the prior year were not significant.

Net income. Net income increased by $29.3 million during the current year compared to the prior year primarily due to improved operating results both from our acute care services and health plan segments.

Year Ended June 30, 2008 Compared to the Year Ended June 30, 2007

Revenues. Patient service revenues increased 7.4% year over year primarily as a result of a 4.8% increase in patient revenues per adjusted discharge and a 2.1% increase in adjusted discharges. Total outpatient volumes increased year over year, including a 2.7% increase in emergency room visits, although outpatient surgeries decreased year over year. We experienced positive year over year payer mix shifts highlighted by an increase in combined Medicare and managed Medicare volumes compared to a decrease in combined Medicaid and managed Medicaid volumes. The acuity level of our patients also increased year over year. However, we continued to generate most of our inpatient stays from emergency room visits and struggled to improve our elective admissions.

Premium revenues increased 12.2% during fiscal 2008 primarily as a result of a 5.7% in year over year annual membership at PHP and a capitation rate increase that went into effect for PHP as of October 1, 2007. PHP's membership increased as a result of a greater number of AHCCCS-eligible residents as a result of weakened general economic conditions and a greater allocation of the AHCCCS enrollees to PHP.

Costs and Expenses. Total costs and expenses, exclusive of income taxes and discontinued operations, were $2,789.4 million or 99.9% of total revenues during fiscal 2008 compared to 104.9% during fiscal 2007. Fiscal 2007 costs and expenses were negatively impacted by the $123.8 million impairment loss related to our Chicago hospitals. Salaries and benefits, supplies, medical claims and provision for doubtful accounts represent our most significant individual costs and expenses or those subject to the greatest level of fluctuation period over period.

- **Salaries and benefits**. Salaries and benefits as a percentage of total revenues were relatively flat period over period. Excluding the growth in our health plan operations, salaries and benefits would have increased to 42.0% during fiscal 2008 compared to the 41.4% during the prior year. The national nursing shortage, which was particularly prevalent in Phoenix, hindered our ability to fully manage salaries and benefits costs. Even with the nursing shortage in Phoenix, we made progress in stabilizing our nurse workforce in Phoenix to reduce contract labor utilization. We incurred a significant increase in period over period salaries and benefits costs in our Massachusetts hospitals primarily resulting from requirements set forth in our collective bargaining agreement ratified with the nurses union at St. Vincent Hospital.

- **Supplies**. Supplies as a percentage of total revenues decreased from 16.3% during fiscal 2007 to 15.5% during fiscal 2008. Supplies as a percentage of patient service revenues decreased to 18.6% during fiscal 2008 compared to 19.4% during fiscal 2007. Fiscal 2008 was the first full year that certain of our supply chain corporate initiatives were fully implemented. These initiatives included formulary refinements, standardization of commodities and supplies reprocessing and improved compliance with our group purchasing contract. Effective May 2008, we renewed our group purchasing contract with HealthTrust Purchasing Group for an additional five years.

- **Health plan claims expense**. Health plan claims expense as a percentage of premium revenues decreased from 74.0% during fiscal 2007 to 72.9% during fiscal 2008. Capitation revenues for our health plans increased at a greater rate year over year than did the utilization of medical services by our health plans' enrollees. Health plan claims expense represents the amounts paid by health plans for healthcare services provided to their members, including an estimate of incurred but not reported claims that is determined based upon lag data and other actuarial assumptions. Revenues and expenses between the health plans and our hospitals and related outpatient service providers of approximately $31.2 million, or 8.7% of gross health plan claims expense, were eliminated in consolidation during fiscal 2008 compared to $34.2 million or 10.3% of gross health plan claims expense during fiscal 2007.

- **Provision for doubtful accounts**. During fiscal 2008, the provision for doubtful accounts as a percentage of patient service revenues increased to 8.8% from 8.0% during fiscal 2007. During fiscal 2008, our self-pay discharges as a percentage of total discharges decreased to 3.5% from 3.7% during fiscal 2007. However, price increases at our hospitals and increased levels of patient co-insurance and deductibles under managed care plans increased our exposure to uncollectible revenues. The previously discussed change in our allowance for doubtful accounts policy during fiscal 2008 resulted in a higher provision for doubtful accounts as a percentage of patient service revenues during fiscal 2008 compared to fiscal 2007. Our provision for doubtful accounts as a percentage of patient service revenues is reduced by our policy of deducting charity accounts from revenues at the time in which those accounts meet our charity care guidelines. On a combined basis, the provision for doubtful accounts and charity care deductions as a percentage of patient service revenues increased to 12.5% during fiscal 2008 compared to 12.0% during fiscal 2007.

Other operating expenses. Other operating expenses include, among others, purchased services, insurance, non-income taxes, rents and leases, repairs and maintenance and utilities. Other operating expenses as a percentage of total revenues were flat year over year. We incurred higher physician recruiting costs, higher repairs and

maintenance costs related to the implementation of our clinical information systems in our hospitals and higher utilities costs during 2008 compared to 2007.

Other. Depreciation and amortization as a percentage of total revenues increased to 4.7% during fiscal 2008 compared to 4.6% during fiscal 2007 as a result of our capital improvement and expansion initiatives. Portions of our clinical quality systems were placed into service during fiscal 2008, and fiscal 2008 was the first full year in which all of our previous significant expansion projects in Phoenix and San Antonio had been fully in service. The decrease in net interest as a percentage of total revenues to 4.4% during fiscal 2008 compared to 4.8% during fiscal 2007 resulted primarily from the increase in total revenues during fiscal 2008 compared to fiscal 2007 without additional debt borrowings.

Income taxes. Income taxes were not significant during fiscal 2008. The effective tax rate for fiscal 2007 was 9.3% due to the majority of the impairment loss being nondeductible for tax purposes.

Discontinued operations. Our loss from discontinued operations was not significant during the fiscal year ended June 30, 2008 due to the winding down of operations at PMH compared to fiscal 2007 when PMH operated as an acute care hospital for the majority of the fiscal year.

Net loss. The $132.0 million year over year decrease in net loss resulted primarily from the improved operating results during fiscal 2008 and the after tax impact of the impairment loss recorded during fiscal 2007.

Liquidity and Capital Resources

Operating Activities

At June 30, 2009, we had working capital of $251.6 million, including cash and cash equivalents of $308.2 million. Working capital at June 30, 2008 was $217.8 million. Cash provided by operating activities increased $135.1 million during the year ended June 30, 2009 compared to the prior year. The increase in operating cash flows was primarily due to improved net cash collections of accounts receivable, the impact of the significant enrollee growth at PHP on capitation payments received from AHCCCS and the timing of claims payments made for new members, the timing of claims payments related to the expansion of our self-insured employee medical plan, the increase in net payments received under the Bexar County, Texas UPL program and the Illinois PTA program and improved operating results during the year ended June 30, 2009 compared to the prior year. Net accounts receivable days decreased by approximately 6 days to 45 days at June 30, 2009 compared to 51 days at June 30, 2008.

Investing Activities

Cash used in investing activities decreased from $143.8 million during the prior year to $133.6 million during the current year, primarily as a result of net $26.3 million purchases of auction rate securities during the prior year that we continued to hold during the current year. Capital expenditures increased $10.5 million during the current year compared to the prior year.

We anticipate spending a total of $180.0 million to $200.0 million in capital expenditures during fiscal 2010 This estimated range includes $71.0 million of replacement, regulatory or maintenance capital and $129.0 million of combined information technology upgrades and other discretionary initiatives. We could choose to defer or cancel most of the information technology and discretionary capital projects included in our fiscal year 2010 capital expenditures estimate should we need to conserve cash, avoid debt covenant violations or for other reasons. Any decision to defer or cancel such capital projects, while providing some short-term benefits, could have negative long-term implications to our operating results and cash flows.

We expect to fund our fiscal 2010 capital expenditures with cash on hand and cash flows from operations. We also have $218.8 million available under our revolving credit facility as of June 30, 2009. We believe our current capital expenditure program is sufficient to service, expand and improve our existing facilities to meet our quality objectives and growth strategies.

Financing Activities

Cash flows used in financing activities were flat year over year. As of June 30, 2009, we had outstanding $1,551.6 million in aggregate indebtedness. Our liquidity requirements are significant, primarily due to debt service requirements. The 9.0% Notes require semi-annual interest payments until their maturity in September 2014. The indenture related to the 9.0% Notes contains a customary restricted payments covenant that restricts certain of our cash payments, including repurchase or redemption prior to maturity of the 11.25% Notes. This covenant restriction does not apply to cash interest payments for the 11.25% Notes. However, at June 30, 2009, we would be able to expend up to approximately $143.0 million free of any such restrictions pursuant to the general restricted payment basket provisions set forth in this covenant. Through October 1, 2009, our interest expense on the 11.25% Notes consists solely of non-cash accretions of principal. Commencing April 1, 2010 through the maturity of the 11.25% Notes in September 2015, we will make semi-annual cash interest payments under the 11.25% Notes.

Our $766.4 million outstanding term loan borrowings bear interest at a rate equal to, at our option, a base rate plus 1.25% per annum or LIBOR plus 2.25% per annum and mature in September 2011. However, $450.0 million of our term loan borrowings are subject to a fixed interest rate under the terms of an interest rate swap agreement effective June 30, 2008 that expires March 31, 2010. We make quarterly principal payments on our outstanding term loan borrowings equal to one-fourth of one percent. Borrowings under our $250.0 million revolving credit facility, which matures in September 2010, would currently bear interest at a rate equal to, at our option, a base rate plus 1.0% per annum or LIBOR plus 2.0% per annum. These rates are subject to increase by up to 0.50% per annum should our leverage ratio exceed certain designated levels. We are required to pay a commitment fee to the lenders under the revolving credit facility in respect of the unutilized commitments thereunder at a rate equal to 0.50% per annum. We also pay customary letter of credit fees.

Debt Covenants

Our term loan facility and revolving credit facility contain a number of covenants that, among other things, restrict, subject to certain exceptions, our ability, and the ability of our subsidiaries, to sell assets, incur additional indebtedness or issue preferred stock, repay other indebtedness (including the 9.0% Notes and 11.25% Notes), pay dividends and distributions or repurchase our capital stock, create liens on assets, make investments, loans or advances, make certain acquisitions, engage in mergers or consolidations, enter into sale and leaseback transactions, engage in certain transactions with affiliates, amend certain material agreements governing our indebtedness, including the 9.0% Notes and 11.25% Notes, change the business conducted by our subsidiaries and enter into certain hedging agreements. In addition, the senior credit facilities require us to maintain the following financial covenants: a maximum total leverage ratio, a maximum senior leverage ratio, a minimum interest coverage ratio and a maximum capital expenditures limitation. As of June 30, 2009, our capital expenditures, as defined in the senior secured credit agreement, were below the maximum covenant amount, and we were in compliance with the other debt covenant ratios as defined in our senior secured credit agreement, as follows.

	Debt Covenant Ratio	Actual Ratio
Interest coverage ratio requirement	2.00x	3.56x
Total leverage ratio limit	4.50x	3.35x
Senior leverage ratio limit	3.50x	1.45x

While we are currently in compliance with all of our debt covenants, factors outside our control may make it more difficult for us to remain in compliance during future periods. These factors include a prolonged economic recession, a higher number of uninsured or underinsured patients and decreased governmental or managed care payer reimbursement, among others, any or all of which could negatively impact our results of operations and cash flows and cause us to violate one or more of these covenants. Violation of one or more of the covenants under our senior secured credit agreement could result in an immediate call of the outstanding principal amount of our term loans or the necessity of lender waivers with more onerous terms including adverse pricing or repayment provisions or more restrictive covenants.

Credit Ratings

The table below summarizes our credit ratings as of the date of this filing.

	Standard & Poor's	Moody's
Corporate credit rating	B	B2
9% Senior Subordinated Notes	CCC+	Caa1
11¼% Senior Discount Notes	CCC+	Caa1
Senior credit facilities	B+	Ba3

Our credit ratings are subject to periodic reviews by the ratings agencies. If our results of operations deteriorate either as a result of the current economic recession or other factors, any or all of our corporate ratings may be downgraded. A credit rating downgrade could further impede our ability to refinance all or a portion of our outstanding debt.

Capital Resources

We expect that cash on hand, cash generated from our operations and cash expected to be available to us under our revolving credit facility will be sufficient to meet our working capital needs, debt service requirements and planned capital expenditure programs during the next twelve months and into the foreseeable future prior to the maturity dates of our outstanding debt. However, we cannot assure you that our operations will generate sufficient cash or that future borrowings under our senior credit facilities will be available to enable us to meet these requirements, especially given the current diminished credit availability and general economic weakness.

Our $250.0 million revolving credit facility expires in September 2010, and we are not certain if we will be able to replace the revolving credit facility with favorable terms at such time given the current instability in the capital and credit markets and with the current uncertainty of when normal credit market liquidity conditions will return. Additionally, our financial position and cash flows could be materially adversely impacted should we be unable to access the current amounts available under our revolving credit facility due to default by one or more of the lenders. Our $766.4 million term debt under our term loan facility matures in September 2011. Our ability to refinance or obtain funds to repay this term debt could also be compromised if the current capital and credit markets do not improve.

We had $308.2 million of cash and cash equivalents as of June 30, 2009. We rely on available cash, cash flows generated by operations and available borrowing capacity under our revolving credit facility to fund our operations and capital expenditures. We invest our cash in accounts in high-quality financial institutions. We continually explore various options to increase the return on our invested cash while preserving our principal cash balances. However, the significant majority of our cash and cash equivalents are not federally-insured and could be at risk in the event of a collapse of those financial institutions.

At June 30, 2009, we held $21.6 million in total available for sale investments in auction rate securities ("ARS") backed by student loans, which are included in long-term investments in auction rate securities on our consolidated balance sheet due to inactivity in the primary ARS market during the past year. The par value of the ARS was $26.3 million as of June 30, 2009.

We also intend to continue to pursue acquisitions or partnering arrangements, either in existing markets or new markets, which fit our growth strategies. To finance such transactions, we might draw upon cash on hand, amounts available under our revolving credit facility or seek additional funding sources. We continually assess our capital needs and may seek additional financing, including debt or equity, as considered necessary to fund potential acquisitions, fund capital projects or for other corporate purposes. However, we may be unable to raise additional equity proceeds from Blackstone or other investors should we need to obtain cash for any of these purposes. Our future operating performance, ability to service our debt and ability to draw upon other sources of capital will be subject to future economic conditions and other business factors, many of which are beyond our control.

Obligations and Commitments

The following table reflects a summary of obligations and commitments outstanding with payment dates as of June 30, 2009.

	Payments due by period				
	Within 1 year	During Years 2-3	During Years 4-5	After 5 years	Total
Contractual Cash Obligations::		*(In millions)*			
Long-term debt (1)	$ 99.8	$ 935.0	$ 152.1	$ 853.3	$ 2,040.2
Operating leases (2)	30.4	48.1	32.2	42.3	153.0
Purchase obligations (2)	17.4	–	–	–	17.4
Health plan claims payable (3)	117.6	–	–	–	117.6
Estimated self-insurance liabilities (4)	47.8	39.0	22.9	14.8	124.5
Subtotal	$ 313.0	$ 1,022.1	$ 207.2	$ 910.4	$ 2,452.7

	Within 1 year	During Years 2-3	During Years 4-5	After 5 years	Total
Other Commitments:		*(In millions)*			
Construction and capital improvements (5)	$ 31.8	$ 1.3	$ –	$ –	$ 33.1
Guarantees of surety bonds (6)	40.0	–	–	–	40.0
Letters of credit (7)	–	31.2	–	–	31.2
Physician commitments (8)	4.4	–	–	–	4.4
FIN 48 net liability (9)	3.2	–	–	–	3.2
Subtotal	$ 79.4	$ 32.5	$ –	$ –	$ 111.9
Total obligations and commitments	$ 392.4	$ 1,054.6	$ 207.2	$ 910.4	$ 2,564.6

(1) Includes both principal and interest portions of outstanding debt. The interest portion of our debt assumes an approximate 5.0% rate over the remaining term of the debt.

(2) These obligations are not reflected in our consolidated balance sheets.

(3) Represents estimated payments to be made in future periods for healthcare costs incurred by enrollees in PHP, AAHP and MHP and is separately stated on our consolidated balance sheets.

(4) Includes the current and long-term portions of our professional and general liability, workers' compensation and employee health reserves.

(5) Represents our estimate of amounts we are committed to fund in future periods through executed agreements to complete projects included as construction in progress on our consolidated balance sheets.

(6) Represents performance bonds we have purchased related to health claims liabilities of PHP.

(7) Amounts relate primarily to instances in which we have letters of credit outstanding with the third party administrator of our self-insured workers' compensation program.

(8) Includes physician guarantee liabilities recognized in our consolidated balance sheets under the provisions of FSP 45-3, *Application of FASB Interpretation No. 45 to Minimum Revenue Guarantees Granted to a Business or Its Owners*, and liabilities for other fixed expenses under physician relocation agreements not yet paid.

(9) Represents expected future tax liabilities determined under the provisions of FIN 48.

Guarantees and Off Balance Sheet Arrangements

We are currently a party to a certain rent shortfall agreement with a certain unconsolidated entity. We also enter into physician income guarantees and service agreement guarantees and other guarantee arrangements, including parent-subsidiary guarantees, in the ordinary course of business. We have not engaged in any transaction or arrangement with an unconsolidated entity that is reasonably likely to materially affect liquidity.

Effects of Inflation and Changing Prices

Various federal, state and local laws have been enacted that, in certain cases, limit our ability to increase prices. Revenues for acute hospital services rendered to Medicare patients are established under the federal government's prospective payment system. We believe that hospital industry operating margins have been, and may continue to be, under significant pressure because of changes in payer mix and growth in operating expenses in excess of the increase in prospective payments under the Medicare program. In addition, as a result of increasing regulatory and competitive pressures, our ability to maintain operating margins through price increases to non-Medicare patients is limited.

Item 7A. Quantitative and Qualitative Disclosures About Market Risk.

We are subject to market risk from exposure to changes in interest rates based on our financing, investing, and cash management activities. As of June 30, 2009, we had in place $1,016.4 million of senior credit facilities bearing interest at variable rates at specified margins above either the agent bank's alternate base rate or its LIBOR rate. The senior credit facilities consist of $766.4 million in term loans maturing in September 2011 and a $250.0 million revolving credit facility maturing in September 2010 (of which $31.2 million of capacity was utilized by outstanding letters of credit as of June 30, 2009). Although changes in the alternate base rate or the LIBOR rate would affect the cost of funds borrowed in the future, we believe the effect, if any, of reasonably possible near-term changes in interest rates would not be material to our results of operations or cash flows. The variable interest rate risk is partially mitigated by the interest rate swap that became effective on June 30, 2008, as discussed below. As of June 30, 2009, the estimated fair values of our term debt, our 9.0% senior subordinated notes and our 11.25% senior discount notes were approximately $735.7 million, $547.7 million and $209.3 million, respectively.

Our $250.0 million revolving credit facility bears interest at the alternate base rate plus a margin ranging from 1.00%-1.50% per annum or the LIBOR rate plus a margin ranging from 2.00%-2.50% per annum, in each case dependent upon our leverage ratio. Our revolving credit facility matures in September 2010. Our $766.4 million in outstanding term loans bear interest at the alternate base rate plus a margin of 1.25% per annum or the LIBOR rate plus a margin of 2.25% per annum and mature in September 2011. The interest rate related to the unhedged term loans was approximately 2.6% as of June 30, 2009.

In April 2008, we entered into an interest rate swap agreement with Bank of America, N.A. (the counterparty) that became effective on June 30, 2008. Under this agreement and through March 31, 2009, we made or received quarterly net interest rate swap payments based upon the difference between the 90-day LIBOR rate and the swap fixed interest rate of 2.785% on a notional $450.0 million of our term debt. We accounted for this swap as a highly effective cash flow hedge with critical terms that substantially match the underlying term debt and measured any ineffectiveness using the hypothetical derivative method. In March 2009, we and the counterparty executed an amended swap agreement with the same terms and provisions as the original agreement except that after March 31, 2009, we will make or receive net interest payments based upon the difference between the 30-day LIBOR rate and the swap fixed interest rate of 2.5775%. As a result of this amended swap agreement, we de-designated our existing cash flow hedge and re-designated the amended swap agreement as a hedge of the remaining interest payments associated with $450.0 million of our outstanding term debt. As the forecasted transactions (i.e. the future interest payments under our outstanding term debt) are still probable of occurring, we did not immediately recognize the accumulated other comprehensive loss balance related to the de-designated swap in earnings. Based on our assessment, we determined this re-designated swap will be highly effective in offsetting the changes in cash flows related to the hedged risk. Upon the execution of the amended swap agreement, we began measuring hedge ineffectiveness by comparing the fair value of the original swap agreement to a new hypothetical derivative using the amended terms to determine if the underlying term debt has been overhedged. We determined that the hedge ineffectiveness was not significant as of June 30, 2009. The fair value of the interest rate swap as of June 30, 2009 was a liability for us of approximately $6.9 million ($4.3 million, net of taxes). We use derivatives such as interest rate swaps from time to time to manage our market risk associated with variable rate debt or similar derivatives for

fixed rate debt. We do not hold or issue derivative instruments for trading purposes and are not a party to any instruments with leverage features.

At June 30, 2009, we held $21.6 million in total available for sale investments in auction rate securities ("ARS") backed by student loans, which are included in long-term investments in auction rate securities on our consolidated balance sheet due to inactivity in the primary ARS market during the past year. The par value of the ARS was $26.3 million as of June 30, 2009. As of June 30, 2008, we had reflected the ARS as current marketable securities. We recorded a $0.6 million realized holding loss on $10.0 million of these marketable securities during the quarter ended September 30, 2008 as a result of a tender offer we received from the issuer of the ARS and accepted. However, the tender offer contained certain conditions that were not met by the December 2008 deadline, and the tender failed. Thus, we reclassified the $9.4 million of marketable securities to investments in auction rate securities, along with the other outstanding ARS, on our condensed consolidated balance sheet as of December 31, 2008. We also recorded temporary impairments totaling $4.1 million ($2.5 million, net of taxes) related to all $26.3 million par value ARS during the year ended June 30, 2009, which are included in accumulated other comprehensive income (loss) on our consolidated balance sheet as of June 30, 2009.

Our ARS were rated "AAA" by one or more major credit rating agencies at June 30, 2009 based on their most recent ratings update. The ratings take into account insurance policies guaranteeing both the principal and accrued interest of the investments. The U.S. government guarantees approximately 96%-98% of the principal and accrued interest on each investment in student loans under the Federal Family Education Loan Program or similar programs.

We will continue to monitor market conditions for this type of ARS to ensure that our classification and fair value estimate remain appropriate. Should market conditions in future periods warrant a reclassification or other than temporary impairment of our ARS, we do not believe our financial position, results of operations, cash flows or compliance with debt covenants would be materially impacted. We believe that we currently have adequate working capital to fund operations during the near future based on access to cash and cash equivalents, expected operating cash flows and availability under our revolving credit facility. We do not expect that our holding of the ARS until market conditions improve will significantly adversely impact our operating cash flows.

Item 8. Financial Statements and Supplementary Data.

INDEX TO AUDITED CONSOLIDATED FINANCIAL STATEMENTS

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

Board of Directors
Vanguard Health Systems, Inc.

We have audited the accompanying consolidated balance sheets of Vanguard Health Systems, Inc. as of June 30, 2009 and 2008, and the related consolidated statements of operations, stockholders' equity and cash flows for each of the three years in the period ended June 30, 2009. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. We were not engaged to perform an audit of the Company's internal control over financial reporting. Our audits included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Vanguard Health Systems, Inc. at June 30, 2009 and 2008, and the consolidated results of its operations and its cash flows for each of the three years in the period ended June 30, 2009, in conformity with U.S. generally accepted accounting principles.

/s/ Ernst & Young LLP

Nashville, Tennessee
September 2, 2009

VANGUARD HEALTH SYSTEMS, INC.
CONSOLIDATED BALANCE SHEETS

	June 30, 2008	June 30, 2009
	(In millions except share and per share amounts)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 141.6	$ 308.2
Restricted cash	2.1	1.9
Marketable securities	26.3	–
Accounts receivable, net of allowance for doubtful accounts of approximately $117.7 and $121.5 at June 30, 2008 and 2009, respectively	300.4	275.3
Inventories	49.2	48.3
Deferred tax assets	24.5	29.6
Prepaid expenses and other current assets	55.8	68.4
Total current assets	599.9	731.7
Property, plant and equipment, net of accumulated depreciation	1,174.0	1,174.1
Goodwill	689.2	692.1
Intangible assets, net of accumulated amortization	61.4	54.6
Investments in and advances to affiliates	6.0	5.4
Investments in auction rate securities	–	21.6
Other assets	51.8	51.6
Total assets	$ 2,582.3	$ 2,731.1
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Accounts payable	$ 155.1	$ 127.9
Accrued salaries and benefits	97.4	133.9
Accrued health plan claims	51.1	117.6
Accrued interest	13.2	13.2
Other accrued expenses and current liabilities	57.3	79.5
Current maturities of long-term debt	8.0	8.0
Total current liabilities	382.1	480.1
Minority interests in equity of consolidated entities	9.1	8.0
Professional and general liability and workers compensation reserves	74.1	76.7
Other liabilities	22.9	34.9
Long-term debt, less current maturities	1,529.5	1,543.6
Commitments and contingencies		
Stockholders' equity:		
Common Stock; $.01 par value, 1,000,000 shares authorized, 749,550 shares issued and outstanding at June 30, 2008 and 2009, respectively	–	–
Additional paid-in capital	647.1	651.3
Accumulated other comprehensive income (loss)	2.8	(6.8)
Retained deficit	(85.3)	(56.7)
Total stockholders' equity	564.6	587.8
Total liabilities and stockholders' equity	$ 2,582.3	$ 2,731.1

See accompanying notes.

VANGUARD HEALTH SYSTEMS, INC.
CONSOLIDATED STATEMENTS OF OPERATIONS

	For the Year Ended June 30,		
	2007	2008	2009
		(In millions)	
Patient service revenues	$ 2,179.3	$ 2,340.5	$ 2,521.7
Premium revenues	401.4	450.2	678.0
Total revenues	2,580.7	2,790.7	3,199.7
Costs and expenses:			
Salaries and benefits (includes stock compensation of $1.2, $2.5 and $4.4, respectively)	1,067.9	1,152.7	1,240.1
Health plan claims expense	297.0	328.2	525.6
Supplies	421.8	434.5	456.3
Provision for doubtful accounts	175.2	205.6	210.8
Purchased services	141.2	149.5	167.4
Non-income taxes	28.6	28.3	52.2
Rents and leases	37.4	41.8	43.5
Other operating expenses	167.8	186.2	205.8
Depreciation and amortization	118.6	131.0	130.6
Interest, net	123.8	122.1	111.6
Impairment loss	123.8	–	6.2
Other expenses	2.8	9.5	5.9
Income (loss) from continuing operations before income taxes	(125.2)	1.3	43.7
Income tax expense (benefit)	(11.6)	1.7	16.0
Income (loss) from continuing operations	(113.6)	(0.4)	27.7
Income (loss) from discontinued operations, net of taxes	(19.1)	(0.3)	0.9
Net income (loss)	$ (132.7)	$ (0.7)	$ 28.6

See accompanying notes.

VANGUARD HEALTH SYSTEMS, INC.
CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

	Common Stock		Additional Paid-In Capital	Accumulated Other Comprehensive Income (Loss)	Retained Earnings (Deficit)	Total Stockholders' Equity
	Shares	Amount				
			(In millions, except share amounts)			
Balance at June 30, 2006	749,550	–	643.7	–	45.5	689.2
Stock compensation (non-cash)	–	–	1.2	–	–	1.2
Repurchase of equity incentive units	–	–	(0.2)	–	–	(0.2)
Issuance of common stock	195	–	0.2	–	–	0.2
Repurchase of common stock	(195)	–	(0.3)	–	–	(0.3)
Net loss	–	–	–	–	(132.7)	(132.7)
Balance at June 30, 2007	749,550	–	644.6	–	(87.2)	557.4
Stock compensation (non-cash)	–	–	2.5	–	–	2.5
Issuance of common stock	168	–	0.2	–	–	0.2
Repurchase of common stock	(168)	–	(0.2)	–	–	(0.2)
Cumulative effect of adoption of FIN 48	–	–	–	–	2.6	2.6
Comprehensive income:						
Change in fair value of interest rate swap (net of tax effect)	–	–	–	2.8	–	2.8
Net income	–	–	–	–	(0.7)	(0.7)
Total comprehensive income	–	–	–	2.8	(0.7)	2.1
Balance at June 30, 2008	749,550	$ –	$ 647.1	$ 2.8	$ (85.3)	$ 564.6
Stock compensation (non-cash)	–	–	4.4	–	–	4.4
Repurchase of equity incentive units	–	–	(0.2)	–	–	(0.2)
Comprehensive income:						
Change in fair value of interest rate swap (net of tax effect)	–	–	–	(7.1)	–	(7.1)
Change in fair value of auction rate securities (net of tax effect)	–	–	–	(2.5)	–	(2.5)
Net income	–	–	–	–	28.6	28.6
Total comprehensive income				(9.6)	28.6	19.0
Balance at June 30, 2009	749,550	$ –	$ 651.3	$ (6.8)	$ (56.7)	$ 587.8

See accompanying notes.

VANGUARD HEALTH SYSTEMS, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS

	For the Year Ended June 30,		
	2007	2008	2009
		(In millions)	
Operating activities:			
Net income (loss)	$ (132.7)	$ (0.7)	$ 28.6
Adjustments to reconcile net income (loss) to net cash provided by operating activities			
Loss (income) from discontinued operations	19.1	0.3	(0.9)
Depreciation and amortization	118.6	131.0	130.6
Provision for doubtful accounts	175.2	205.6	210.8
Amortization of loan costs	4.5	4.9	5.4
Accretion of principal on senior discount notes	17.5	19.5	21.8
Loss (gain) on disposal of assets	(4.1)	0.9	(2.3)
Stock compensation	1.2	2.5	4.4
Deferred income taxes	(12.7)	(2.2)	5.6
Impairment loss	123.8	–	6.2
Realized holding loss on investments	–	–	0.6
Changes in operating assets and liabilities, net of effects of acquisitions and dispositions			
Accounts receivable	(204.0)	(223.6)	(185.2)
Inventories	(1.9)	(4.1)	1.0
Prepaid expenses and other current assets	(30.0)	(19.7)	(13.0)
Accounts payable	7.4	12.2	(27.3)
Accrued expenses and other liabilities	37.8	45.0	121.0
Net cash provided by operating activities – continuing operations	119.7	171.6	307.3
Net cash provided by operating activities – discontinued operations	3.6	1.5	0.9
Net cash provided by operating activities	123.3	173.1	308.2
Investing activities:			
Acquisitions	(0.2)	(0.2)	(4.4)
Capital expenditures	(164.3)	(121.6)	(132.1)
Proceeds from asset dispositions	9.5	0.4	4.9
Purchases of marketable securities	(120.0)	(90.0)	–
Sales of marketable securities	120.0	63.7	–
Other	2.0	1.1	(2.0)
Net cash used in investing activities – continuing operations	(153.0)	(146.6)	(133.6)
Net cash provided by investing activities – discontinued operations	34.5	2.8	–
Net cash used in investing activities	(118.5)	(143.8)	(133.6)
Financing activities:			
Payments of long-term debt	(8.0)	(7.8)	(7.8)
Payments to retire stock, equity incentive units and stock options	(0.5)	(0.2)	(0.2)
Proceeds from the exercise of stock options	0.2	0.2	–
Net cash used in financing activities	(8.3)	(7.8)	(8.0)
Increase (decrease) in cash and cash equivalents	(3.5)	21.5	166.6
Cash and cash equivalents at beginning of year	123.6	120.1	141.6
Cash and cash equivalents at end of year	$ 120.1	$ 141.6	$ 308.2

VANGUARD HEALTH SYSTEMS, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS
(continued)

	For the Year Ended June 30,		
	2007	2008	2009
		(In millions)	
Supplemental cash flow information:			
Net interest paid	$ 107.8	$ 99.1	$ 86.4
Net income taxes paid	$ 0.9	$ 1.3	$ 17.3
Supplemental noncash activities:			
Capitalized interest	$ 3.0	$ 1.4	$ 2.0
Change in fair value of interest rate swap, net of taxes	$ –	$ 2.8	$ (7.1)
Change in fair value of auction rate securities, net of taxes	$ –	$ –	$ (2.5)
Acquisitions of businesses:			
Cash paid, net of cash received	$ 0.2	$ 0.2	$ 4.4
Fair value of assets acquired	–	0.2	2.1
Liabilities assumed	–	–	(0.6)
Net assets acquired	–	0.2	1.5
Goodwill and intangible assets acquired	$ 0.2	$ –	$ 2.9
Dispositions of businesses:			
Cash received	$ 37.0	$ 3.0	$ –
Carrying value of assets sold	(42.1)	–	–
Escrow receivable	3.0	(3.0)	–
Liabilities assumed by buyer	5.5	–	–
Goodwill and intangible assets disposed	$ 3.4	$ –	$ –

See accompanying notes.

1. Business and Basis of Presentation

Business

Vanguard Health Systems, Inc. ("Vanguard") is an investor-owned healthcare company whose affiliates own and operate hospitals and related healthcare businesses in urban and suburban areas. As of June 30, 2009, Vanguard's affiliates owned and managed 15 acute care hospitals with 4,135 licensed beds and related outpatient service locations complementary to the hospitals providing healthcare services in San Antonio, Texas; metropolitan Phoenix, Arizona; metropolitan Chicago, Illinois; and Massachusetts. Vanguard also owns managed health plans in Chicago and Phoenix and two surgery centers in Orange County, California.

Basis of Presentation

The accompanying consolidated financial statements include the accounts of subsidiaries and affiliates controlled by Vanguard. Vanguard generally defines control as the ownership of the majority of an entity's voting interests. Vanguard also consolidates any entities for which it receives the majority of the entity's expected returns or is at risk for the majority of the entity's expected losses based upon its investment or financial interest in the entity. All material intercompany accounts and transactions have been eliminated. Since none of Vanguard's common shares are publicly held, no earnings per share information is presented in the accompanying consolidated financial statements. Certain prior year amounts from the accompanying consolidated balance sheet have been reclassified to conform to current year presentation. The majority of Vanguard's expenses are "cost of revenue" items. Costs that could be classified as general and administrative include certain Vanguard corporate office costs, which approximated $30.2 million, $44.3 million and $54.5 million for the years ended June 30, 2007, 2008 and 2009, respectively.

Use of Estimates

In preparing Vanguard's consolidated financial statements in conformity with accounting principles generally accepted in the United States, management makes estimates and assumptions that affect the amounts recorded or classification of items in the consolidated financial statements and accompanying notes. Actual results could differ from those estimates.

2. Summary of Significant Accounting Policies

Revenues and Revenue Deductions

Vanguard recognizes patient service revenues during the period the healthcare services are provided based upon estimated amounts due from payers. Vanguard estimates contractual adjustments and allowances based upon payment terms set forth in managed care health plan contracts and by federal and state regulations. For the majority of its patient service revenues, Vanguard applies contractual adjustments to patient accounts at the time of billing using specific payer contract terms entered into the accounts receivable systems, but in some cases Vanguard records an estimated allowance until payment is received. Vanguard derives most of its patient service revenues from healthcare services provided to patients with Medicare and related managed Medicare plans or managed care insurance coverage. Medicare, which represented 26%, 26% and 25% of Vanguard's net patient revenues during its fiscal years ended June 30, 2007, 2008 and 2009, respectively, was the only individual payer for which Vanguard derived more than 10% of net patient revenues during those periods.

Services provided to Medicare and related managed Medicare patients are generally reimbursed at prospectively determined rates per diagnosis ("PPS"), while services provided to managed care patients are generally reimbursed based upon predetermined rates per diagnosis, per diem rates or discounted fee-for-service rates. Medicaid reimbursements vary by state.

Medicare regulations and Vanguard's principal managed care contracts are often complex and may include multiple reimbursement mechanisms for different types of services provided in its healthcare facilities. To obtain reimbursement for certain services under the Medicare program, Vanguard must submit annual cost reports and record estimates of amounts owed to or receivable from Medicare. These cost reports include complex calculations and estimates related to indirect medical education, disproportionate share payments, reimbursable Medicare bad debts and other items that are often subject to interpretation that could result in payments that differ from recorded estimates. Vanguard estimates amounts owed to or receivable from the Medicare program using the best information available and its interpretation of the applicable Medicare regulations. Vanguard includes differences between original estimates and subsequent revisions to those estimates (including final cost report settlements) in the consolidated statements of operations in the period in which the revisions are made. Net adjustments for final third party settlements increased patient service revenues and income from continuing operations before income taxes by $6.3 million, $7.9 million and $8.0 million during the years ended June 30, 2007, 2008 and 2009, respectively. Additionally, updated regulations and contract negotiations occur frequently, which necessitates continual review of estimation processes by management. Management believes that future adjustments to its current third party settlement estimates will not significantly impact Vanguard's results of operations or financial position.

Vanguard does not pursue collection of amounts due from uninsured patients that qualify for charity care under its guidelines (currently those uninsured patients whose incomes are equal to or less than 200% of the current federal poverty guidelines set forth by the Department of Health and Human Services). Vanguard deducts charity care accounts from revenues when it determines that the account meets its charity care guidelines. Vanguard also provides discounts from billed charges and alternative payment structures for uninsured patients who do not qualify for charity care but meet certain other minimum income guidelines, primarily those uninsured patients with incomes between 200% and 500% of the federal poverty guidelines. During the years ended June 30, 2007, 2008 and 2009, Vanguard deducted $86.1 million, $86.1 million and $91.8 million of charity care from revenues, respectively.

During the third quarter of its fiscal year ended June 30, 2007, Vanguard was approved to receive payments under the Bexar County, Texas upper payment limit ("UPL") Medicaid payment program. UPL programs allow private hospitals to enter into indigent care affiliation agreements with governmental entities. Within the parameters of these programs, private hospitals expand charity care services to indigent patients and alleviate expenses for the governmental entity. The governmental entity is then able to utilize its tax revenue to fund the Medicaid program for private hospitals. Vanguard recognizes revenues from the UPL program when Vanguard becomes entitled to the expected reimbursements, including a federal match portion, and such reimbursements are assured.

During the third quarter of fiscal 2009, the federal government approved federal matching funds for the Illinois Provider Tax Assessment ("PTA") program. The PTA program enables the state of Illinois to increase funding for its state Medicaid plan. Hospitals providing services to Medicaid enrollees receive funds directly from the state. Hospital providers, with certain exceptions, are then assessed a provider tax, which is payable to the state, and may or may not exceed funds received from the state. Vanguard recognizes revenues equal to the gross payments to be received when such payments are assured. Vanguard received $24.9 million of cash from this program during the year ended June 30, 2009, all of which increased revenues and $13.4 million of which was subsequently paid to the state and is included in non-income taxes in our consolidated statement of operations for the year ended June 30, 2009.

Effective for service dates on or after April 1, 2009, as a result of a state mandate, Vanguard implemented a new uninsured discount policy for those patients receiving services in its Illinois hospitals who had no insurance coverage and who did not otherwise qualify for charity care under its guidelines. Under this policy, Vanguard applies an uninsured discount (calculated as a standard percentage of gross charges) at the time of patient billing and includes this discount as a reduction to patient service revenues. These discounts were approximately $11.7 million for the year ended June 30, 2009. Vanguard implemented this policy for most of its remaining facilities effective July 1, 2009 and expects to implement it at all of its facilities by the end of its fiscal year 2010.

Vanguard had premium revenues from its health plans of $401.4 million, $450.2 million and $678.0 million during the years ended June 30, 2007, 2008 and 2009, respectively. Vanguard's health plans, Phoenix Health Plan ("PHP"), Abrazo Advantage Health Plan ("AAHP") and MacNeal Health Providers ("MHP"), have agreements with the Arizona Health Care Cost Containment System ("AHCCCS"), Centers for Medicare and Medicaid Services ("CMS") and various health maintenance organizations ("HMOs"), respectively, to contract to provide medical services to subscribing participants. Under these agreements, Vanguard's health plans receive monthly payments based on the number of HMO participants in MHP or the number and coverage type of enrollees in PHP and AAHP. Vanguard's health plans recognize the payments as revenues in the month in which members are entitled to healthcare services with the exception of AAHP Medicare Part D reinsurance premiums and low income subsidy cost sharing premiums that are recorded as a liability to fund future healthcare costs or else repaid to the government.

Cash and Cash Equivalents

Vanguard considers all highly liquid investments with maturity of 90 days or less when purchased to be cash equivalents. Vanguard manages its credit exposure by placing its investments in high quality securities and by periodically evaluating the relative credit standing of the financial institutions holding its cash and investments.

Restricted Cash

As of June 30, 2008 and 2009, Vanguard had restricted cash balances of $2.1 million and $1.9 million, respectively. These balances primarily represent restricted cash accounts related to liquidity requirements of AAHP and certain other arrangements.

Accounts Receivable

Vanguard's primary concentration of credit risk is patient accounts receivable, which consists of amounts owed by various governmental agencies, insurance companies and private patients. Vanguard manages the receivables by regularly reviewing its accounts and contracts and by providing appropriate allowances for contractual discounts and uncollectible amounts. Vanguard typically writes off uncollected accounts receivable 180 days subsequent to discharge date. Medicare program net receivables, including managed Medicare receivables, comprised approximately 31% and 33% of net patient receivables as of June 30, 2008 and 2009, respectively. Medicare revenues are included in the acute care services operating segment. Receivables from various state Medicaid programs and managed Medicaid programs comprised approximately 23% and 21% of net patient receivables as of June 30, 2008 and 2009, respectively. Remaining receivables relate primarily to various HMO and Preferred Provider Organization ("PPO") payers, commercial insurers and private patients. Concentration of credit risk for these payers is limited by the number of patients and payers.

Effective July 1, 2007, Vanguard began estimating the allowance for doubtful accounts using a standard policy that reserves 100% of all accounts aged greater than 365 days subsequent to discharge date plus a standard percentage of uninsured accounts less than 365 days old plus a standard percentage of self-pay after insurance/Medicare less than 365 days old. Vanguard's previous policy reserved all accounts greater than 180 days plus a market-specific percentage of uninsured and self-pay after insurance/Medicare balances. Effective June 30, 2008, Vanguard adjusted its policy to increase the standard percentages applied to uninsured accounts and self-pay after insurance/Medicare accounts. Vanguard adjusted its standard percentages again in April 2009 to consider the impact of its new uninsured discount policy, as previously described. Vanguard tests its allowance for doubtful accounts policy quarterly using a hindsight calculation that utilizes write-off data for all payer classes during the previous twelve-month period to estimate the allowance for doubtful accounts at a point in time. Vanguard also supplements its analysis by comparing cash collections to net patient revenues and monitoring self-pay utilization. Significant changes in payer mix, business office operations, general economic conditions and healthcare coverage provided by federal or state governments or private insurers may have a significant impact on Vanguard's estimates and significantly affect its results of operations and cash flows.

Prior to the implementation of its new uninsured discount policy and for those accounts not yet transitioned to the new uninsured discount policy, Vanguard classifies accounts pending Medicaid approval as Medicaid accounts in its accounts receivable aging report and records a manual contractual allowance for these accounts based upon the

average Medicaid reimbursement rate for that specific state. For accounts that do not successfully qualify for Medicaid coverage and do not meet the requisite charity guidelines, the previously recorded Medicaid contractual adjustment remains a revenue deduction, and the remaining net account balance is reclassified to the uninsured status and subjected to the allowance for doubtful accounts policy. If accounts do not qualify for Medicaid but, do qualify as charity care, the contractual adjustments are reversed and the gross account balance is recorded as a charity deduction.

Upon the implementation of the new uninsured discount policy, all uninsured accounts (including those pending Medicaid qualification) that do not qualify for charity care receive the standard uninsured discount with the balance subject to Vanguard's allowance for doubtful accounts policy. For accounts subsequently qualified for Medicaid coverage, the uninsured discount is reversed and the account is reclassified into Medicaid accounts receivable with the appropriate contractual deduction applied.

A summary of Vanguard's allowance for doubtful accounts activity, including those for discontinued operations, during the three most recent fiscal years follows (in millions).

	Balance at Beginning of Period	Additions Charged to Costs and Expenses	Accounts Written Off, Net of Recoveries	Balance at End of Period
Allowance for doubtful accounts:				
Year ended June 30, 2007	$ 103.5	$ 191.3	$ 181.6	$ 113.2
Year ended June 30, 2008	$ 113.2	$ 201.0	$ 196.5	$ 117.7
Year ended June 30, 2009	$ 117.7	$ 210.8	$ 207.0	$ 121.5

Inventories

Inventories, consisting of medical supplies and pharmaceuticals, are stated at the lower of cost (first-in, first-out) or market.

Property, Plant and Equipment

Purchases of property, plant and equipment are stated at cost. Routine maintenance and repairs are charged to expense as incurred. Expenditures that increase values, change capacities or extend useful lives are capitalized. For assets other than leasehold improvements depreciation is computed using the straight-line method over the estimated useful lives of the assets, which approximate 18 months to 44 years. Leasehold improvements are depreciated over the lesser of the estimated useful life or term of the lease. Depreciation expense was approximately $115.4 million, $127.8 million and $127.0 million for the years ended June 30, 2007, 2008 and 2009, respectively. Vanguard tests its property, plant and equipment and other long-lived assets for impairment as management becomes aware of impairment indicators.

During fiscal 2007, 2008 and 2009, Vanguard capitalized $3.0 million, $1.4 million and $2.0 million of interest, respectively, associated with certain of its hospital construction and expansion projects. Vanguard estimates that it is contractually obligated to expend approximately $33.1 million related to projects classified as construction in progress as of June 30, 2009. Vanguard also capitalizes costs associated with developing computer software for internal use under the provisions of AICPA Statement of Position 98-1 ("SOP 98-1"). Under SOP 98-1, Vanguard capitalizes both internal and external direct costs, excluding training, during the application development stage primarily for the purpose of customizing vendor software to integrate with our hospitals' information systems. The estimated net value of capitalized internal use software, under SOP 98-1, included in net property, plant and equipment, was approximately $49.0 million and $52.0 million as of June 30, 2008 and 2009, respectively. The amortization expense for internal use software, included in depreciation expense, was $6.3 million, $9.9 million and $9.5 million for the years ended June 30, 2007, 2008 and 2009, respectively.

The following table provides the gross asset balances for each major class of asset and total accumulated depreciation as of June 30, 2008 and 2009 (in millions).

	June 30, 2008	June 30, 2009
Class of asset:		
Land and improvements	$ 143.5	$ 148.7
Buildings and improvements	826.2	842.4
Equipment	558.9	641.5
Construction in progress	40.4	60.0
	1,569.0	1,692.6
Less: accumulated depreciation	(395.0)	(518.5)
Net property, plant and equipment	$ 1,174.0	$ 1,174.1

Investments in Auction Rate Securities

At June 30, 2009, Vanguard held $21.6 million in total available for sale investments in auction rate securities ("ARS") backed by student loans, which are included in long-term investments in auction rate securities on its consolidated balance sheet due to inactivity in the primary ARS market during the past year. The par value of the ARS was $26.3 million as of June 30, 2009. As of June 30, 2008, Vanguard had reflected the ARS as current marketable securities at par value. Vanguard recorded a $0.6 million realized holding loss on $10.0 million of these marketable securities during the quarter ended September 30, 2008, as a result of a tender offer Vanguard received from the issuer of the ARS and accepted. However, the tender offer contained certain conditions that were not met by the December 2008 deadline, and the tender failed. Thus, Vanguard reclassified the $9.4 million of marketable securities to investments in auction rate securities, along with the other outstanding ARS, on its condensed consolidated balance sheet as of December 31, 2008. Vanguard also recorded temporary impairments totaling $4.1 million ($2.5 million, net of taxes) related to all $26.3 million par value ARS during the year ended June 30, 2009, which are included in accumulated other comprehensive income (loss) on its consolidated balance sheet as of June 30, 2009.

Vanguard's ARS were rated "AAA" by one or more major credit rating agencies at June 30, 2009. The ratings take into account insurance policies guaranteeing both the principal and accrued interest of the investments. The U.S. government guarantees approximately 96%-98% of the principal and accrued interest on each investment in student loans under the Federal Family Education Loan Program or other similar programs.

Vanguard does not currently intend to sell and does not believe it is more likely than not it will be required to sell its ARS prior to liquidity returning to the market and their fair value recovering to par value. Vanguard will continue to monitor market conditions for this type of ARS to ensure that its classification and fair value estimate for the ARS remain appropriate in future periods. If Vanguard intends to sell any of the ARS, prior to maturity, at an amount below carrying value, or if it becomes more likely than not that Vanguard will be required to sell its ARS, Vanguard will be required to recognize an other-than-temporary impairment.

Long-Lived Assets and Goodwill

Long-lived assets, including property, plant and equipment and amortizable intangible assets, comprise a significant portion of Vanguard's total assets. Vanguard evaluates the carrying value of long-lived assets when impairment indicators are present or when circumstances indicate that impairment may exist under the provisions of SFAS 144, *Accounting for the Impairment or Disposal of Long-Lived Assets*. When management believes impairment indicators may exist, projections of the undiscounted future cash flows associated with the use of and eventual disposition of long-lived assets held for use are prepared. If the projections indicate that the carrying values of the long-lived assets are not expected to be recoverable, Vanguard reduces the carrying values to fair value. For long-lived assets held for sale, Vanguard compares the carrying values to an estimate of fair value less selling costs to determine potential impairment. Vanguard tests for impairment of long-lived assets at the lowest level for which

cash flows are measurable. These impairment tests are heavily influenced by assumptions and estimates that are subject to change as additional information becomes available. Given the relatively few number of hospitals Vanguard owns and the significant amounts of long-lived assets attributable to those hospitals, an impairment of the long-lived assets for even a single hospital could materially adversely impact its operating results or financial position.

Goodwill also represents a significant portion of Vanguard's total assets. Vanguard reviews goodwill for impairment annually during its fourth fiscal quarter or more frequently if certain impairment indicators arise under the provisions of SFAS 142, *Goodwill and Other Intangible Assets*. Vanguard reviews goodwill at the reporting unit level, which is one level below an operating segment. Vanguard compares the carrying value of the net assets of each reporting unit to the net present value of estimated discounted future cash flows of the reporting unit. If the carrying value exceeds the net present value of estimated discounted future cash flows, an impairment indicator exists and an estimate of the impairment loss is calculated. The fair value calculation includes multiple assumptions and estimates, including the projected cash flows and discount rates applied. Changes in these assumptions and estimates could result in goodwill impairment that could materially adversely impact Vanguard's results of operations or statement of position.

Amortization of Intangible Assets

Amounts allocated to contract-based intangible assets, which represent PHP's contract with AHCCCS and PHP's various contracts with network providers, are amortized over their useful lives, which equal 10 years. No amortization is recorded for indefinite-lived intangible assets. Deferred loan costs and syndication costs are amortized over the life of the applicable credit facility or notes using the effective interest method. Physician income and service agreement guarantee intangible assets are recorded based upon the estimated future payments under the contracts and are amortized over the applicable contract service periods. The useful lives over which intangible assets are amortized range from two years to ten years.

Income Taxes

Vanguard accounts for income taxes using the asset and liability method in accordance with SFAS No. 109, *Accounting for Income Taxes* ("SFAS 109") and FASB Interpretation No. 48, *Accounting for Uncertainty in Income Taxes – An Interpretation of FASB Statement No. 109* ("FIN 48"). These guidelines require the recognition of deferred tax assets and liabilities for the expected future tax consequences of temporary differences between the carrying amounts and the tax bases of assets and liabilities.

Vanguard believes that its tax return provisions are accurate and supportable, but certain tax matters require interpretations of tax law that may be subject to future challenge and may not be upheld under tax audit. To reflect the possibility that all of its tax positions may not be sustained, Vanguard maintains tax reserves that are subject to adjustment as updated information becomes available or as circumstances change. Vanguard records the impact of tax reserve changes to its income tax provision in the period in which the additional information, including the progress of tax audits, is obtained.

Vanguard assesses the realization of its deferred tax assets to determine whether an income tax valuation allowance is required. Based on all available evidence, both positive and negative, and the weight of that evidence to the extent such evidence can be objectively verified, Vanguard determines whether it is more likely than not that all or a portion of the deferred tax assets will be realized. The factors used in this determination include the following:

- Cumulative losses in recent years
- Income/losses expected in future years
- Unsettled circumstances that, if favorably resolved, would adversely affect future operations
- Availability, or lack thereof, of taxable income in prior carryback periods that would limit realization of tax benefits
- Carryforward period associated with the deferred tax assets and liabilities
- Prudent and feasible tax planning strategies

In addition, financial forecasts used in determining the need for or amount of federal and state valuation allowances are subject to changes in underlying assumptions and fluctuations in market conditions that could significantly alter Vanguard's recoverability analysis and thus have a material adverse impact on Vanguard's consolidated financial condition, results of operations or cash flows.

Accrued Health Plan Claims

During the years ended June 30, 2007, 2008 and 2009, health plan claims expense was $297.0 million, $328.2 million and $525.6 million, respectively, primarily representing health claims incurred by enrollees in PHP. Vanguard estimates PHP's reserve for health claims using historical claims experience (including cost per member and payment lag time) and other actuarial data including number of enrollees and certain enrollee demographic information. Accrued health plan claims, including incurred but not reported claims, for all Vanguard health plans combined was approximately $51.1 million and $117.6 million as of June 30, 2008 and 2009, respectively. While management believes that its estimation methodology effectively captures trends in medical claims costs, actual payments could differ significantly from its estimates given changes in the healthcare cost structure or adverse experience. During the years ended June 30, 2007, 2008 and 2009, approximately $34.2 million, $31.2 million and $34.0 million, respectively, of accrued and paid claims for services provided to Vanguard's health plan enrollees by its hospitals and its other healthcare facilities were eliminated in consolidation. Vanguard's operating results and cash flows could be materially affected by increased or decreased utilization of its healthcare facilities by enrollees in its health plans.

Employee Health Insurance Reserve

Effective July 1, 2008, Vanguard began covering all of its employees under its self-insured medical plan. Prior to that, only a portion of Vanguard's employees were covered under this self-insured plan. Claims are accrued under the self-insured medical plan as the incidents that give rise to them occur. Unpaid claims accruals are based on the estimated ultimate cost of settlement, including claim settlement expenses, in accordance with an average lag time and historical experience. The reserve for self-insured medical plan was approximately $1.5 million and $13.4 million as of June 30, 2008 and 2009, respectively, and is included in accrued salaries and benefits in the accompanying consolidated balance sheets. Vanguard mitigated its self-insured risk by purchasing stop-loss coverage for catastrophic claims at a $500,000 per enrollee annual limit. During the year ended June 30, 2009, approximately $23.1 million was eliminated upon consolidation related to self-insured medical claims expense incurred and revenues earned due to employee utilization of Vanguard's healthcare facilities.

Professional and General Liability and Workers Compensation Reserves

Given the nature of its operating environment, Vanguard is subject to professional and general liability and workers compensation claims and related lawsuits in the ordinary course of business. For professional and general liability claims incurred from June 1, 2002 to May 31, 2006, Vanguard's wholly owned captive subsidiary insured its professional and general liability risks at a $10.0 million retention level. For professional and general liability claims incurred from June 1, 2006 to June 30, 2009, Vanguard self-insured the first $9.0 million per claim, and the captive subsidiary insured the next $1.0 million per claim. Vanguard maintains excess coverage from independent third party insurers on a claims-made basis for individual claims exceeding $10.0 million up to $75.0 million, but limited to total annual payments of $65.0 million in the aggregate.

Vanguard insures its excess coverage under a retrospectively rated policy, and premiums under this policy are recorded based on Vanguard's historical claims experience. Vanguard self-insures its workers compensation claims up to $1.0 million per claim and purchases excess insurance coverage for claims exceeding $1.0 million.

Vanguard's reserves for professional and general liability as of the years ended June 30, 2008 and 2009 were $74.3 million and $92.9 million, respectively. As of June 30, 2008 and 2009 the reserves for workers' compensation were $18.8 million and $18.2 million, respectively. Vanguard utilizes actuarial information to estimate its reserves for professional and general liability and workers compensation claims. Each reserve is comprised of estimated indemnity and expense payments related to: (1) reported events ("case reserves") and (2) incurred but not reported ("IBNR") events as of the end of the period. Management uses information from its risk managers and its best judgment to estimate case reserves. Actuarial IBNR estimates are dependent on multiple variables including

Vanguard's risk exposures, its self-insurance limits, geographic locations in which it operates, the severity of its historical losses compared to industry averages and the reporting pattern of its historical losses compared to industry averages, among others. Most of these variables require judgment, and changes in these variables could result in significant period over period fluctuations in Vanguard's estimates. Vanguard discounts its workers compensation reserve using a 5% factor, an actuarial estimate of projected cash payments in future periods. Vanguard does not discount the reserve for estimated professional and general liability claims. Vanguard adjusts these reserves from time to time as it receives updated information. Due to changes in historical loss trends, during its fiscal years ended June 30, 2007 and 2008, Vanguard decreased its professional and general liability reserve related to prior fiscal years by $4.5 million and $0.6 million, respectively. During its fiscal year ended June 30, 2009, Vanguard increased its professional and general liability reserve related to prior fiscal years by $13.4 million. Similarly, Vanguard decreased its workers compensation reserve related to prior fiscal years by $2.3 million and $3.8 million during its fiscal years ended June 30, 2008 and 2009. Adjustments to the workers compensation reserve related to prior years during the fiscal year ended June 30, 2007 were not significant. Additional adjustments to prior year estimates may be necessary in future periods as Vanguard's reporting history and loss portfolio matures.

Market and Labor Risks

Vanguard operates primarily in four geographic markets. If economic or other factors limit its ability to provide healthcare services in one or more of these markets, Vanguard's cash flows and results of operations could be materially adversely impacted. Approximately 1,600 full-time employees in Vanguard's Massachusetts hospitals are subject to collective organizing agreements. This group represents approximately 8% of Vanguard's workforce. During fiscal 2007, Vanguard entered into a new three-year contract with the union representing the majority of this group that ends on December 31, 2009. If Vanguard experiences significant future labor disruptions related to these unionized employees, its cash flows and results of operations could be materially adversely impacted.

Stock-Based Compensation

Vanguard accounts for stock-based employee compensation granted prior to July 1, 2006 under the provisions of Statement of Financial Accounting Standards No. 123, *Accounting for Stock-Based Compensation* ("SFAS 123"). Effective July 1, 2003, Vanguard adopted SFAS 123 on a prospective basis, an acceptable transition method set forth in SFAS No. 148, *Accounting for Stock-Based Compensation Transition and Disclosure* ("SFAS 148"). For grants dated July 1, 2006 and subsequent, Vanguard accounts for stock-based employee compensation under the provisions of Statement of Financial Accounting Standards No. 123(R), *Share-Based Payment* ("SFAS 123(R)"). Vanguard also adopted SFAS 123(R) on a prospective basis and such adoption did not significantly impact Vanguard's results of operations or cash flows.

The following table sets forth the weighted average assumptions utilized in the minimum value pricing model for stock option grants under the 2004 Option Plan prior to July 1, 2006 and those utilized in the Black-Scholes-Merton valuation model for grants under the 2004 Option Plan subsequent to July 1, 2006.

	Minimum Value	Black-Scholes-Merton
Risk-free interest rate	4.11% - 4.95%	3.61% - 5.13%
Dividend yield	0.0%	0.0%
Volatility (wtd avg)	N/A	30.10%
Volatility (annual)	N/A	26.39% - 37.73%
Expected option life	10 years	6.5 years

For stock options included in the Black-Scholes-Merton valuation model, Vanguard used historical stock price information of certain peer group companies for a period of time equal to the expected option life period to determine estimated volatility. Vanguard determined the expected life of the stock options by averaging the contractual life of the options and the vesting period of the options. The estimated fair value of options is amortized to expense on a straight-line basis over the options' vesting period.

Subsequent Events

In May 2009, the Financial Accounting Standards Board ("FASB") issued Statement of Financial Accounting Standards No. 165, *Subsequent Events* ("SFAS 165"). In accordance with the adoption of SFAS 165, Vanguard has evaluated subsequent events for the year ended June 30, 2009 through September 2, 2009, the date these financial statements were issued. No significant subsequent events were noted that would require recognition or disclosure at this time.

Recently Issued Accounting Pronouncements

In June 2009, FASB issued Statement of Financial Accounting Standards No. 168, *The FASB Codification and the Hierarchy of Generally Accepted Accounting Principles* ("SFAS 168" or "Codification"). When it becomes effective for financial statements covering periods ending after September 15, 2009, the *Codification* will be the single source of authoritative U.S. GAAP applicable to all non-governmental entities and will supersede all existing FASB, AICPA, and Emerging Issues Task Force (EITF) pronouncements and related literature (i.e. all codified literature will carry the same level of authority and non-codified GAAP literature will become non-authoritative). The *Codification* will also include relevant portions of authoritative SEC content relating to matters within the basic financial statements, which are considered as sources of authoritative GAAP for SEC registrants. As of July 1, 2009, the FASB no longer issues Statements, Interpretations, Staff Positions, or EITF abstracts. Irrespective of how they would have been issued under the previous structure, all changes to GAAP will henceforth be only in the form of Accounting Standards Updates, which will serve to update the *Codification* itself. When the *Codification* becomes effective, SFAS No. 162, *The Hierarchy of Generally Accepted Accounting Principles*, will be rendered irrelevant to give effect to the new GAAP hierarchy established in the *Codification*. SFAS 168 is effective for Vanguard's fiscal quarter beginning July 1, 2009. Other than modifications to the currently required disclosures, Vanguard does not expect the adoption of SFAS 168 to have a significant impact on its financial position, results of operations or cash flows.

In June 2009, FASB issued Statement of Financial Accounting Standards No. 167, *Amendments to FASB Interpretation No. 46 (R)*("SFAS 167"). SFAS 167 amends FASB's Interpretation (FIN) No. 46(R) , *Consolidation of Variable Interest Entities*, mainly to (1) require an enterprise to conduct a qualitative analysis for the purpose of determining whether, based on its variable interests, it also has a controlling interest in a variable interest entity (VIE), and (2) make the consequential changes resulting from elimination of the concept of a qualifying special-purpose entity (QSPE) in SFAS No. 140 , *Accounting for Transfers and Servicing of Financial Assets and Extinguishments of Liabilities*, thus subjecting an entity previously designated as a QSPE to the same evaluation as that of any other VIE for consolidation purposes. Amended FIN No. 46(R) is effective as of the start of the first annual reporting period beginning after November 15, 2009, for interim periods within the first annual reporting period, and for all subsequent annual and interim reporting periods. Earlier application is not permitted, but retrospective application to previously issued financial statements for previous years is allowed but, not required. Vanguard does not expect the adoption of SFAS 167 to have a significant impact on its financial position, results of operations or cash flows.

In December 2007, FASB issued Statement of Financial Accounting Standards No. 141(R), *Business Combinations* ("SFAS 141(R)"). SFAS 141(R) applies to all transactions or other events in which an entity obtains control of one or more businesses even if the acquirer does not acquire 100% of all interests of the target. Under SFAS 141(R) the acquirer recognizes 100% of the fair values of acquired assets, including goodwill, and assumed liabilities with only limited exceptions. This methodology replaces the previous cost-allocation process set forth in SFAS No. 141 that often resulted in the measurement of assets and liabilities at values other than fair value at the acquisition date. SFAS 141(R) also requires contingent consideration to be measured at fair value at acquisition date with subsequent adjustments measured in future periods. Transactions costs are not considered part of the acquired assets and thus are expensed as incurred under SFAS 141(R). The acquisition date is deemed to be the date on which the acquisition is completed, not when the acquisition agreement is executed. Vanguard will adopt SFAS 141(R) prospectively for acquisitions completed on or after July 1, 2009. However, SFAS 141(R) requires changes to estimates of deferred taxes arising from business combinations to be adjusted through earnings even if the business combination occurred prior to the effective date of SFAS 141(R).

Since the issuance of SFAS 141(R), constituents have expressed concern regarding certain aspects of its application to pre-acquisition contingencies. Accordingly, in April 2009 the FASB issued FASB Staff Position No. SFAS 141(R)-1, *Accounting for Assets Acquired and Liabilities Assumed in a Business Combination That Arise from Contingencies* ("FSP 141(R)-1"), which amends SFAS 141(R) to provide guidance in respect of initial recognition and measurement, subsequent measurement, and disclosures concerning assets and liabilities arising from pre-acquisition contingencies in a business combination. Vanguard will adopt FSP 141(R)-1 prospectively for acquisitions completed on or after July 1, 2009. SFAS 141(R) and FSP 141(R)-1 will affect Vanguard's future financial position, results of operations or cash flows to the extent Vanguard completes a business combination on or subsequent to July 1, 2009 and could significantly impact Vanguard's future results of operations should deferred tax estimates attributable to the Blackstone merger differ significantly from their ultimate resolution.

In December 2007, FASB issued Statement of Financial Accounting Standards No. 160, *Noncontrolling Interests in Consolidated Financial Statements* ("SFAS 160"). SFAS 160 amended Accounting Research Bulletin No. 51, *Consolidated Financial Statements*, to establish a single method of accounting for non-controlling interests in subsidiaries, or previously referred to as minority interests. SFAS 160 requires that the noncontrolling interest in a subsidiary be reported as a component of stockholder's equity in the consolidated balance sheet. SFAS 160 also requires that consolidated net income include both the parent and noncontrolling interest's portion of the operating results of the subsidiary with separate disclosure on the statement of operations of the amounts attributable to the parent versus the noncontrolling interest. Changes in the parent's ownership interest that do not result in deconsolidation are treated as equity transactions under SFAS 160. Vanguard will adopt SFAS 160 prospectively on July 1, 2009 with retrospective presentation for comparative periods shown. Vanguard does not expect SFAS 160 to have a material impact on its future financial position, results of operations or cash flows.

In February 2007, FASB issued Statement of Financial Accounting Standards No. 159, *The Fair Value Option for Financial Assets and Financial Liabilities* ("SFAS 159"). SFAS 159 gives entities the option to voluntarily choose, at certain election dates, to measure many financial assets and liabilities at fair value. Elections are made on an instrument by instrument basis and are irrevocable once made. Subsequent changes to the fair value of any instrument for which an election is made are reflected through earnings. SFAS 159 was effective for Vanguard as of July 1, 2008. The adoption of SFAS 159 did not significantly impact Vanguard's financial position, results of operations or cash flows.

On September 15, 2006, FASB issued Statement of Financial Accounting Standards No. 157, *Fair Value Measurement* ("SFAS 157"). SFAS 157 sets forth comprehensive guidance for measuring fair value of assets and liabilities. Under the provisions of SFAS 157, fair value should be based on the assumptions market participants would use to complete the sale of an asset or transfer of a liability. SFAS 157 provides a hierarchy of information to be used to determine the applicable market assumptions, and fair value measurements would be separately disclosed under each applicable layer of the hierarchy. SFAS 157 does not expand or restrict the use of fair value for measuring assets and liabilities but provides a single methodology to be used when fair value accounting is applied. For those financial assets and financial liabilities defined in SFAS 159, SFAS 157 was effective for Vanguard's fiscal year beginning July 1, 2008. For non-recurring nonfinancial assets and nonfinancial liabilities, SFAS 157 is effective for Vanguard's fiscal year beginning July 1, 2009. Vanguard does not expect the adoption of SFAS 157 for non-financial assets and non-financial liabilities to significantly impact its future financial position, results of operations or cash flows.

3. Discontinued Operations

On October 1, 2006, certain of Vanguard's subsidiaries completed the sale of their three hospitals in Orange County, California (West Anaheim Medical Center, Huntington Beach Hospital and La Palma Intercommunity Hospital) to subsidiaries of Prime Healthcare, Inc. for net proceeds of $40.0 million, comprised of cash proceeds of $37.0 million and $3.0 million of proceeds placed in escrow which was distributed to a subsidiary of Vanguard on July 2, 2007. Approximately $12.8 million of retained working capital, including $25.3 million of patient accounts receivable, was excluded from the sale.

The operations of the California hospitals are included in discontinued operations, net of taxes, in the accompanying statements of operations for all periods presented in accordance with SFAS 144, *Accounting for the*

Impairment or Disposal of Long-Lived Assets ("SFAS 144") and EITF 03-13, *Applying the Conditions of Paragraph 42 of FASB Statement No. 144 in Determining Whether to Report Discontinued Operations* ("EITF 03-13").

In June 2007, Vanguard ceased providing acute care services at Phoenix Memorial Hospital ("PMH") and began leasing certain floors of the building to various third party healthcare providers. The leases are 5-year and 7-year leases with renewal options. When comparing the projected lease income to the historical total revenues of PMH, Vanguard determined that the expected cash inflows under the leases were insignificant and deemed indirect cash flows. Thus, the acute care operations of PMH are included in discontinued operations, net of taxes in the accompanying statements of operations for all periods presented in accordance with SFAS 144 and EITF 03-13.

The following table sets forth the components of discontinued operations, net of taxes for the years ended June 30, 2007, 2008 and 2009, respectively (in millions).

	Year Ended June 30,		
	2007	2008	2009
Total revenues	$ 91.7	$ (1.5)	$ 1.7
Operating expenses	115.9	(1.6)	0.2
Allocated interest	2.7	–	–
Loss on sale of assets	1.7	0.6	–
Income tax expense (benefit)	(9.5)	(0.2)	0.6
Income (loss) from discontinued operations, net of taxes	$ (19.1)	$ (0.3)	$ 0.9

The interest allocation to discontinued operations for the year ended June 30, 2007 was based upon the ratio of net assets to be divested to the sum of total net assets and Vanguard's outstanding debt. Income taxes were calculated using an effective tax rate of approximately 33.2%, 40.0% and 40.0% for the years ended June 30, 2007, 2008 and 2009, respectively.

4. Fair Value Measurements

On July 1, 2008, Vanguard adopted the provisions of Financial Accounting Standards No. 157, *Fair Value Measurement* ("SFAS 157") for financial assets and financial liabilities defined in Financial Accounting Standards No. 159, *The Fair Value Option for Financial Assets and Financial Liabilities* ("SFAS 159"). For non-recurring nonfinancial assets and nonfinancial liabilities, SFAS 157 is effective for Vanguard's fiscal year beginning July 1, 2009. SFAS 157 defines fair value, establishes a framework for measuring fair value and expands disclosures about fair value measurements.

Under SFAS 157, fair value is determined using assumptions that market participants would use to determine the price of the asset or liability as opposed to measurements determined based upon information specific to the entity holding those assets and liabilities. To determine those market participant assumptions, SFAS 157 established a hierarchy of inputs that the entity must consider including both independent market data inputs and the entity's own assumptions about the market participant assumptions. This hierarchy is summarized as follows.

Level 1 Unadjusted quoted prices in active markets for identical assets and liabilities.

Level 2 Directly or indirectly observable inputs, other than quoted prices included in Level 1. Level 2 inputs may include, among others, interest rates and yield curves observable at commonly quoted intervals, volatilities, loss severities, credit risks and other inputs that are derived principally from or corroborated by observable market data by correlation or other means.

Level 3 Unobservable inputs used when there is little, if any, market activity for the asset or liability at the measurement date. These inputs represent the entity's own assumptions about the assumptions that market participants would use to price the asset or liability developed using the best information available.

In April 2009, the FASB issued FASB Staff Position No. FAS 157-4, *Determining Fair Value When the Volume and Level of Activity for the Asset or Liability Have Significantly Decreased and Identifying Transactions That Are Not Orderly* ("FSP 157-4"). FSP 157-4 clarifies the application of SFAS 157 in cases where the volume and level of activity for an asset or liability have significantly decreased, and identifying circumstances indicating that a transaction is not an orderly one. Vanguard considered the guidance provided by FSP 157-4 in its determination of estimated fair values as of June 30, 2009, and the impact was not material.

The following table summarizes Vanguard's assets measured at fair value on a recurring basis as of June 30, 2009, aggregated by the fair value hierarchy level within which those measurements were made (in millions).

	Fair Value	Level 1 Inputs	Level 2 Inputs	Level 3 Inputs
Assets:				
Investments in auction rate securities	$ 21.6	$ –	$ –	$ 21.6
Liabilities:				
Interest rate swap liability	$ 6.9	$ –	$ 6.9	$ –

The following table provides a reconciliation of the beginning and ending balances for the year ended June 30, 2009 for those fair value measurements using significant Level 3 unobservable inputs (in millions).

	Balance at July 1, 2008	Asset Reclassification	Other-than-temporary impairment	Unrealized holding loss	Balance at June 30, 2009
Marketable securities	$ 26.3	$ (25.7)	$ (0.6)	$ –	$ –
Investments in auction rate securities	–	25.7	–	(4.1)	21.6
Total Level 3 inputs	$ 26.3	$ –	$ (0.6)	$ (4.1)	$ 21.6

Auction Rate Securities

At June 30, 2009, Vanguard held $21.6 million in total available for sale investments in auction rate securities ("ARS") backed by student loans, which are included in investments in auction rate securities on the accompanying consolidated balance sheet. These ARS are accounted for as long-term available for sale securities under SFAS 115, *Accounting for Certain Investments in Debt and Equity Securities*. The par value of the ARS was $26.3 million at June 30, 2009. The ARS have maturity dates ranging from 2039 to 2043 and are guaranteed by the U.S. government at approximately 96%-98% of the principal and accrued interest under the Federal Family Education Loan Program or other similar programs. Due to the lack of market liquidity and other observable market inputs for these ARS, Vanguard utilized Level 3 inputs to estimate the $21.6 million fair value of these ARS. Valuations from forced liquidations or distressed sales are inconsistent with the definition of fair value set forth in SFAS 157, which assumes an orderly market. For its valuation estimate, management utilized a discounted cash flow analysis that included estimates of the timing of liquidation of these ARS and the impact of market risks on exit value. Vanguard does not currently intend to sell and does not believe it is more likely than not it will be required to sell these ARS prior to liquidity returning to the market and their fair value recovering to par value.

In September 2008, Vanguard received a tender offer for $10.0 million par value of ARS at 94% of par value. As a result of Vanguard's acceptance of the tender offer and the other-than-temporary decline in fair value, Vanguard recorded a $0.6 million realized holding loss on these marketable securities during the quarter ended September 30, 2008, which is included in other expenses on the accompanying consolidated statement of operations for the year ended June 30, 2009. However, the tender offer contained certain conditions that were not met as of the December 2008 deadline, and the tender failed. As a result of the failed tender, all $21.6 million of ARS are presented as long-term assets on the accompanying consolidated balance sheet as of June 30, 2009. In addition, Vanguard recorded a temporary impairment of $4.1 million ($2.5 million, net of taxes) related to the ARS during the

year ended June 30, 2009, which is included in accumulated other comprehensive income (loss) ("OCI") on the consolidated balance sheet as of June 30, 2009.

Interest Rate Swap Agreement

Vanguard enters into derivative instruments from time to time to manage the cash flows risk associated with the variable interest component of its outstanding term debt or to manage the fair value risk of its other debt instruments with fixed interest rates. Vanguard does not hold or issue derivative instruments for trading purposes and is not a party to any instrument with leverage features.

During April 2008, Vanguard entered into an interest rate swap agreement with Bank of America, N.A. (the "counterparty") that went into effect on June 30, 2008 for a notional $450.0 million of its outstanding term debt. Under this agreement and through March 31, 2009, Vanguard made or received net interest payments based upon the difference between the 90-day LIBOR rate and the swap fixed interest rate of 2.785%. Vanguard accounted for this swap as a highly effective cash flow hedge with critical terms that substantially match the underlying term debt and measured any ineffectiveness using the hypothetical derivative method.

In March 2009, Vanguard and the counterparty executed an amended swap agreement with the same terms and provisions as the original agreement except that after March 31, 2009, Vanguard will make or receive net interest payments based upon the difference between the 30-day LIBOR rate and the swap fixed interest rate of 2.5775%. As a result of this amended swap agreement, Vanguard de-designated its existing cash flow hedge and re-designated the amended swap agreement as a hedge of the remaining interest payments associated with $450.0 million of Vanguard's outstanding term debt. As the forecasted transactions (i.e. the future interest payments under Vanguard's outstanding term debt) are still probable of occurring, Vanguard did not immediately recognize the accumulated other comprehensive loss balance related to the de-designated swap in earnings. Based on its assessment, Vanguard determined that this re-designated swap will be highly effective in offsetting the changes in cash flows related to the hedged risk. Upon the execution of the amended swap agreement, Vanguard measured hedge ineffectiveness by comparing the fair value of the original swap agreement to a new hypothetical derivative using the amended terms to determine if the underlying term debt has been overhedged. Vanguard determined that the hedge ineffectiveness was not significant as of June 30, 2009. Vanguard will continue this measurement process on a quarterly basis until the termination of the amended swap on March 31, 2010. The valuation of the amended interest rate swap is based upon a discounted cash flows analysis that reflects the term of the agreement and an observable market-based input, the 30-day LIBOR interest rate curve, which is observable at commonly quoted intervals for the full term of the swap. Vanguard also considered potential credit adjustment risks related to its own performance and the counterparty's performance under the swap agreement. Management deemed the credit adjustment risks as Level 3 inputs. However, management determined that any potential credit adjustment risks were not significant and thus classified the entire interest rate swap valuation in Level 2 of the fair value hierarchy.

The following tables provide information regarding the valuation and presentation of assets, liabilities and expenses related to this interest rate swap for the respective periods (in millions).

Interest rate swap contract:	June 30, 2008 Balance Sheet Location	June 30, 2008 Fair Value	June 30, 2009 Balance Sheet Location	June 30, 2009 Fair Value
Gross valuation	Prepaid expenses and other current assets	$ 4.6	Other accrued expenses and current liabilities	$ (6.9)
Tax effect	Deferred tax assets	(1.8)	Deferred tax assets	2.6
Net asset (liability) balance offset to accumulated OCI		$ 2.8		$ (4.3)

	Year ended June 30, 2008 Amount of gain (loss) recognized in OCI on derivative	Location of gain (loss) recognized on derivative-reclassified from OCI	Amount of gain (loss) recognized on derivative - reclassified from OCI	Year ended June 30, 2009 Amount of gain (loss) recognized in OCI on derivative	Location of gain (loss) recognized on derivative-reclassified from OCI	Amount of gain (loss) recognized on derivative - reclassified from OCI
Interest rate swap contract, net of taxes	$ 2.8	n/a	$ –	$ (7.1)	Interest, net	$ (2.8)

The $4.3 million balance included in accumulated OCI, net of taxes, is expected to be reclassified to net interest during the fiscal year ending June 30, 2010 since the interest rate swap expires on March 31, 2010.

Cash and Cash Equivalents and Restricted Cash

The carrying amounts reported for cash and cash equivalents and restricted cash approximate fair value because of the short-term maturity of these instruments.

Accounts Receivable and Accounts Payable

The carrying amounts reported for accounts receivable and accounts payable approximate fair value because of the short-term maturity of these instruments.

Long-Term Debt

The fair values of Vanguard's 9.0% Notes, and 11.25% Notes and term loans as of June 30, 2009 were approximately $547.7 million, $209.3 million and $735.7 million, respectively, based upon stated market prices. The fair values are subject to change as market conditions change.

5. Prepaid Expenses and Other Current Assets

Prepaid expenses and other current assets in the accompanying consolidated balance sheets consist of the following at June 30, 2008 and 2009 (in millions).

	2008	2009
Prepaid insurance	$ 5.2	$ 6.1
Prepaid maintenance contracts	4.5	7.9
Other prepaid expenses	6.0	8.9
Interest rate swap receivable	2.8	–
Third party settlements	4.4	2.1
Reinsurance receivables	9.8	17.2
Other receivables	23.1	26.2
	$ 55.8	$ 68.4

6. Impairment of Long-Lived Assets and Goodwill

Vanguard completed its annual goodwill impairment test required by SFAS 142 during the fourth quarter of fiscal 2009 noting no impairment. However, Vanguard's Chicago market, with goodwill of approximately $43.1 million as of June 30, 2009, will require continual monitoring during fiscal year 2010 due to the sensitivity of the projected operating results of this reporting unit to the goodwill impairment analysis. If actual future cash flows become less favorable than those projected by management, an impairment charge may become necessary that could have a material adverse impact on Vanguard's financial position and results of operations.

In accordance with SFAS 144, during the fourth quarter of fiscal 2009 Vanguard noted events and conditions indicating that the carrying value of the asset group related to a building at one of its non-hospital facilities included in the acute care services segment may not be recoverable. Utilizing management estimates and appraisal information, Vanguard recorded an impairment charge of approximately $6.2 million ($3.8 million, net of taxes) to write down the building carrying value to fair value during the fourth quarter of fiscal 2009.

7. Goodwill and Intangible Assets

The following table provides information regarding the intangible assets, including deferred loan costs, included in the accompanying consolidated balance sheets as of June 30, 2008 and 2009 (in millions).

	Gross Carrying Amount		Accumulated Amortization	
Class of Intangible Asset	2008	2009	2008	2009
Amortized intangible assets:				
Deferred loan costs	$ 43.8	$ 43.8	$ 16.1	$ 21.5
Contracts	31.4	31.4	11.8	14.9
Physician income and other guarantees	22.2	27.2	12.1	18.3
Other	1.3	4.7	0.5	1.0
Subtotal	98.7	107.1	40.5	55.7
Indefinite-lived intangible assets:				
License and accreditation	3.2	3.2	–	–
Total	$ 101.9	$ 110.3	$ 40.5	$ 55.7

Amortization expense for contract-based intangibles and other intangible assets during the fiscal years ended June 30, 2007, 2008 and 2009 was approximately $3.2 million, $3.2 million and $3.6 million, respectively. Total

estimated amortization expense for these intangible assets during the next five years and thereafter is as follows (in millions).

2010	$ 3.7
2011	3.7
2012	3.7
2013	3.7
2014	3.7
Thereafter	1.5
	$ 20.0

In connection with the Blackstone merger, Vanguard incurred $43.8 million of deferred offering and loan costs related to the 9.0% Notes, the 11.25% Notes and term and revolving loan borrowings under the merger credit facilities and the 2005 term loan facility.

Amortization of deferred loan costs of $4.5 million, $4.9 million and $5.4 million during the years ended June 30, 2007, 2008 and 2009, respectively, is included in net interest. Amortization of physician income and other guarantees of $5.1 million, $6.7 million and $6.2 million during the years ended June 30, 2007, 2008 and 2009, respectively, is included in purchased services or other operating expenses.

The following table presents the changes in the carrying amount of goodwill from June 30, 2008 through June 30, 2009 (in millions).

	Acute Care Services	Health Plans	Total
Balance as of June 30, 2008	$ 609.8	$ 79.4	$ 689.2
Acquisition of healthcare entities	2.9	–	2.9
Balance as of June 30, 2009	$ 612.7	$ 79.4	$ 692.1

Vanguard completed its annual impairment test of goodwill and indefinite-lived intangible assets during the fourth quarter of fiscal 2009 noting no impairment. Approximately $151.5 million of Vanguard's goodwill is deductible for tax purposes.

8. Other Accrued Expenses and Current Liabilities

The following table presents summaries of items comprising other accrued expenses and current liabilities in the accompanying consolidated balance sheets as of June 30, 2008 and 2009 (in millions).

	2008	2009
Property taxes	$ 14.6	$ 17.0
Current portion of professional and general liability and workers compensation insurance	19.0	34.4
Accrued income guarantees	4.4	3.0
Income taxes payable (receivable)	2.4	(5.0)
Interest rate swap payable	–	6.9
Other	16.9	23.2
	$ 57.3	$ 79.5

9. Long-Term Debt

A summary of Vanguard's long-term debt at June 30, 2008 and 2009 follows (in millions).

	2008	2009
9.0% Senior Subordinated Notes	$ 575.0	$ 575.0
11.25% Senior Discount Notes	188.4	210.2
Term loans payable under credit facility	774.1	766.4
	1,537.5	1,551.6
Less: current maturities	(8.0)	(8.0)
	$ 1,529.5	$ 1,543.6

9.0% Notes

In connection with the acquisition of Vanguard by merger on September 23, 2004 by certain investment funds affiliated with The Blackstone Group L.P. (collectively "Blackstone"), two of Vanguard's wholly owned subsidiaries, Vanguard Health Holding Company II, LLC and Vanguard Holding Company II, Inc. (collectively, the "Issuers"), completed a private placement of $575.0 million 9% Senior Subordinated Notes due 2014 ("9.0% Notes"). Interest on the 9.0% Notes is payable semi-annually on October 1st and April 1st of each year. The 9.0% Notes are general unsecured senior subordinated obligations and rank junior in right of payment to all existing and future senior indebtedness of the Issuers. All payments on the 9.0% Notes are guaranteed jointly and severally on a senior subordinated basis by Vanguard and its domestic subsidiaries, other than those subsidiaries that do not guarantee the obligations of the borrowers under the senior credit facilities.

Prior to October 1, 2009, the Issuers may redeem the 9.0% Notes, in whole or in part, at a price equal to 100% of the principal amount thereof plus a make-whole premium. On or after October 1, 2009, the Issuers may redeem all or part of the 9.0% Notes at various redemption prices given the date of redemption as set forth in the indenture governing the 9.0% Notes. The initial redemption price for the 9.0% Notes on October 1, 2009 is equal to 104.50% of their principal amount, plus accrued and unpaid interest. The redemption price declines each year after 2009. The redemption price will be 100% of the principal amount, plus accrued and unpaid interest, beginning on October 1, 2012.

11.25% Notes

In connection with the Blackstone merger on September 23, 2004, two of Vanguard's wholly owned subsidiaries, Vanguard Health Holding Company I, LLC and Vanguard Holding Company I, Inc. (collectively, the "Discount Issuers"), completed a private placement of $216.0 million aggregate principal amount at maturity ($124.7 million in gross proceeds) of 11.25% Senior Discount Notes due 2015 ("11.25% Notes"). The 11.25% Notes accrete at the stated rate compounded semi-annually on April 1 and October 1 of each year to, but not including, October 1, 2009. Subsequent to October 1, 2009, cash interest on the 11.25% Notes will accrue at 11.25% per annum, and will be payable on April 1 and October 1 of each year, commencing on April 1, 2010 until maturity. The 11.25% Notes are general senior unsecured obligations and rank junior in right of payment to all existing and future senior indebtedness of the Discount Issuers but senior to any of the Discount Issuers' future senior subordinated indebtedness. All payments on the 11.25% Notes are guaranteed by Vanguard as a holding company guarantee.

Prior to October 1, 2009, the Discount Issuers may redeem the 11.25% Notes, in whole or in part, at a price equal to 100% of the accreted value thereof, plus accrued and unpaid interest, plus a make-whole premium. On or after October 1, 2009, the Discount Issuers may redeem all or a part of the 11.25% Notes at various redemption prices given the date of redemption as set forth in the indenture governing the 11.25% Notes. The initial redemption price for the 11.25% Notes on October 1, 2009 is equal to 105.625% of their principal amount, plus accrued and unpaid interest. The redemption price declines each year after 2009. The redemption price will be 100% of the principal amount, plus accrued and unpaid interest, beginning on October 1, 2012.

Credit Facility Debt

In connection with the Blackstone merger on September 23, 2004, two of Vanguard's wholly owned subsidiaries, Vanguard Health Holding Company II, LLC and Vanguard Holding Company II, Inc. (collectively, the "Co-borrowers"), entered into new senior secured credit facilities (the "merger credit facilities") with various lenders and Bank of America, N.A. as administrative agent and Citicorp North America, Inc. as syndication agent, and repaid all amounts outstanding under its previous credit facility. The merger credit facilities include a seven-year term loan facility in the aggregate principal amount of $800.0 million and a six-year $250.0 million revolving credit facility.

On September 26, 2005, the Co-borrowers refinanced and repriced all $795.7 million of the then outstanding term loans under the merger credit facilities by borrowing $795.7 million of replacement term loans that also mature on September 23, 2011 (the "2005 term loan facility"). In addition, upon the occurrence of certain events, the Co-borrowers may request an incremental term loan facility to be added to the 2005 term loan facility in an amount not to exceed $300.0 million in the aggregate, subject to receipt of commitments by existing lenders or other financing institutions and to the satisfaction of certain other conditions. The revolving loan facility under the merger credit facilities did not change in connection with the term loan refinancing. As of June 30, 2009, $766.4 million of indebtedness was outstanding under the 2005 term loan facility. Vanguard's remaining borrowing capacity under the revolving credit facility, net of letters of credit outstanding, was $218.8 million as of June 30, 2009.

The 2005 term loan facility borrowings bear interest at a rate equal to, at Vanguard's option, LIBOR plus 2.25% per annum or a base rate plus 1.25% per annum. As discussed in Note 4, $450.0 million of the term loan facility borrowings are subject to a fixed interest rate of 4.8275% per annum under the terms of an interest rate swap agreement that expires on March 31, 2010. The interest rate applicable to the unhedged portion of Vanguard's term loan facility borrowings was approximately 2.6% as of June 30, 2009. Borrowings under the revolving credit facility currently bear interest at a rate equal to, at Vanguard's option, LIBOR plus 2.0% per annum or a base rate plus 1.0% per annum, subject to an increase of up to 0.50% per annum should Vanguard's leverage ratio increase over certain designated levels. Vanguard also pays a commitment fee to the lenders under the revolving credit facility in respect of unutilized commitments thereunder at a rate equal to 0.50% per annum. Vanguard also pays customary letter of credit fees under this facility. Vanguard makes quarterly principal payments equal to one-fourth of one percent of the outstanding principal balance of the 2005 term loan facility and will continue to make such payments until maturity of the term debt.

Vanguard is subject to certain restrictive and financial covenants under the credit agreement governing the 2005 term loan facility and the revolving credit facility including a total leverage ratio, senior leverage ratio, interest coverage ratio and capital expenditure restrictions. Vanguard was in compliance with each of these financial covenants as of June 30, 2009. Obligations under the credit agreement are unconditionally guaranteed by Vanguard and Vanguard Health Holding Company I, LLC ("VHS Holdco I") and, subject to certain exceptions, each of VHS Holdco I's wholly-owned domestic subsidiaries (the "U.S. Guarantors"). Obligations under the credit agreement are also secured by substantially all of the assets of Vanguard Health Holding Company II, LLC ("VHS Holdco II") and the U.S. Guarantors including a pledge of 100% of the membership interests of VHS Holdco II, 100% of the capital stock of substantially all U.S. Guarantors (other than VHS Holdco I) and 65% of the capital stock of each of VHS Holdco II's non-U.S. subsidiaries that are directly owned by VHS Holdco II or one of the U.S. Guarantors and a security interest in substantially all tangible and intangible assets of VHS Holdco II and each U.S. Guarantor.

Interest Rate Swap Agreement

In March 2009, Vanguard and Bank of America N.A. ("the counterparty") executed an amended swap agreement with the same terms and provisions as the original agreement except that after March 31, 2009, Vanguard will make or receive net interest payments based upon the difference between the 30-day LIBOR rate and the swap fixed interest rate of 2.5775% (see Note 4). Given the turbulence in the credit markets and the attractive swap rates then available, Vanguard amended the swap agreement to hedge its cash flows related to a portion of the 2005 term loan facility against potential market fluctuations to the variable 30-day LIBOR interest rate. Vanguard will continue to make its normal quarterly interest payments under the 2005 term loan facility as described above. Vanguard deems the counterparty to be creditworthy. As of June 30, 2009, the estimated fair value of the interest rate swap

was a liability for Vanguard of approximately $6.9 million ($4.3 million net of taxes of $2.6 million), which is included in other accrued expenses and current liabilities and accumulated other comprehensive income on the accompanying balance sheet. Vanguard will make quarterly adjustments to other comprehensive income (loss) equal to the change in the fair value of the swap from quarter to quarter until the maturity of the swap on March 31, 2010 with any ineffectiveness included immediately in earnings.

Future Maturities

Future maturities of Vanguard's debt as of June 30, 2009 follow (in millions).

Fiscal Year	Amount
2010	$ 8.0
2011	7.9
2012	750.5
2013	-
2014	-
Thereafter	791.0
	$ 1,557.4

Other Information

Vanguard conducts substantially all of its business through its subsidiaries. Most of Vanguard's subsidiaries jointly and severally guarantee the 9.0% Notes on an unsecured senior subordinated basis. Certain of Vanguard's other consolidated wholly-owned and non wholly-owned entities do not guarantee the 9.0% Notes in conformity with the provisions of the indenture governing the 9.0% Notes and do not guarantee Vanguard's 2005 term loan facility in conformity with the provisions thereof. The condensed consolidating financial information for the parent company, the issuers of the 9.0% Notes, the issuers of the 11.25% Notes, the guarantor subsidiaries, the combined non-guarantor subsidiaries, certain eliminations and consolidated Vanguard as of June 30, 2008 and 2009, and for the years ended June 30, 2007, 2008 and 2009, follows.

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING BALANCE SHEETS
June 30, 2008

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
ASSETS							
Current assets:							
Cash and cash equivalents	$ –	$ –	$ –	$ 82.0	$ 59.6	$ –	$ 141.6
Restricted cash	–	–	–	0.3	1.8	–	2.1
Marketable securities	–	–	–	–	26.3	–	26.3
Accounts receivable, net	–	–	–	275.7	24.7	–	300.4
Inventories	–	–	–	44.3	4.9	–	49.2
Prepaid expenses and other current assets	0.1	–	–	62.5	20.0	(2.3)	80.3
Total current assets	0.1	–	–	464.8	137.3	(2.3)	599.9
Property, plant and equipment, net	–	–	–	1,106.4	67.6	–	1,174.0
Goodwill	–	–	–	605.6	83.6	–	689.2
Intangible assets, net	–	24.5	3.2	12.9	20.8	–	61.4
Investments in consolidated subsidiaries	608.8	–	–	–	16.7	(625.5)	–
Other assets	–	–	–	57.6	0.2	–	57.8
Total assets	$ 608.9	$ 24.5	$ 3.2	$ 2,247.3	$ 326.2	$ (627.8)	$ 2,582.3
LIABILITIES AND STOCKHOLDERS' EQUITY							
Current liabilities:							
Accounts payable	$ –	$ –	$ –	$ 137.2	$ 17.9	$ –	$ 155.1
Accrued expenses and other current liabilities	–	13.2	–	132.9	72.9	–	219.0
Current maturities of long-term debt	–	8.0	–	(0.2)	0.2	–	8.0
Total current liabilities	–	21.2	–	269.9	91.0	–	382.1
Other liabilities	–	–	–	70.6	38.7	(3.2)	106.1
Long-term debt, less current maturities	–	1,341.1	188.4	–	–	–	1,529.5
Intercompany	44.3	(900.0)	(120.8)	1,373.9	(51.9)	(345.5)	–
Stockholders' equity	564.6	(437.8)	(64.4)	532.9	248.4	(279.1)	564.6
Total liabilities and stockholders' equity	$ 608.9	$ 24.5	$ 3.2	$ 2,247.3	$ 326.2	$ (627.8)	$ 2,582.3

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING BALANCE SHEETS
June 30, 2009

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
ASSETS							
Current assets:							
Cash and cash equivalents	$ –	$ –	$ –	$ 168.3	$ 139.9	$ –	$ 308.2
Restricted cash	–	–	–	0.2	1.7	–	1.9
Accounts receivable, net	–	–	–	257.0	18.3	–	275.3
Inventories	–	–	–	44.5	3.8	–	48.3
Prepaid expenses and other current assets	2.5	–	–	94.9	34.6	(34.0)	98.0
Total current assets	2.5	–	–	564.9	198.3	(34.0)	731.7
Property, plant and equipment, net	–	–	–	1,114.7	59.4	–	1,174.1
Goodwill	–	–	–	608.5	83.6	–	692.1
Intangible assets, net	–	19.4	2.9	13.5	18.8	–	54.6
Investments in consolidated subsidiaries	608.8	–	–	–	24.5	(633.3)	–
Investments in auction rate securities	–	–	–	–	21.6	–	21.6
Other assets	–	–	–	56.8	0.2	–	57.0
Total assets	$ 611.3	$ 19.4	$ 2.9	$ 2,358.4	$ 406.4	$ (667.3)	$ 2,731.1
LIABILITIES AND STOCKHOLDERS' EQUITY							
Current liabilities:							
Accounts payable	$ –	$ –	$ –	$ 112.7	$ 15.2	$ –	$ 127.9
Accrued expenses and other current liabilities	–	20.0	–	201.9	122.3	–	344.2
Current maturities of long-term debt	–	8.0	–	(0.2)	0.2	–	8.0
Total current liabilities	–	28.0	–	314.4	137.7	–	480.1
Other liabilities	–	–	–	79.9	73.7	(34.0)	119.6
Long-term debt, less current maturities	–	1,333.4	210.2	–	–	–	1,543.6
Intercompany	23.5	(810.4)	(120.9)	1,306.8	(60.1)	(338.9)	–
Stockholders' equity	587.8	(531.6)	(86.4)	657.3	255.1	(294.4)	587.8
Total liabilities and stockholders' equity	$ 611.3	$ 19.4	$ 2.9	$ 2,358.4	$ 406.4	$ (667.3)	$ 2,731.1

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF OPERATIONS
For the year ended June 30, 2007

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Patient service revenues	$ –	$ –	$ –	$ 2,053.9	$ 150.9	$ (25.5)	$ 2,179.3
Premium revenues	–	–	–	56.5	345.3	(0.4)	401.4
Total revenues	–	–	–	2,110.4	496.2	(25.9)	2,580.7
Salaries and benefits	1.2	–	–	986.6	80.1	–	1,067.9
Supplies	–	–	–	394.1	27.7	–	421.8
Health plan claims expense	–	–	–	35.6	286.9	(25.5)	297.0
Purchased services	–	–	–	126.6	14.6	–	141.2
Provision for doubtful accounts	–	–	–	169.2	6.0	–	175.2
Other operating expenses	0.2	–	–	171.2	25.4	(0.4)	196.4
Rents and leases	–	–	–	30.8	6.6	–	37.4
Depreciation and amortization	–	–	–	104.1	14.5	–	118.6
Interest, net	–	119.5	17.7	(8.2)	(5.2)	–	123.8
Management fees	–	–	–	(8.2)	8.2	–	–
Impairment loss	–	–	–	120.1	3.7	–	123.8
Other	–	–	–	2.8	–	–	2.8
Total costs and expenses	1.4	119.5	17.7	2,124.7	468.5	(25.9)	2,705.9
Income (loss) from continuing operations before income taxes	(1.4)	(119.5)	(17.7)	(14.3)	27.7	–	(125.2)
Income tax expense (benefit)	(11.6)	–	–	–	2.1	(2.1)	(11.6)
Equity in earnings of subsidiaries	(142.9)	–	–	–	–	142.9	–
Income (loss) from continuing operations	(132.7)	(119.5)	(17.7)	(14.3)	25.6	145.0	(113.6)
Loss from discontinued operations, net of taxes	–	–	–	(6.0)	(13.1)	–	(19.1)
Net income (loss)	$ (132.7)	$ (119.5)	$ (17.7)	$ (20.3)	$ 12.5	$ 145.0	$ (132.7)

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF OPERATIONS
For the year ended June 30, 2008

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Patient service revenues	$ –	$ –	$ –	$ 2,212.2	$ 150.8	$ (22.5)	$ 2,340.5
Premium revenues	–	–	–	57.7	392.7	(0.2)	450.2
Total revenues	–	–	–	2,269.9	543.5	(22.7)	2,790.7
Salaries and benefits	2.5	–	–	1,068.7	81.5	–	1,152.7
Supplies	–	–	–	405.8	28.7	–	434.5
Health plan claims expense	–	–	–	35.8	314.9	(22.5)	328.2
Purchased services	–	–	–	136.5	13.0	–	149.5
Provision for doubtful accounts	–	–	–	196.9	8.7	–	205.6
Other operating expenses	0.2	–	–	182.4	32.1	(0.2)	214.5
Rents and leases	–	–	–	34.8	7.0	–	41.8
Depreciation and amortization	–	–	–	116.8	14.2	–	131.0
Interest, net	–	109.9	19.8	(9.3)	1.7	–	122.1
Management fees	–	–	–	(8.2)	8.2	–	–
Other	–	–	–	63.5	(54.0)	–	9.5
Total costs and expenses	2.7	109.9	19.8	2,223.7	456.0	(22.7)	2,789.4
Income (loss) from continuing operations before income taxes	(2.7)	(109.9)	(19.8)	46.2	87.5	–	1.3
Income tax expense (benefit)	1.7	–	–	–	13.4	(13.4)	1.7
Equity in earnings of subsidiaries	3.7	–	–	–	–	(3.7)	–
Income (loss) from continuing operations	(0.7)	(109.9)	(19.8)	46.2	74.1	9.7	(0.4)
Income (loss) from discontinued operations, net of taxes	–	–	–	2.9	(3.2)	–	(0.3)
Net income (loss)	$ (0.7)	$ (109.9)	$ (19.8)	$ 49.1	$ 70.9	$ 9.7	$ (0.7)

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF OPERATIONS
For the year ended June 30, 2009

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Patient service revenues	$ –	$ –	$ –	$ 2,373.8	$ 171.2	$ (23.3)	$ 2,521.7
Premium revenues	–	–	–	60.2	618.0	(0.2)	678.0
Total revenues	–	–	–	2,434.0	789.2	(23.5)	3,199.7
Salaries and benefits	4.4	–	–	1,144.7	91.0	–	1,240.1
Supplies	–	–	–	423.7	32.6	–	456.3
Health plan claims expense	–	–	–	34.8	514.1	(23.3)	525.6
Purchased services	–	–	–	152.7	14.7	–	167.4
Provision for doubtful accounts	–	–	–	200.7	10.1	–	210.8
Other operating expenses	0.2	–	–	201.3	56.7	(0.2)	258.0
Rents and leases	–	–	–	36.5	7.0	–	43.5
Depreciation and amortization	–	–	–	116.4	14.2	–	130.6
Interest, net	–	93.8	22.1	(6.7)	2.4	–	111.6
Management fees	–	–	–	(14.1)	14.1	–	–
Impairment loss	–	–	–	6.2	–	–	6.2
Other	–	–	–	5.9	–	–	5.9
Total costs and expenses	4.6	93.8	22.1	2,302.1	756.9	(23.5)	3,156.0
Income (loss) from continuing operations before income taxes	(4.6)	(93.8)	(22.1)	131.9	32.3	–	43.7
Income tax expense (benefit)	16.0	–	–	–	9.4	(9.4)	16.0
Equity in earnings of subsidiaries	49.2	–	–	–	–	(49.2)	–
Income (loss) from continuing operations	28.6	(93.8)	(22.1)	131.9	22.9	(39.8)	27.7
Income from discontinued operations, net of taxes	–	–	–	0.6	0.3	–	0.9
Net income (loss)	$ 28.6	$ (93.8)	$ (22.1)	$ 132.5	$ 23.2	$ (39.8)	$ 28.6

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS
For the year ended June 30, 2007

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Operating activities:							
Net income (loss)	$ (132.7)	$ (119.5)	$ (17.7)	$ (20.3)	$ 12.5	$ 145.0	$ (132.7)
Adjustments to reconcile net income (loss) to net cash provided by (used in) operating activities							
Loss from discontinued operations	–	–	–	6.0	13.1	–	19.1
Depreciation and amortization	–	–	–	104.1	14.5	–	118.6
Provision for doubtful accounts	–	–	–	169.2	6.0	–	175.2
Deferred income taxes	(12.7)	–	–	–	–	–	(12.7)
Amortization of loan costs	–	4.3	0.2	–	–	–	4.5
Accretion of principal on senior discount notes	–	–	17.5	–	–	–	17.5
Gain on disposal of assets	–	–	–	(4.1)	–	–	(4.1)
Stock compensation	1.2	–	–	–	–	–	1.2
Impairment loss	–	–	–	120.1	3.7	–	123.8
Changes in operating assets and liabilities, net of effects of acquisitions:							
Equity in earnings of subsidiaries	142.9	–	–	–	–	(142.9)	–
Accounts receivable	–	–	–	(206.9)	2.9	–	(204.0)
Inventories	–	–	–	(2.9)	1.0	–	(1.9)
Prepaid expenses and other current assets	–	–	–	(28.5)	(1.5)	–	(30.0)
Accounts payable	–	–	–	11.2	(3.8)	–	7.4
Accrued expenses and other liabilities	1.3	0.1	–	61.3	(22.8)	(2.1)	37.8
Net cash provided by (used in) operating activities – continuing operations	–	(115.1)	–	209.2	25.6	–	119.7
Net cash provided by operating activities - discontinued operations	–	–	–	0.5	3.1	–	3.6
Net cash provided by (used in) operating activities	–	(115.1)	–	209.7	28.7	–	123.3
Investing activities:							
Acquisitions	–	–	–	(0.2)	–	–	(0.2)
Capital expenditures	–	–	–	(153.3)	(11.0)	–	(164.3)
Proceeds from asset dispositions	–	–	–	9.5	–	–	9.5
Purchases of short-term investments	–	–	–	–	(120.0)	–	(120.0)
Sales of short-term investments	–	–	–	–	120.0	–	120.0
Other	–	–	–	1.8	0.2	–	2.0
Net cash used in investing activities-continuing operations	–	–	–	(142.2)	(10.8)	–	(153.0)
Net cash provided by (used in) operating activities – discontinued operations	–	–	–	36.3	(1.8)	–	34.5
Net cash used in investing activities	–	–	–	(105.9)	(12.6)	–	(118.5)

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS
For the year ended June 30, 2007
(continued)

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Financing activities:							
Payments of long-term debt	–	(7.9)	–	–	(0.1)	–	(8.0)
Payments to retire stock, equity incentive units and stock options	–	–	–	(0.5)	–	–	(0.5)
Cash provided by (used in) intercompany activity	–	123.0	–	(130.3)	7.3	–	–
Exercise of stock options	–	–	–	0.2	–	–	0.2
Net cash provided by (used in) financing activities	–	115.1	–	(130.6)	7.2	–	(8.3)
Net increase (decrease) in cash and cash equivalents	–	–	–	(26.8)	23.3	–	(3.5)
Cash and cash equivalents, beginning of period	–	–	–	38.5	85.1	–	123.6
Cash and cash equivalents, end of period	$ –	$ –	$ –	$ 11.7	$ 108.4	$ –	$ 120.1

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS
For the year ended June 30, 2008

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Operating activities:							
Net income (loss)	$ (0.7)	$ (109.9)	$ (19.8)	$ 49.1	$ 70.9	$ 9.7	$ (0.7)
Adjustments to reconcile net income (loss) to net cash provided by (used in) operating activities							
Loss (income) from discontinued operations	–	–	–	(2.9)	3.2	–	0.3
Depreciation and amortization	–	–	–	116.8	14.2	–	131.0
Provision for doubtful accounts	–	–	–	196.9	8.7	–	205.6
Deferred income taxes	(2.2)	–	–	–	–	–	(2.2)
Amortization of loan costs	–	4.6	0.3	–	–	–	4.9
Accretion of principal on senior discount notes	–	–	19.5	–	–	–	19.5
Loss on disposal of assets	–	–	–	0.9	–	–	0.9
Stock compensation	2.5	–	–	–	–	–	2.5
Changes in operating assets and liabilities, net of effects of acquisitions:							
Equity in earnings of subsidiaries	(3.7)	–	–	–	–	3.7	–
Accounts receivable	–	–	–	(217.5)	(6.1)	–	(223.6)
Inventories	–	–	–	(4.3)	0.2	–	(4.1)
Prepaid expenses and other current assets	(4.5)	–	–	(17.6)	2.4	–	(19.7)
Accounts payable	–	–	–	5.6	6.6	–	12.2
Accrued expenses and other liabilities	4.9	(0.2)	–	75.3	(21.6)	(13.4)	45.0
Net cash provided by (used in) operating activities – continuing operations	(3.7)	(105.5)	–	202.3	78.5	–	171.6
Net cash provided by operating activities – discontinued operations	–	–	–	0.2	1.3	–	1.5
Net cash provided by (used in) operating activities	(3.7)	(105.5)	–	202.5	79.8	–	173.1
Investing activities:							
Acquisitions	–	–	–	(0.2)	–	–	(0.2)
Capital expenditures	–	–	–	(118.1)	(3.5)	–	(121.6)
Purchases of marketable securities	–	–	–	–	(90.0)	–	(90.0)
Sales of marketable securities	–	–	–	–	63.7	–	63.7
Other	–	–	–	–	1.5	–	1.5
Net cash used in investing activities – continuing operations	–	–	–	(118.3)	(28.3)	–	(146.6)
Net cash provided by (used in) operating activities – discontinued operations	–	–	–	3.1	(0.3)	–	2.8
Net cash used in investing activities	–	–	–	(115.2)	(28.6)	–	(143.8)

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS
For the year ended June 30, 2008
(continued)

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Financing activities:							
Payments of long-term debt	–	(7.8)	–	–	–	–	(7.8)
Payments to retire stock, equity incentive units and stock options	–	–	–	(0.2)	–	–	(0.2)
Cash provided by (used in) intercompany activity	3.7	113.3	–	(17.0)	(100.0)	–	–
Exercise of stock options	–	–	–	0.2	–	–	0.2
Net cash provided by (used in) financing activities	3.7	105.5	–	(17.0)	(100.0)	–	(7.8)
Net increase (decrease) in cash and cash equivalents	–	–	–	70.3	(48.8)	–	21.5
Cash and cash equivalents, beginning of period	–	–	–	11.7	108.4	–	120.1
Cash and cash equivalents, end of period	$ –	$ –	$ –	$ 82.0	$ 59.6	$ –	$ 141.6

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS
For the year ended June 30, 2009

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Operating activities:							
Net income (loss)	$ 28.6	$ (93.8)	$ (22.1)	$ 132.5	$ 23.2	$ (39.8)	$ 28.6
Adjustments to reconcile net income (loss) to net cash provided by (used in) operating activities							
Income from discontinued operations	–	–	–	(0.6)	(0.3)	–	(0.9)
Depreciation and amortization	–	–	–	116.4	14.2	–	130.6
Provision for doubtful accounts	–	–	–	200.7	10.1	–	210.8
Deferred income taxes	5.6	–	–	–	–	–	5.6
Amortization of loan costs	–	5.1	0.3	–	–	–	5.4
Accretion of principal on senior discount notes	–	–	21.8	–	–	–	21.8
Gain on disposal of assets	–	–	–	(2.3)	–	–	(2.3)
Stock compensation	4.4	–	–	–	–	–	4.4
Impairment loss	–	–	–	6.2	–	–	6.2
Realized holding loss on investments	–	–	–	–	0.6	–	0.6
Changes in operating assets and liabilities, net of effects of acquisitions:							
Equity in earnings of subsidiaries	(49.2)	–	–	–	–	49.2	–
Accounts receivable	–	–	–	(182.2)	(3.0)	–	(185.2)
Inventories	–	–	–	0.8	0.2	–	1.0
Prepaid expenses and other current assets	–	–	–	7.6	(20.6)	–	(13.0)
Accounts payable	–	–	–	(24.6)	(2.7)	–	(27.3)
Accrued expenses and other liabilities	10.6	6.8	–	29.6	83.4	(9.4)	121.0
Net cash provided by (used in) operating activities – continuing operations	–	(81.9)	–	284.1	105.1	–	307.3
Net cash provided by operating activities – discontinued operations	–	–	–	0.6	0.3	–	0.9
Net cash provided by (used in) operating activities	–	(81.9)	–	284.7	105.4	–	308.2
Investing activities:							
Acquisitions	–	–	–	(4.4)	–	–	(4.4)
Capital expenditures	–	–	–	(122.3)	(9.8)	–	(132.1)
Proceeds from asset dispositions	–	–	–	4.9	–	–	4.9
Other	–	–	–	(1.7)	(0.3)	–	(2.0)
Net cash used in investing activities	–	–	–	(123.5)	(10.1)	–	(133.6)

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS
For the year ended June 30, 2009
(continued)

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Financing activities:							
Payments of long-term debt	–	(7.8)	–	–	–	–	(7.8)
Payments to retire stock, equity incentive units and stock options	–	–	–	(0.2)	–	–	(0.2)
Cash provided by (used in) intercompany activity	–	89.7	–	(74.7)	(15.0)	–	–
Net cash provided by (used in) financing activities	–	81.9	–	(74.9)	(15.0)	–	(8.0)
Net increase in cash and cash equivalents	–	–	–	86.3	80.3	–	166.6
Cash and cash equivalents, beginning of period	–	–	–	82.0	59.6	–	141.6
Cash and cash equivalents, end of period	$ –	$ –	$ –	$ 168.3	$ 139.9	$ –	$ 308.2

10. Income Taxes

Significant components of income tax expense/benefit attributable to continuing operations are as follows (in millions):

	2007	2008	2009
Current:			
Federal	$ 0.9	$ 1.5	$ 8.2
State	0.1	2.4	2.2
	1.0	3.9	10.4
Deferred:			
Federal	(13.7)	(1.2)	7.9
State	(4.8)	(8.6)	(1.0)
	(18.5)	(9.8)	6.9
Change in valuation allowance	5.9	7.6	(1.3)
Total	$ (11.6)	$ 1.7	$ 16.0

The following table presents the income taxes associated with continuing operations and discontinued operations as reflected in the accompanying consolidated statements of operations (in millions).

	2007	2008	2009
Continuing operations	$ (11.6)	$ 1.7	$ 16.0
Discontinued operations	(9.5)	(0.2)	0.6
Total	$ (21.1)	$ 1.5	$ 16.6

The increases in the valuation allowance during all three years presented result from state net operating loss carryforwards that may not ultimately be utilized because of the uncertainty regarding Vanguard's ability to generate taxable income in certain states. The effective income tax rate differed from the federal statutory rate for the years ended June 30, 2007, 2008 and 2009 as follows:

	2007	2008	2009
Income tax expense at federal statutory rate	35.0%	35.0%	35.0%
Income tax expense at state statutory rate	3.6	(564.6)	0.9
Nondeductible expenses and other	(0.6)	44.0	3.6
Change in valuation allowance	(4.7)	616.4	(2.9)
Nondeductible impairment loss	(24.0)	–	–
Effective income tax rate	9.3%	130.8%	36.6%

Deferred income taxes reflect the net tax effects of temporary differences between the carrying amounts of assets and liabilities for financial reporting purposes and the amounts used for income tax purposes. Significant components of Vanguard's deferred tax assets and liabilities as of June 30, 2008 and 2009, were as follows (in millions):

	2008	2009
Deferred tax assets:		
Net operating loss carryover	$ 69.7	$ 33.7
Excess tax basis over book basis of accounts receivable	8.2	10.2
Accrued expenses and other	24.7	42.2
Deferred loan costs	2.3	1.4
Professional and general liabilities reserves	16.4	21.6
Health plan claims, workers compensation and employee health reserves	9.4	13.7
Alternative minimum tax credit and other credits	3.4	–
Deferred interest expense	–	30.9
Total deferred tax assets	134.1	153.7
Valuation allowance	(29.9)	(28.6)
Total deferred tax assets, net of valuation allowance	104.2	125.1
Deferred tax liabilities:		
Depreciation, amortization and fixed assets basis differences	29.3	33.1
Excess book basis over tax basis of prepaid assets and other	8.0	24.4
Total deferred tax liabilities	37.3	57.5
Net deferred tax assets and liabilities	$ 66.9	$ 67.6

Net non-current deferred tax assets of $42.4 million and $38.0 million as of June 30, 2008 and 2009, respectively, are included in the accompanying consolidated balance sheets in other assets. Net current deferred tax assets were $24.5 million and $29.6 million as of June 30, 2008 and 2009, respectively.

As of June 30, 2009, Vanguard had generated net operating loss ("NOL") carryforwards for federal income tax purposes and state income tax purposes of approximately $9.0 million and $560.0 million, respectively. The significant decrease in the federal income tax NOL carryforward from $107.0 million as of June 30, 2008 to $9.0 million as of June 30, 2009 and the related $30.9 million deferred tax asset recognized during fiscal 2009 is primarily due to certain interest deductions that Vanguard determined will not be deductible until paid. The federal and state NOL carryforwards expire from 2020 to 2027 and 2010 to 2028, respectively. Approximately $2.5 million of these NOLs are subject to annual limitations for federal purposes. These limitations are not expected to significantly affect Vanguard's ability to ultimately recognize the benefit of these NOLs in future years.

Accounting for Uncertainty in Income Taxes

Effective July 1, 2007, Vanguard adopted the provisions of FIN 48. In connection with the adoption of FIN 48, Vanguard recorded a $0.4 million net liability for unrecognized tax benefits, accrued interest and penalties.

The table below summarizes the total changes in unrecognized tax benefits during the years ended June 30, 2008 and 2009 (in millions).

Balance at July 1, 2007	$	0.4
Additions based on tax positions related to the current year		–
Additions for tax positions of prior years		0.2
Reductions for tax positions of prior years		–
Settlements		–
Balance at June 30, 2008	$	0.6
Additions based on tax positions related to the current year		–
Additions for tax positions of prior years		2.9
Reductions for tax positions of prior years		(0.3)
Settlements		–
Balance at June 30, 2009	$	3.2

The $3.2 million balance as of June 30, 2009 of unrecognized tax benefits would impact the effective tax rate if recognized.

The provisions of FIN 48 allow for the classification of interest on an underpayment of income taxes, when the tax law required interest to be paid, and penalties, when a tax position does not meet the minimum statutory threshold to avoid payment of penalties, in income taxes, interest expense or another appropriate expense classification based on the accounting policy election of the company. Vanguard has elected to classify interest and penalties related to the unrecognized tax benefits as a component of income tax expense. During the years ended June 30, 2008 and 2009, Vanguard recognized approximately $20,000 and $40,000, respectively, of such interest and penalties.

$2.6 million of the current year increase in the FIN 48 liability was formerly accounted for as a reduction in Vanguard's net operating loss carryforward deferred tax asset. This amount is now accounted for as a tax liability due to Vanguard utilizing its federal net operating loss carryforward during the period.

Vanguard's U.S. federal income tax returns for tax years 2005 and beyond remain subject to examination by the Internal Revenue Service.

11. Stockholders' Equity

Vanguard has the authority to issue 1,000,000 shares of common stock, par value $.01 per share.

Common Stock of Vanguard and Class A Membership Units of Holdings

In connection with the Blackstone merger, Blackstone, Morgan Stanley Capital Partners and its affiliates (collectively, "MSCP"), management and other investors purchased $624.0 million of Class A Membership Units of Holdings. Holdings then invested the $624.0 million in the common stock of Vanguard, and in addition Blackstone invested $125.0 million directly in the common stock of Vanguard. In February 2005, other investors purchased approximately $0.6 million of Class A membership units of Holdings. Holdings then invested the $0.6 million in the common stock of Vanguard.

Equity Incentive Membership Units of Holdings

In connection with the Blackstone merger, certain members of senior management purchased Class B, Class C and Class D membership units in Holdings (collectively the "equity incentive units") for approximately $5.7 million pursuant to the Amended and Restated Limited Liability Company Operating Agreement of Holdings dated September 23, 2004 ("LLC Agreement"). Vanguard determined the value of the equity incentive units by utilizing appraisal information. The Class B and D units vest 20% on each of the first five anniversaries of the purchase date, while the Class C units vest on the eighth anniversary of the purchase date subject to accelerated vesting upon the

occurrence of a sale by Blackstone of at least 25% of its Class A units at a price per unit exceeding 2.5 times the per unit price paid on September 23, 2004. Upon a change of control (as defined in the LLC Agreement), all Class B and D units fully vest, and Class C units fully vest if the change in control constitutes a liquidity event (as defined in the LLC Agreement). In exchange for a cash payment of $5.7 million, Vanguard issued to Holdings 83,890 warrants with an exercise price of $1,000 per share and 35,952 warrants with an exercise price of $3,000 per share to purchase Vanguard's common stock. The warrants may be exercised at any time. Vanguard reserved 119,842 shares of its common stock to be issued upon exercise of the warrants.

During the years ended June 30, 2007, 2008 and 2009, Vanguard and Holdings repurchased a total of 7,491 outstanding equity incentive units from former executive officers for approximately $0.4 million. The purchase price for unvested units was based upon the lower of cost or fair market value (determined by an independent appraisal) or the lower of cost or fair market value less a 25% discount, as set forth in the LLC Agreement. The purchase price for vested units was fair market value or fair market value less a 25% discount.

Put and Call Features of Acquisition Subsidiary Stock

For a period of 30 days commencing June 1, 2007 and each June 1 thereafter, University of Chicago Hospitals ("UCH") has the right to require Vanguard to purchase its shares in the subsidiary that acquired Louis A. Weiss Memorial Hospital for a purchase price equal to four times the acquisition subsidiary's Adjusted EBITDA (as defined in the shareholders agreement between the parties) for the most recent 12 months of operations less all indebtedness of the acquisition subsidiary (including capital leases) at such time, multiplied by UCH's percentage interest in the acquisition subsidiary on the date of purchase. Similarly, during the same 30-day periods, Vanguard has the right to require UCH to sell to it UCH's shares in the acquisition subsidiary for a purchase price equal to the greater of (i) six times the acquisition subsidiary's Adjusted EBITDA (as defined in the shareholders agreement among the parties) for the most recent 12 months of operations less all indebtedness of the acquisition subsidiary (including capital leases) at such time, times UCH's percentage interest in the acquisition subsidiary on the date of purchase, and (ii) the price paid by UCH for its interest in the acquisition subsidiary minus dividends or other distributions to UCH in respect of that interest.

12. Comprehensive Income (Loss)

Comprehensive income consists of two components: net income (loss) and other comprehensive income (loss). Other comprehensive income refers to revenues, expenses, gains and losses that under SFAS 130, *Reporting Comprehensive Income,* are recorded as an element of stockholders' equity but are excluded from net income. The following table presents the components of comprehensive income (loss) for the years ended June 30, 2007, 2008 and 2009 (in millions).

	June 30, 2007	June 30 2008	June 30 2009
Net income (loss)	$ (132.7)	$ (0.7)	$ 28.6
Change in fair value of interest rate swap	–	4.6	(11.5)
Change in unrealized holding losses on auction rate securities	–	–	(4.1)
Change in income tax (expense) benefit	–	(1.8)	6.0
Comprehensive income (loss)	$ (132.7)	$ 2.1	$ 19.0

The components of accumulated other comprehensive income (loss) as of June 30, 2008 and June 30, 2009 are as follows (in millions).

	June 30, 2008	June 30, 2009
Fair value of interest rate swap	$ 4.6	$ (6.9)
Unrealized holding loss on investments in auction rate securities	–	(4.1)
Income tax (expense) benefit	(1.8)	4.2
Accumulated other comprehensive income (loss)	$ 2.8	$ (6.8)

13. Stock Based Compensation

As previously discussed, Vanguard used the minimum value pricing model permitted under SFAS 123 to determine stock compensation costs related to stock option grants prior to July 1, 2006. On July 1, 2006, Vanguard adopted the provisions of SFAS 123(R), to account for stock option grants subsequent to July 1, 2006. Vanguard adopted SFAS 123(R) on a prospective basis as required for companies that chose to adopt SFAS 123 using the transition guidance set forth in SFAS 148. During fiscal years 2007, 2008 and 2009, Vanguard incurred stock compensation of $1.2 million and $2.5 million and $4.4 million, respectively, related to grants under its 2004 Stock Incentive Plan.

2004 Stock Incentive Plan

After the Blackstone merger, Vanguard adopted the 2004 Stock Incentive Plan ("the 2004 Option Plan"). As of June 30, 2009, the 2004 Option Plan, as amended, allows for the issuance of up to 105,611 options to purchase common stock of Vanguard to its employees, members of its Board of Directors or other service providers of Vanguard or any of its affiliates. The stock options may be granted as Liquidity Event Options, Time Options or Performance Options at the discretion of the Board. The Liquidity Event Options vest 100% at the eighth anniversary of the date of grant and have an exercise price per share as determined by the Board or a committee thereof. The Time Options vest 20% at each of the first five anniversaries of the date of grant and have an exercise price per share as determined by the Board or a committee thereof. The Performance Options vest 20% at each of the first five anniversaries of the date of grant and have an exercise price equal to $3,000 per share or as determined by the Board. The Time Options and Performance Options immediately vest upon a change of control, while the Liquidity Event Options immediately vest only upon a qualifying Liquidity Event, as defined in the Plan Document. As of June 30, 2009, 102,455 options were outstanding under the 2004 Option Plan, as amended.

The following tables summarize options transactions during the years ended June 30, 2007, 2008 and 2009.

	2004 Stock Incentive Plan	
	# of Options	Wtd Avg Exercise Price
Options outstanding at June 30, 2006	70,657	$ 1,644.12
Options granted	10,110	1,715.06
Options exercised	(195)	1,000.00
Options cancelled	(14,998)	1,624.81
Options outstanding at June 30, 2007	65,574	1,661.39
Options granted	30,583	1,611.90
Options exercised	(168)	1,038.49
Options cancelled	(7,291)	1,667.85
Options outstanding at June 30, 2008	88,698	1,644.97
Options granted	17,341	1,634.36
Options exercised	–	–
Options cancelled	(3,584)	1,648.93
Options outstanding at June 30, 2009	102,455	$ 1,643.04
Options available for grant at June 30, 2009	2,652	$ 1,640.19
Options exercisable at June 30, 2009	27,436	$ 1,960.02

The following table provides information relating to the 2004 Option Plan during each period presented.

	Year ended June 30,		
	2007	2008	2009
Weighted average fair value of options granted during each year	$ 590.70	$ 408.59	$ 315.20
Intrinsic value of options exercised during each year (in millions)	$ 0.1	$ 0.1	$ –
Fair value of outstanding options that vested during each year (in millions)	$ 1.0	$ 1.2	$ 1.6

The following table sets forth certain information regarding vested options at June 30, 2009, options expected to vest subsequent to June 30, 2009 and the total options expected to vest over the life of all options granted.

	Currently Vested	Additional Expected to Vest	Total Expected to Vest
Number of options at June 30, 2009	27,436	54,584	82,020
Weighted average exercise price	$ 1,960.02	$ 1,192.32	$ 1,449.12
Aggregate intrinsic value at June 30, 2009 (in millions)	$ 5.9	$ 13.4	$ 19.2
Weighted average remaining contractual term	6.43 years	7.5 years	7.1 years

14. Defined Contribution Plan

Effective June 1, 1998, Vanguard adopted its defined contribution employee benefit plan, the Vanguard 401(k) Retirement Savings Plan (the "401(k) Plan"). The 401(k) Plan is a multiple employer defined contribution plan whereby employees who are age 21 or older are eligible to participate.

The 401(k) Plan allows eligible employees to make contributions of 2% to 20% of their annual compensation. Employer matching contributions, which vary by employer, vest 20% after two years of service and continue vesting at 20% per year until fully vested. For purposes of determining vesting percentages in the 401(k) Plan, many employees received credit for years of service with their respective predecessor companies. Vanguard's matching

expense for the years ended June 30, 2007, 2008 and 2009 was approximately $13.8 million, $14.5 million and $15.7 million, respectively.

15. Leases

Vanguard leases certain real estate properties and equipment under operating leases having various expiration dates. Future minimum operating lease payments under non-cancelable leases for each fiscal year presented below are approximately as follows (in millions).

	Operating Leases
2010	$ 30.4
2011	25.8
2012	22.3
2013	17.8
2014	14.4
Thereafter	42.3
Total minimum lease payments	$ 153.0

During the years ended June 30, 2007, 2008 and 2009, rent expense was approximately $37.4 million, $41.8 million and $43.5 million, respectively.

16. Contingencies and Healthcare Regulation

Contingencies

Vanguard is presently, and from time to time, subject to various claims and lawsuits arising in the normal course of business. In the opinion of management, the ultimate resolution of these matters is not expected to have a material adverse effect on Vanguard's financial position or results of operations.

Professional and General Liability Insurance

Given the nature of its operating environment, Vanguard is subject to professional and general liability claims and related lawsuits in the ordinary course of business. For professional and general liability claims incurred from June 1, 2002 to May 31, 2006, Vanguard's wholly owned captive subsidiary insured its risks at a $10.0 million retention level. For claims incurred from June 1, 2006 to June 30, 2009, Vanguard self-insured the first $9.0 million per claim, and the captive subsidiary insured the next $1.0 million per claim. Vanguard's captive subsidiary maintains excess coverage from independent third party insurers on a claims-made basis for individual claims exceeding $10.0 million up to $75.0 million, but limited to total annual payments of $65.0 million in the aggregate. In April 2009, a jury awarded damages to the plaintiff in a professional liability case against one of Vanguard's hospitals in the amount of approximately $14.9 million, which exceeded Vanguard's captive subsidiary's $10.0 million self insured limit. Based upon this verdict, Vanguard increased its professional and general liability reserve for the year ended June 30, 2009, by the excess of the verdict amount over its previously established case reserve estimate and recorded a receivable from its captive subsidiary's third party excess carrier for that portion exceeding $10.0 million. Vanguard then reduced this receivable by the additional premium due to the excess carrier under Vanguard's retrospectively rated insurance policy for that particular policy year. Vanguard has appealed this verdict since most of the verdict represented non-economic damages like pain and suffering, but can not predict whether or not the verdict will be reduced upon appeal at this time.

Governmental Regulation

Laws and regulations governing the Medicare, Medicaid and other federal healthcare programs are complex and subject to interpretation. Vanguard's management believes that it is in compliance with all applicable laws and regulations in all material respects. However, compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties, and exclusion from the Medicare, Medicaid and other federal healthcare programs. Vanguard is not aware of any material regulatory proceeding or investigation underway or threatened involving allegations of potential wrongdoing.

Reimbursement

Final determination of amounts earned under prospective payment and cost-reimbursement activities is subject to review by appropriate governmental authorities or their agents. In the opinion of Vanguard's management, adequate provision has been made for any adjustments that may result from such reviews.

Laws and regulations governing the Medicare and Medicaid and other federal healthcare programs are complex and subject to interpretation. Vanguard's management believes that it is in compliance with all applicable laws and regulations in all material respects and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing related to Medicare and Medicaid programs. While no such regulatory inquiries have been made, Vanguard's compliance with such laws and regulations is subject to future government review and interpretation. Non-compliance with such laws and regulations could result in significant regulatory action including fines, penalties, and exclusion from the Medicare, Medicaid and other federal healthcare programs.

Acquisitions

Vanguard has acquired and may continue to acquire businesses with prior operating histories. Acquired companies may have unknown or contingent liabilities, including liabilities for failure to comply with healthcare laws and regulations, such as billing and reimbursement, fraud and abuse and similar anti-referral laws. Although Vanguard institutes policies designed to conform practices to its standards following the completion of its acquisitions, there can be no assurance that it will not become liable for past activities of prior owners that may later be asserted to be improper by private plaintiffs or government agencies. Although Vanguard generally seeks to obtain indemnification from prospective sellers covering such matters, there can be no assurance that any such matter will be covered by indemnification, or if covered, that such indemnification will be adequate to cover potential losses and fines.

Employment-Related Agreements

Effective June 1, 1998, Vanguard executed employment agreements with three of its current senior executive officers. Vanguard executed an employment agreement with a fourth current senior executive officer on September 1, 1999. The employment agreements were amended on September 23, 2004 to extend the term of each employment agreement another 5 years and to provide that the Blackstone merger did not constitute a change of control, as defined in the agreements. On November 15, 2007, Vanguard entered into written employment agreements with two other executive officers for terms expiring on November 15, 2012. The employment agreements will renew automatically for additional one-year periods, unless terminated by Vanguard or the executive officer. The employment agreements provide, among other things, for minimum salary levels, for participation in bonus plans, and for amounts to be paid as liquidated damages in the event of a change in control or termination by Vanguard without cause.

Vanguard has executed severance protection agreements ("severance agreements") between Vanguard and each of its other officers who do not have employment agreements. The severance agreements are automatically extended for successive one year terms at the discretion of Vanguard unless a change in control occurs, as defined in the severance agreement, at which time the severance agreement continues in effect for a period of not less than three years beyond the date of such event. Vanguard may be obligated to pay severance payments as set forth in the severance agreements in the event of a change in control and the termination of the executive's employment of Vanguard.

Guarantees

Physician Guarantees

In the normal course of its business, Vanguard enters into physician relocation agreements under which it guarantees minimum monthly income, revenues or collections or guarantees reimbursement of expenses up to maximum limits to physicians during a specified period of time (typically, 12 months to 24 months). In return for the guarantee payments, the physicians are required to practice in the community for a stated period of time (typically, 3 to 4 years) or else return the guarantee payments to Vanguard. In January 2006, Vanguard adopted Financial Accounting Standards Board Staff Position FIN 45-3, *Application of FASB Interpretation No. 45 to Minimum Revenue Guarantees Granted to a Business or Its Owners* ("FSP 45-3"). FSP 45-3 requires that a liability be recorded at fair value for all guarantees entered into on or after January 1, 2006. Vanguard determines this liability and an offsetting intangible asset by calculating an estimate of expected payments to be made over the guarantee period. Vanguard reduces the liability as it makes guarantee payments and amortizes the intangible asset over the term of the physicians' relocation agreements. Vanguard also estimates the fair value of liabilities and offsetting intangible assets related to payment guarantees for physician service agreements for which no repayment provisions exist. As of June 30, 2009, Vanguard had a net intangible asset of $8.4 million and a remaining liability of $3.0 million related to these physician income and service guarantees. The maximum amount of Vanguard's unpaid physician income and service guarantees under FSP 45-3 as of June 30, 2009 was approximately $5.1 million.

Other Guarantees

As part of its contract with the Arizona Health Care Cost Containment System, one of Vanguard's health plans, Phoenix Health Plan, is required to maintain a performance guarantee, the amount of which is based upon Plan membership and capitation premiums received. As of June 30, 2009, Vanguard maintained this performance guarantee in the form of $40.0 million of surety bonds with independent third party insurers collateralized by letters of credit of approximately $5.0 million. These surety bonds expire on September 30, 2009.

17. Related Party Transactions

Pursuant to the Blackstone merger agreement, Vanguard entered into a transaction and monitoring fee agreement with Blackstone and Metalmark Subadvisor LLC ("Metalmark SA"), which is an affiliate of Metalmark Capital LLC, which has shared voting or investment power in Holdings' units owned by the MSCP Funds. Under the terms of the agreement, Vanguard agreed to pay Blackstone and Metalmark SA an annual monitoring fee of $4.0 million and $1.2 million, respectively, plus out of pocket expenses. The monitoring fee represents compensation to Blackstone and Metalmark SA for their advisory and consulting services with respect to financing transactions, strategic decisions, dispositions or acquisitions of assets and other Vanguard affairs from time to time. Blackstone also has the option under the agreement to elect at any time in anticipation of a change in control or initial public offering to require Vanguard to pay both Blackstone and Metalmark SA a lump sum monitoring fee, calculated as the net present value of future annual monitoring fees assuming a remaining ten-year payment period, in lieu of the remaining annual monitoring fee payments. If Blackstone chooses a lump sum payment, Metalmark SA is entitled to receive not less than 15% of the sum of the initial $20.0 million Blackstone transaction fee and the cumulative monitoring fees and lump sum monitoring fee paid to Blackstone less the cumulative aggregate monitoring fees paid to Metalmark SA to date. During the years ended 2007 and 2009, Vanguard paid $4.0 million and $1.2 million in monitoring fees to Blackstone and Metalmark SA, respectively. During fiscal 2008, Vanguard paid approximately $5.2 million and $1.2 million in monitoring fees and expenses to Blackstone and Metalmark SA, respectively.

Blackstone and Metalmark SA have the ability to control Vanguard's policies and operations, and their interests may not in all cases be aligned with Vanguard's interests. Vanguard also conducts business with other entities controlled by Blackstone or Metalmark SA. Vanguard's results of operations could be materially different as a result of Blackstone and Metalmark SA's control than such results would be if Vanguard were autonomous.

Effective July 1, 2008, Vanguard entered into an Employer Health Program Agreement with Equity Healthcare LLC ("Equity Healthcare"), which is an affiliate of Blackstone. Equity Healthcare negotiates with providers of standard administrative services for health benefit plans as well as other related services for cost discounts and

quality of service monitoring capability by Equity Healthcare. Equity Healthcare receives from Vanguard a fee of $2 per employee per month ("PEPM Fee"). As of June 30, 2009, Vanguard has approximately 11,750 employees enrolled in these health and welfare benefit plans.

18. Segment Information

Vanguard's acute care hospitals and related healthcare businesses are similar in their activities and economic environments in which they operate (i.e. urban markets). Accordingly, Vanguard's reportable operating segments consist of 1) acute care hospitals and related healthcare businesses, collectively, and 2) health plans consisting of MacNeal Health Providers, a contracting entity for MacNeal Hospital and Weiss Memorial Hospital in the metropolitan Chicago area, Phoenix Health Plan, a Medicaid managed health plan operating in Arizona, and Abrazo Advantage Health Plan, a Medicare and Medicaid dual eligible managed health plan operating in Arizona. The following tables provide financial information by business segment for the years ended June 30, 2007, 2008 and 2009.

	For the Year Ended June 30, 2007			
	Health Plans	Acute Care Services	Eliminations	Consolidated
		(In millions)		
Patient service revenues (1)	$ –	$ 2,179.3	$ –	$ 2,179.3
Capitation premiums	401.4	–	–	401.4
Inter-segment revenues	–	34.2	(34.2)	–
Total revenues	401.4	2,213.5	(34.2)	2,580.7
Salaries and benefits (excludes stock compensation of $1.2 million)	14.7	1,052.0	–	1,066.7
Supplies	0.2	421.6	–	421.8
Health plan claims expense (1)	297.0	–	–	297.0
Provision for doubtful accounts	–	175.2	–	175.2
Other operating expenses – external	27.3	347.7	–	375.0
Operating expenses – inter-segment	34.2	–	(34.2)	–
Total operating expenses	373.4	1,996.5	(34.2)	2,335.7
Segment EBITDA (2)	28.0	217.0	–	245.0
Depreciation and amortization	4.3	114.3	–	118.6
Interest, net	(5.8)	129.6	–	123.8
Minority interests	–	2.6	–	2.6
Equity method income	–	(0.9)	–	(0.9)
Stock compensation	–	1.2	–	1.2
Gain on disposal of assets	–	(4.1)	–	(4.1)
Impairment loss	–	123.8	–	123.8
Monitoring fees and expenses	–	5.2	–	5.2
Income (loss) from continuing operations before income taxes	$ 29.5	$ (154.7)	$ –	$ (125.2)
Segment assets	$ 197.3	$ 2,340.8	$ –	$ 2,538.1
Capital expenditures	$ 0.2	$ 164.1	$ –	$ 164.3

(1) Vanguard eliminates in consolidation those patient service revenues earned by its hospitals and related healthcare facilities attributable to services provided to enrollees in its owned health plans and also eliminates the corresponding medical claims expenses incurred by the health plans for those services.

(2) Segment EBITDA is defined as income before interest expense (net of interest income), income taxes, depreciation and amortization, minority interests, equity method income or loss, stock compensation, debt extinguishment costs, gain or loss on disposal of assets, monitoring fees and expenses, impairment loss, realized loss on investments and discontinued operations. Management uses Segment EBITDA to measure performance for Vanguard's segments and to develop strategic objectives and operating plans for those segments. Segment EBITDA eliminates the uneven effect of non-cash depreciation of tangible assets and amortization of intangible assets, much of which results from acquisitions accounted for under the purchase method of accounting. Segment EBITDA also eliminates the effects of changes in interest rates which management believes relate to general trends in global capital markets, but are not necessarily indicative of the operating performance of Vanguard's segments. Management believes that Segment EBITDA provides useful information about the financial performance of Vanguard's segments to investors, lenders, financial analysts and rating agencies. Additionally, management believes that investors and lenders view Segment EBITDA as an important factor in making investment decisions and assessing the value of Vanguard. Segment EBITDA is not a substitute for net income, operating cash flows or other cash flow statement data determined in accordance with accounting principles generally accepted in the United States. Segment EBITDA, as presented, may not be comparable to similarly titled measures of other companies.

	For the Year Ended June 30, 2008			
	Health Plans	Acute Care Services	Eliminations	Consolidated
		(In millions)		
Patient service revenues (1)	$ –	$ 2,340.5	$ –	$ 2,340.5
Capitation premiums	450.2	–	–	450.2
Inter-segment revenues	–	31.2	(31.2)	–
Total revenues	450.2	2,371.7	(31.2)	2,790.7
Salaries and benefits (excludes stock compensation of $2.5 million)	16.0	1,134.2	–	1,150.2
Supplies	0.2	434.3	–	434.5
Health plan claims expense (1)	328.2	–	–	328.2
Provision for doubtful accounts	–	205.6	–	205.6
Other operating expenses – external	29.9	375.9	–	405.8
Operating expenses – inter-segment	31.2	–	(31.2)	–
Total operating expenses	405.5	2,150.0	(31.2)	2,524.3
Segment EBITDA (2)	44.7	221.7	–	266.4
Depreciation and amortization	4.2	126.8	–	131.0
Interest, net	(4.5)	126.6	–	122.1
Minority interests	–	3.0	–	3.0
Equity method income	–	(0.7)	–	(0.7)
Stock compensation	–	2.5	–	2.5
Loss on disposal of assets	–	0.9	–	0.9
Monitoring fees and expenses	–	6.3	–	6.3
Income (loss) from continuing operations before income taxes	$ 45.0	$ (43.7)	$ –	$ 1.3
Segment assets	$ 181.5	$ 2,400.8	$ –	$ 2,582.3
Capital expenditures	$ 0.6	$ 121.0	$ –	$ 121.6

(1) Vanguard eliminates in consolidation those patient service revenues earned by its hospitals and related healthcare facilities attributable to services provided to enrollees in its owned health plans and also eliminates the corresponding medical claims expenses incurred by the health plans for those services.

(2) Segment EBITDA is defined as income before interest expense (net of interest income), income taxes, depreciation and amortization, minority interests, equity method income or loss, stock compensation, debt extinguishment costs, gain or loss on disposal of assets, monitoring fees and expenses, impairment loss, realized loss on investments and discontinued operations. Management uses Segment EBITDA to measure performance for Vanguard's segments and to develop strategic objectives and operating plans for those segments. Segment EBITDA eliminates the uneven effect of non-cash depreciation of tangible assets and amortization of intangible assets, much of which results from acquisitions accounted for under the purchase method of accounting. Segment EBITDA also eliminates the effects of changes in interest rates which management believes relate to general trends in global capital markets, but are not necessarily indicative of the operating performance of Vanguard's segments. Management believes that Segment EBITDA provides useful information about the financial performance of Vanguard's segments to investors, lenders, financial analysts and rating agencies. Additionally, management believes that investors and lenders view Segment EBITDA as an important factor in making investment decisions and assessing the value of Vanguard. Segment EBITDA is not a substitute for net income, operating cash flows or other cash flow statement data determined in accordance with accounting principles generally accepted in the United States. Segment EBITDA, as presented, may not be comparable to similarly titled measures of other companies.

	For the Year Ended June 30, 2009			
	Health Plans	Acute Care Services	Eliminations	Consolidated
		(In millions)		
Patient service revenues (1)	$ –	$ 2,521.7	$ –	$ 2,521.7
Capitation premiums	678.0	–	–	678.0
Inter-segment revenues	–	34.0	(34.0)	–
Total revenues	678.0	2,555.7	(34.0)	3,199.7
Salaries and benefits (excludes stock compensation of $4.4 million)	30.6	1,205.1	–	1,235.7
Supplies	0.3	456.0	–	456.3
Health plan claims expense (1)	525.6	–	–	525.6
Provision for doubtful accounts	–	210.8	–	210.8
Other operating expenses – external	36.4	432.5	–	468.9
Operating expenses – inter-segment	34.0	–	(34.0)	–
Total operating expenses	626.9	2,304.4	(34.0)	2,897.3
Segment EBITDA (2)	51.1	251.3	–	302.4
Depreciation and amortization	4.1	126.5	–	130.6
Interest, net	(0.6)	112.2	–	111.6
Minority interests	–	3.2	–	3.2
Equity method income	–	(0.8)	–	(0.8)
Stock compensation	–	4.4	–	4.4
Gain on disposal of assets	–	(2.3)	–	(2.3)
Monitoring fees and expenses	–	5.2	–	5.2
Realized loss on investments	–	0.6	–	0.6
Impairment loss	–	6.2	–	6.2
Income (loss) from continuing operations before income taxes	$ 47.6	$ (3.9)	$ –	$ 43.7
Segment assets	$ 250.3	$ 2,480.8	$ –	$ 2,731.1
Capital expenditures	$ 1.7	$ 130.4	$ –	$ 132.1

(1) Vanguard eliminates in consolidation those patient service revenues earned by its hospitals and related healthcare facilities attributable to services provided to enrollees in its owned health plans and also eliminates the corresponding medical claims expenses incurred by the health plans for those services.

(2) Segment EBITDA is defined as income before interest expense (net of interest income), income taxes, depreciation and amortization, minority interests, equity method income or loss, stock compensation, debt extinguishment costs, gain or loss on disposal of assets, monitoring fees and expenses, impairment loss, realized loss on investments and discontinued operations. Management uses Segment EBITDA to measure performance for Vanguard's segments and to develop strategic objectives and operating plans for those segments. Segment EBITDA eliminates the uneven effect of non-cash depreciation of tangible assets and amortization of intangible assets, much of which results from acquisitions accounted for under the purchase method of accounting. Segment EBITDA also eliminates the effects of changes in interest rates which management believes relate to general trends in global capital markets, but are not necessarily indicative of the operating performance of Vanguard's segments. Management believes that Segment EBITDA provides useful information about the financial performance of Vanguard's segments to investors, lenders, financial analysts and rating agencies. Additionally, management believes that investors and lenders view Segment EBITDA as an important factor in making investment decisions and assessing the value of Vanguard. Segment EBITDA is not a substitute for net income, operating cash flows or other cash flow statement data determined in accordance with accounting principles generally accepted in the United States. Segment EBITDA, as presented, may not be comparable to similarly titled measures of other companies.

19. Unaudited Quarterly Operating Results

The following table presents summarized unaudited quarterly results of operations for the fiscal years ended June 30, 2008 and 2009. Management believes that all necessary adjustments have been included in the amounts stated below for a fair presentation of the results of operations for the periods presented when read in conjunction with Vanguard's consolidated financial statements for the fiscal years ended June 30, 2008 and 2009. Results of operations for a particular quarter are not necessarily indicative of results of operations for an annual period and are not predictive of future periods (in millions).

	September 30, 2007	December 31, 2007	March 31, 2008	June 30, 2008
Total revenues	$ 662.5	$ 686.0	$ 725.6	$ 716.6
Net income (loss)	$ (6.9)	$ 0.5	$ 6.5	$ (0.8)

	September 30, 2008	December 31, 2008	March 31, 2009	June 30, 2009
Total revenues	$ 719.0	$ 792.6	$ 858.0	$ 830.1
Net income	$ 0.9	$ 10.1	$ 15.8	$ 1.8

Item 9. Changes in and Disagreements With Accountants on Accounting and Financial Disclosure.

None.

Item 9A(T). Controls and Procedures.

Evaluation of Disclosure Control and Procedures

As of the end of the period covered by this report, our management conducted an evaluation, with the participation of our chief executive officer and chief financial officer, of the effectiveness of our disclosure controls and procedures (as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934 (the "Exchange Act")). Based on this evaluation, our chief executive officer and chief financial officer have concluded that our disclosure controls and procedures are effective to ensure that information required to be disclosed by us in the reports that we file or submit under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in Securities and Exchange Commission's rules and forms and that such information is accumulated and communicated to management, including our chief executive officer and chief financial officer, as appropriate to allow timely decisions regarding required disclosure.

Report of Management on Internal Control over Financial Reporting

The management of Vanguard Health Systems, Inc. is responsible for the preparation, integrity and fair presentation of the consolidated financial statements appearing in our periodic filings with the Securities and Exchange Commission. The consolidated financial statements were prepared in conformity with generally accepted accounting principles appropriate in the circumstances and, accordingly, include certain amounts based on our best judgments and estimates.

Management is also responsible for establishing and maintaining adequate internal control over financial reporting as such term is defined in Rules 13a-15(f) under the Securities and Exchange Act of 1934. Internal control over financial reporting is a process to provide reasonable assurance regarding the reliability of our financial reporting in accordance with accounting principles generally accepted in the United States of America. Our internal control over financial reporting includes a program of internal audits and appropriate reviews by management, written policies and guidelines, careful selection and training of qualified personnel including a dedicated Compliance department and a written Code of Business Conduct and Ethics adopted by our Board of Directors, applicable to all of our directors, officers and employees.

Internal control over financial reporting includes maintaining records that in reasonable detail accurately and fairly reflect our transactions; providing reasonable assurance that transactions are recorded as necessary for preparation of our financial statements; providing reasonable assurance that receipts and expenditures of company assets are made in accordance with management authorization; and providing reasonable assurance that unauthorized acquisition, use or disposition of company assets that could have a material effect on our financial statements would be prevented or detected in a timely manner. Because of its inherent limitations, including the possibility of human error and the circumvention or overriding of control procedures, internal control over financial reporting is not intended to provide absolute assurance that a misstatement of our financial statements would be prevented or detected. Therefore, even those internal controls determined to be effective can provide only reasonable assurance with respect to financial statement preparation and presentation.

Management conducted an evaluation of the effectiveness of our internal control over financial reporting based on the framework in *Internal Control – Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission. Based on this evaluation, management concluded that the Company's internal control over financial reporting was effective as of June 30, 2009.

This annual report does not include an attestation report of the Company's independent registered public accounting firm regarding internal control over financial reporting. Management's report was not subject to attestation by the Company's independent registered public accounting firm pursuant to the rules of the United States Securities and Exchange Commission that permit the Company to provide only management's report in this annual report for the year ended June 30, 2009.

Changes in Internal Control Over Financial Reporting

There was no change in our internal control over financial reporting during our fiscal quarter ended June 30, 2009 that materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

Item 9B. Other Information.

None.

PART III

Item 10. Directors, Executive Officers and Corporate Governance.

The table below presents information with respect to the members of our board of directors and our executive officers and their ages as of September 1, 2009.

Name	Age	Position
Charles N. Martin, Jr.	66	Chairman of the Board & Chief Executive Officer; Director
Kent H. Wallace	54	President & Chief Operating Officer
Keith B. Pitts	52	Vice Chairman
Mark R. Montoney, MD	52	Executive Vice President & Chief Medical Officer
Joseph D. Moore	62	Executive Vice President
Bradley A. Perkins, MD	50	Executive Vice President-Strategy and Innovation & Chief Transformation Officer
Phillip W. Roe	48	Executive Vice President, Chief Financial Officer & Treasurer
Ronald P. Soltman	63	Executive Vice President, General Counsel & Secretary
Dan F. Ausman	54	Senior Vice President-Operations
Reginald M. Ballantyne III	65	Senior Vice President-Market Strategy & Government Affairs
Bruce F. Chafin	53	Senior Vice President-Compliance & Ethics
Paul T. Dorsa	52	Senior Vice President-Development
Karen Fowler	48	Senior Vice President-Physician & Ambulatory Services
Larry Fultz	54	Senior Vice President-Human Resources
Joseph J. Mullany	45	Senior Vice President-Operations
Harold H. Pilgrim III	48	Senior Vice President & Chief Development Officer
Graham Reeve	45	Senior Vice President-Operations
James H. Spalding	50	Senior Vice President, Assistant General Counsel & Assistant Secretary
Jana S. Stonestreet	56	Senior Vice President & Chief Nursing Executive
Alan G. Thomas	55	Senior Vice President-Operations Finance
Thomas M. Ways	59	Senior Vice President-Managed Care
Gary D. Willis	44	Senior Vice President, Controller & Chief Accounting Officer
Deanna L. Wise	40	Senior Vice President & Chief Information Officer
Michael A. Dal Bello	38	Director
M. Fazle Husain	45	Director
Alan M. Muney, MD	56	Director
Michael J. Parsons	54	Director
James A. Quella	59	Director
Neil P. Simpkins	43	Director

Charles N. Martin, Jr. has served as Chairman of the board of directors and Chief Executive Officer of Vanguard since July 1997. Until May 31, 2001, he was also Vanguard's President. From January 1992 until January 1997, Mr. Martin was Chairman, President and Chief Executive Officer of OrNda HealthCorp ("OrNda"), a hospital management company. Prior thereto Mr. Martin was President and Chief Operating Officer of HealthTrust, Inc., a hospital management company, from September 1987 until October 1991. Mr. Martin is also a director of several privately held companies.

Kent H. Wallace has served as Vanguard's President & Chief Operating Officer since September 2005. Prior thereto he was a Senior Vice President - Operations of Vanguard from February 2003 until September 2005. Prior thereto from July 2001 to December 2002 he was Regional Vice President of Province Healthcare Company of Brentwood, Tennessee, an owner and operator of 20 non-urban, acute care hospitals in 13 states of the United States. During this time Mr. Wallace had managerial responsibility for seven of these hospitals. From June 1999 until June 2001 Mr. Wallace was President and Chief Executive Officer of Custom Curb, Inc. of Chattanooga, Tennessee, a family owned company which manufactured roof accessories. Prior thereto from January 1997 until May 1999 Mr.

Wallace was a Vice President - Acquisitions and Development of Tenet Healthcare Corporation of Dallas, Texas, a hospital management company ("Tenet").

Keith B. Pitts has been Vanguard's Vice Chairman since May 2001, was a director of Vanguard from August 1999 until September 2004, and was an Executive Vice President of Vanguard from August 1999 until May 2001. Prior thereto, from November 1997 until June 1999, he was the Chairman and Chief Executive Officer of Mariner Post-Acute Network, Inc. and its predecessor, Paragon Health Network, Inc., which is a nursing home management company. Prior thereto from August 1992 until January 1997, Mr. Pitts served as Executive Vice President and Chief Financial Officer of OrNda.

Mark R. Montoney, MD has been Vanguard's Executive Vice President & Chief Medical Officer since December 2008. Prior to his employment with Vanguard, from July 2005 to December 2008 Dr. Montoney was System Vice President and Chief Medical Officer of OhioHealth Corporation, a not-for-profit regional hospital management company headquartered in Columbus, Ohio, which operates 8 hospitals, over 20 health and surgery centers, and has affiliation agreements with 9 hospitals, within a 40-county area in central Ohio. Prior thereto, from July 2000 to July 2005, Dr. Montoney was Vice President – Quality & Clinical Support, of Riverside Methodist Hospital, a 985-bed tertiary care hospital in Columbus, Ohio.

Joseph D. Moore has served as an Executive Vice President of Vanguard since November 2007. He served as Executive Vice President, Chief Financial Officer and Treasurer of Vanguard from July 1997 until November 2007 and was a director of Vanguard from July 1997 until September 2004. From February 1994 to April 1997, he was Senior Vice President - Development of Columbia/HCA Healthcare Corporation ("Columbia"), a hospital management company. Mr. Moore first joined Hospital Corporation of America (a predecessor of Columbia) in April 1970, rising to Senior Vice President - Finance and Development in January 1993.

Bradley A. Perkins, MD has been Executive Vice President – Strategy and Innovation & Chief Transformation Officer of Vanguard since July 2009. Prior to his employment with Vanguard, Dr. Perkins held various positions with the Centers for Disease Control & Prevention ("CDC") from July 1989 to June 2009, including Chief Strategy & Innovation Officer and Chief, Office of Strategy & Innovation from December 2005 to June 2009, and Deputy Director, Office of Strategy & Innovation, from May 2004 to December 2005.

Phillip W. Roe has been Executive Vice President, Chief Financial Officer and Treasurer since November 2007. He was Senior Vice President, Controller and Chief Accounting Officer of Vanguard from July 1997 to November 2007. Prior thereto he was Senior Vice President, Controller and Chief Accounting Officer of OrNda from September 1996 until January 1997 and was Vice President, Controller and Chief Accounting Officer of OrNda from October 1994 until September 1996.

Ronald P. Soltman has been Vanguard's Executive Vice President, General Counsel and Secretary since July 1997 and was a director of Vanguard from July 1997 until September 2004. From April 1994 until January 1997, he was Senior Vice President, General Counsel and Secretary of OrNda. From February 1994 until March 1994, he was Vice President and Assistant General Counsel of Columbia. From 1984 until February 1994, he was Vice President and Assistant General Counsel of Hospital Corporation of America.

Dan F. Ausman has served as a Senior Vice President - Operations of Vanguard since February 2006. Prior thereto from May 2005 to February 2006 he was Vice President - Operations of Vanguard. From 1998 to April 2005 Mr. Ausman was the President & Chief Executive Officer of Irvine Regional Hospital and Medical Center, a 176-bed acute care hospital in Irvine, CA which is owned by an affiliate of Tenet.

Reginald M. Ballantyne III, joined Vanguard in May 2001 and has served as Senior Vice President - Market Strategy & Government Affairs of Vanguard since January 2002. From 1984 to 2001, he served as President of PMH Health Resources, Inc., an Arizona based multi-unit healthcare system. Prior to 1984, Mr. Ballantyne served as President of Phoenix Memorial Hospital in Phoenix, Arizona. Mr. Ballantyne served as Chairman of the American Hospital Association ("AHA") in 1997 and as Speaker of the AHA House of Delegates in 1998. He is a Fellow of the American College of Healthcare Executives ("ACHE") and a recipient of the ACHE Gold Medal Award for Management Excellence. Mr. Ballantyne also served as a member of the national Board of Commissioners for the Joint Commission on Accreditation of Healthcare Organizations and as Chairman of the

AHA Committee of Commissioners from 1992 until 1995. Mr. Ballantyne was recently elected Chairman-elect of the Arizona Chamber of Commerce and Industry. He has previously served as a director of Superior Consultant Holdings Corporation and is currently a director of several privately held companies.

Bruce F. Chafin has served as Senior Vice President - Compliance & Ethics of Vanguard since July 1997. Prior thereto, from April 1995 to January 1997, he served as Vice President - Compliance & Ethics of OrNda.

Paul T. Dorsa has served Senior Vice President – Development of Vanguard since September 2008. Prior to his employment with Vanguard, from May 2004 to September 2008 he was the Vice President – Mergers & Acquisition of DaVita Inc., an El Segundo, California-based provider of dialysis services and education for patients with chronic kidney failure and end stage renal disease, managing in the United States more than 1,000 outpatient facilities and acute units in more than 700 hospitals.

Karen Fowler has served as Senior Vice President - Physician & Ambulatory Services of Vanguard since September 11, 2007. Prior thereto from May 1999 until July 2007 she was Vice President - Physician Integration/Managed Care of Triad Hospitals, Inc., an investor owned hospital management company headquartered in Plano, Texas. Prior thereto from May 1996 until May 1999 she was Vice President - Physician Integration/Managed Care of the Central and Pacific Group of Columbia.

Larry Fultz has served as Senior Vice President - Human Resources of Vanguard since February 2009. Prior to his employment with Vanguard, from October 2007 to January 2009 he was Executive Vice President – Human Resources of the Victoria Secret Brand division of Limited Brands, Inc., headquartered in Columbus, Ohio. The Victoria Secret Brand division sells women's intimate and other apparel, personal care and beauty products and accessories under the Victoria's Secret brand name through retail stores, its website and its catalogue. Prior thereto from April 2006 to October 2007, Mr. Fultz was Executive Vice President – Human Resources of the Victoria Secret retail store division of Limited Brands, Inc. Prior to joining Victoria Secret, from September 2000 to April 2006 Mr. Fultz was Vice President – Human Resources of Cintas Corporation, headquartered in Cincinnati, Ohio. Cintas designs, manufactures and implements corporate identity uniform programs, and provides entrance mats, restroom supplies, promotional products, first aid, safety, fire protection products and services and document management services for other businesses.

Joseph J. Mullany has served as a Senior Vice President - Operations of Vanguard since September 2005. Prior thereto from October 2002 to August 2005 he was a Regional Vice President of Essent Healthcare, Inc. of Nashville, TN, an investor-owned hospital management company, responsible for its New England Division. Prior thereto from October 1998 to October 2002 Mr. Mullany was a Division Vice President of Health Management Associates, Inc. of Naples, Florida, an investor-owned hospital management company, responsible for its Mississippi Division.

Harold H. Pilgrim III has served as the Senior Vice President & Chief Development Officer of Vanguard since July 2009. Prior thereto from September 2005 to June 2009 he was a Senior Vice President - Operations of Vanguard. From February 2003 to September 2005 he was Vice President - Business Development of Vanguard, responsible for development for Vanguard's Texas operations. Prior thereto from November 2001 to January 2003 Mr. Pilgrim was Vanguard's Vice President - Investor Relations, and during that period he was also involved in Vanguard's acquisitions and development activities.

Graham Reeve has served as a Senior Vice President - Operations of Vanguard since July 2009. Prior thereto from April 2009 to June 2009 he was Vice President and Chief Operating Officer of Vanguard's Texas operations. From December 2005 to April 2009 he was President and Chief Executive Officer of Vanguard's St. Luke's Baptist Hospital in San Antonio, Texas. Prior thereto from September 2003 to November 2005 he was Vice President – Ambulatory Services of Vanguard's Texas operations. Prior to joining Vanguard, Mr. Reeve was employed by HealthSouth Corporation, a Birmingham, Alabama-based owner of rehabilitation and surgery hospitals and rehabilitation and surgery outpatient centers, holding various positions from December 1995 through August 2003, with his last position being Vice President - Surgical Operations for HealthSouth's southwestern surgery hospitals and surgery centers.

James H. Spalding has served as Senior Vice President, Assistant General Counsel and Assistant Secretary of Vanguard since November 1998. Prior thereto he was Vice President, Assistant General Counsel and Assistant

Secretary of Vanguard from July 1997 until November 1998. Prior thereto from April 1994 until January 1997, he served as Vice President, Assistant General Counsel and Assistant Secretary of OrNda.

Jana S. Stonestreet has served as Vanguard's Senior Vice President & Chief Nursing Executive since June 2009. Prior thereto from January 2006 to June 2009, Dr. Stonestreet was Chief Nursing Executive of Vanguard's Texas operations. Prior to joining Vanguard, from June 2004 to January 2006 Dr. Stonestreet was Chief Patient Care Officer of Memorial Hermann Southwest Hospital, a 563-bed hospital located in Houston, Texas.

Alan G. Thomas has been Senior Vice President - Operations Finance of Vanguard since July 1997. Prior thereto, Mr. Thomas was Senior Vice President - Hospital Financial Operations of OrNda from April 1995 until January 1997. Prior thereto he was Vice President - Reimbursement and Revenue Enhancement of OrNda from June 1994 until April 1995.

Thomas M. Ways has served as Senior Vice President - Managed Care of Vanguard since March 1998. Prior thereto from February 1997 to February 1998, he was Chief Executive Officer of MSO/Physician Practice Development for the Southern California Region of Tenet. Prior thereto from August 1994 to January 1997, he was Vice President - Physician Integration of OrNda.

Gary D. Willis has served as Senior Vice President, Controller and Chief Accounting Officer of Vanguard since May 2008. From February 2006 to May 2008, he was Senior Vice President and Chief Accounting Officer of LifePoint Hospitals ("LifePoint"), a hospital management company based in Brentwood, Tennessee. From December 2002 to February 2006, he was Vice President and Controller of LifePoint.

Deanna L. Wise has served as Senior Vice President and Chief Information Officer of Vanguard since November 2006. Prior thereto from August 2004 to October 2006 she was the Chief Information Officer of Vanguard's operating region managing its Phoenix-area healthcare facilities. From November 2002 until August 2004 she was chief information officer of the Maricopa Integrated Health System in Phoenix, Arizona, which was a county integrated health care system including an acute care hospital, health clinics and health plans. Prior thereto, from October 1997 to November 2002 she was the director of applications of Ascension Health –Central Indiana Health System in Indianapolis, Indiana, a regional healthcare management organization supervising the operations of twelve acute care hospitals.

Michael A. Dal Bello became a member of Vanguard's board of directors on September 23, 2004. Mr. Dal Bello is a Managing Director in the Private Equity Group of Blackstone and has been with the firm since 2002. While at Blackstone, Mr. Dal Bello has been actively involved in Blackstone's healthcare investment activities. Prior to joining Blackstone, Mr. Dal Bello received an M.B.A. from Harvard Business School in 2002. Mr. Dal Bello worked at Hellman & Friedman LLC from 1998 to 2000 and prior thereto at Bain & Company. He currently serves on the board of representatives or directors of Apria Healthcare Group Inc., Alliant Holdings I, Inc., Team Finance LLC, Biomet, Inc., Catalent Pharma Solutions, Inc. and Sithe Global.

M. Fazle Husain became a member of Vanguard's board of directors on November 7, 2007. Mr. Husain is a Managing Director of Metalmark Capital, the private equity division of Citigroup Alternative Investments. Prior to joining Metalmark, Mr. Husain was with Morgan Stanley & Co. for 18 years, where he was a Managing Director in the private equity and venture capital investment business. Mr. Husain currently also serves on the board of directors of SouthernCare, Inc. and National Healing Corporation.

Alan M. Muney, MD became a member of Vanguard's board of directors on May 6, 2008. Dr. Muney has served as an Executive Director in the Private Equity Group of Blackstone since October 2007. Before joining Blackstone Dr. Muney was the executive vice president and chief medical officer of Oxford Health Plans and the chief medical officer of United Healthcare (Northeast region) from 1998 to September 2007. He also currently serves as a member of the board of representatives of Team Finance LLC.

Michael J. Parsons became a member of Vanguard's board of directors on May 6, 2008. In April 2009 Mr. Parson became the Chief Executive Officer of SouthernCare, Inc., a hospice provider based in Birmingham, Alabama with offices in 15 states. Beginning in March 2009 he became the interim Chief Executive Officer of SouthernCare. SouthernCare provides hospice services to patients who reside in private homes, group homes,

assisted living facilities and skilled nursing facilities. From July 2007 to March 2009 Mr. Parsons was a private investor. From May 1999 until July 2007 he served as Executive Vice President and Chief Operating Officer of Triad Hospitals, Inc., an investor owned hospital management company headquartered in Plano, Texas, which was acquired by Community Health Systems, Inc. in July 2007. Mr. Parsons currently serves as a director of SouthernCare, Inc.

James A. Quella became a member of Vanguard's board of directors on September 11, 2007. Mr. Quella is a Senior Managing Director and Senior Operating Partner in the Private Equity Group at Blackstone. Prior to joining Blackstone in 2004, Mr. Quella was a Managing Director and Senior Operating Partner with DLJ Merchant Banking Partners-CSFB Private Equity from June 2000 to February 2004. Prior to that, Mr. Quella worked at Mercer Management Consulting and Strategic Planning Associates, its predecessor firm, from September 1981 to January 2000 where he served as a Senior Consultant to chief executive officers and senior management teams, and was Co-Vice Chairman with shared responsibility for overall management of the firm. Mr. Quella currently serves as a director of Graham Packaging Holdings Company, Intelenet Global Services, The Nielsen Company, Michaels Stores, Inc. and Freescale Semiconductor, Inc.

Neil P. Simpkins became a member of Vanguard's board of directors on September 23, 2004. Mr. Simpkins has served as a Senior Managing Director in the Private Equity Group of Blackstone since December 1999. From 1993 until the time he joined Blackstone, Mr. Simpkins was a Principal at Bain Capital. Prior to joining Bain Capital, Mr. Simpkins was a consultant at Bain & Company in London and the Asia Pacific region. He currently serves as Chairman of the board of directors of TRW Automotive Holdings Corp. and is a member of the board of representatives of Team Finance LLC and of the board of directors of Apria Healthcare Group Inc.

Composition of the Board of Directors

General

As of the date of this report, the board of directors of Vanguard consists of seven members, four of whom were nominated by Blackstone, one of whom was nominated by MSCP, one of whom is our chief executive officer (and, if our chief executive officer is not Charles N. Martin, Jr., such other person designated by senior management) and one independent director. Blackstone has the right to increase the size of Vanguard's board from seven to nine members, with one additional director to be designated by Blackstone and one additional director to be an independent person identified by our chief executive officer and acceptable to Blackstone. MSCP and, subject to the conditions above, senior management, will each continue to be entitled to nominate and elect one director unless and until the respective group ceases to own at least 50.0% of the Class A membership units in VHS Holdings LLC ("Holdings") owned on September 23, 2004. Holdings acquired Vanguard pursuant to a merger (the "Merger") on September 23, 2004. See "Item 1. Business – The Merger".

Committees

Our board of directors currently does not have any standing committees, including an audit committee. Our entire board of directors is acting as our audit committee to oversee our accounting and financial reporting processes and the audits of our financial statements, as allowed under the Securities Exchange Act of 1934 for issuers without securities listed on a national securities exchange or on an automated national quotation system. Additionally, because our securities are not so listed, our board of directors is not required to have on it a person who qualifies under the rules of the Securities and Exchange Commission as an "audit committee financial expert" or as having accounting or financial management expertise under the similar rules of the national securities exchanges. While our board of directors has not designated any of its members as an audit committee financial expert, we believe that each of the current board members is fully qualified to address any accounting, financial reporting or audit issues that may come before it.

Code of Ethics

We have adopted a Code of Business Conduct and Ethics that applies to all of our officers and employees, including our principal executive officer, principal financial officer and principal accounting officer, which has been posted on our Internet website at www.vanguardhealth.com/pdfs/codeofbusinessconductandethics.pdf. Our Code of

Business Conduct and Ethics is a "code of ethics", as defined in Item 406(b) of Regulation S-K of the Securities and Exchange Commission. Please note that our Internet website address is provided as an inactive textual reference only. We will make any legally required disclosures regarding amendments to, or waivers of, provisions of our code of ethics on our Internet website.

Item 11. Executive Compensation.

COMPENSATION DISCUSSION AND ANALYSIS

Overview

This section discusses the principles underlying our executive compensation policies and decisions. It provides qualitative information regarding the manner in which compensation is earned by our executive officers and places in context the data presented in the tables that follow. In addition, in this section, we address the compensation paid or awarded during fiscal year 2008 to: Charles N. Martin, Jr., our Chief Executive Officer (principal executive officer); Phillip W. Roe, our Chief Financial Officer (principal financial officer); and three other executive officers who were our three other most highly compensated executive officers in fiscal year 2009, Keith B. Pitts, our Vice Chairman; Kent H. Wallace, our President and Chief Operating Officer; and Joseph J. Mullany, one of our Senior Vice Presidents-Operations. We refer to these five executive officers as our "named executive officers."

On September 23, 2004, we were acquired in the Merger by private equity investment funds associated with Blackstone Group who invested $494.4 million in our equity for a 66% equity interest, with private equity funds associated with our former equity sponsor, MSCP, retaining a 17.3% equity interest in us by reinvesting $130 million in our equity and with 12 of our 23 current executive officers retaining a 11.4% equity interest in us by reinvesting $85.7 million in us (such $85.7 million exclusive of amounts invested by our executive officers in Holdings' Class B, C and D units, as discussed below). As a result of the Merger, we are privately held and controlled by private equity funds associated with Blackstone and MSCP (the "Sponsors") with a board of directors made up of five representatives of the Sponsors, one independent director and our Chief Executive Officer. As discussed in more detail below, various aspects of named executive officer compensation were negotiated and determined at the time of the Merger.

As a privately-owned company with a relatively small board of directors, our entire board of directors acts as our Compensation Committee (hereinafter referred to either as the "Committee", the "Compensation Committee" or the "board of directors"). Our executive compensation program is overseen and administered by the Compensation Committee. The Compensation Committee operates somewhat informally without a written charter and has responsibility for discharging the responsibilities of the board of directors relating to the compensation of our executive officers and related duties. As a member of the Compensation Committee, our Chief Executive Officer presents cash, equity and benefits compensation recommendations to the Compensation Committee for its consideration and approval. The Compensation Committee reviews these proposals and makes all final compensation decisions for executive officers by exercising its discretion in accepting, modifying or rejecting any such recommendations.

Philosophy of Executive Compensation Programs

Our overall executive compensation objective is to provide a comprehensive plan designed to focus on our strategic business initiatives, financial performance objectives and the creation and maintenance of equity value. The following are the principal objectives in the design of our executive compensation programs:

- Attract, retain, and motivate superior management talent critical to our long-term success with compensation that is competitive within the marketplace;
- Maintain a reasonable balance among base salary, annual incentive payments and long-term equity-based incentive compensation and other benefits;
- Ensure compensation levels reflect the internal value and future potential of each executive within the Company and the achievement of outstanding individual results;

- Link executive compensation to the creation and maintenance of long-term equity value;
- Promote equity ownership by executives in order to align their interests with the interests of our equity holders; and
- Ensure that incentive compensation is linked to the achievement of specific financial and strategic objectives, which are established in advance and approved by the Committee.

To meet these objectives, our compensation program balances short-term and long-term performance goals and mixes fixed and at-risk compensation that is directly related to stockholder value and overall performance.

During our fiscal year ended June 30, 2009, the Committee did not retain the services of any external compensation consultant. Our Chief Executive Officer, Charles N. Martin, Jr., as a member of the board of directors, is also a member of the Committee, presents his recommendations to the Committee on all executive compensation matters and participates in discussions and deliberations of the Committee. While other named executive officers may also attend the Committee meetings and participate in Committee discussions, they would do so only if and when required by the Committee and such attendance has been rare in recent years. Any deliberations and decisions by the Committee regarding compensation for Mr. Martin or other named executive officers take place while the Committee is in executive session without such persons in attendance.

The Committee believes that compensation to its executive officers should be aligned closely with our short-term and long-term financial performance goals. As a result, a portion of executive compensation is "at risk" and is tied to the attainment of previously established financial goals. However, the Committee also believes that it is prudent to provide competitive base salaries and benefits to attract and retain superior talent in order to achieve our strategic objectives.

Elements of Our Executive Compensation Program

In fiscal year 2009, the principal elements of our compensation for our executive officers, including our named executive officers were:

- Base Salary;
- Annual cash incentive opportunities;
- Long-term equity based incentives; and
- Benefits and executive perquisites.

Detail regarding each of these elements is discussed below.

Base Salaries

Annual base salaries reflect the fixed component of the compensation for an executive's ongoing contribution to the operating performance of his or her functional area of responsibility with us. The Committee believes that base salaries must be competitive based upon the scope of responsibilities and market compensation of similar executives while also reserving a substantial portion of compensation for the other compensation elements that are directly related to company performance. To determine base salary market compensation, our Human Resources Department provides our Chief Executive Officer and the Committee with market data which it obtained in our fiscal year ended June 30, 2009 from the following human resources sources: Mercer; Sullivan, Cotter & Associates; Salary.com; and/or Management Performance International, Inc. Other factors such as internal equity and comparability are also considered when establishing a base salary for a given executive. The Committee also utilizes the experience, market knowledge and insight of its members in evaluating the competitiveness of current salary levels. Our Human Resources Department is also a resource for such additional information as needed by our Chief Executive Officer or by the Committee.

Generally, base salaries of all executive officers, including the named executive officers, are reviewed and adjusted by the Committee once a year based upon the recommendations of our Chief Executive Officer (except he makes no recommendation as to his own salary). In turn, our Chief Executive Officer bases his recommendations upon his assessment of each executive's performance, our overall budgetary guidelines and market data provided to him by our Human Resources Department. In previous fiscal years, the annual salary review for executive officers (including the named executive officers) was done effective January 1 of each year. However, in our fiscal year ended June 30, 2009, the annual salary review was done effective April 1, 2009, and the next salary review is expected to occur effective July 1, 2010, with future yearly reviews currently planned to remain at July 1 of each year (which is the first day of our fiscal year). As a result, our executive officer raises this year, including those of the named executive officers, were increased by additional amounts to reflect this year's 15-month salary review cycle and next year's planned 15-month salary review cycle. In addition to the annual salary review, based upon the recommendations of our Chief Executive Officer, the Committee may also adjust base salaries at other times during the year in connection with promotions, increased responsibilities or to maintain competitiveness within the market.

In our fiscal year ended June 30, 2009, the base salaries of our named executive officers were increased by the following amounts, effective April 1, 2009: Mr. Martin: 4.55%; Mr. Roe: 10.53%; Mr. Pitts: 6.72%; Mr. Wallace: 14.17% and Mr. Mullany: 7.37%. As a result of these increases, the annual base salary rates of our named executive officers increased to the following amounts as of April 1, 2009: Mr. Martin: $1,098,079; Mr. Roe: $525,000; Mr. Pitts: $685,000; Mr. Wallace: $685,000; and Mr. Mullany: $510,000. The salary for each named executive officer for our fiscal year ended June 30, 2009 is reported in the Summary Compensation Table below.

Annual Incentive Compensation

Annual cash incentive awards are available to the named executive officers, as well as to Vanguard's other executive officers, under the Vanguard Health Systems, Inc. 2001 Annual Incentive Plan (the "Annual Incentive Plan"). The Annual Incentive Plan is designed to align our executives' short-term compensation opportunity with our annual financial and operation goals and the growth objectives of our stockholders and to motivate our executives' annual performance.

Each year under the Annual Incentive Plan the Committee establishes specific earnings-related or operations-related goals for all of our executive officers, including the named executive officers, for the fiscal year based upon the recommendations of our Chief Executive Officer. The executive officers are eligible to receive a cash award or awards based primarily on the extent to which the Company meets its pre-established earnings and/or cash flow and/or other operations-related goals. The Committee determines one or more target awards for each executive officer, designates a Company performance level or levels required to earn each target award and may also determine threshold performance levels at which minimum awards are earned and performance levels that result in maximum awards to be paid. Target awards may vary among executives based on competitive market practices for comparable positions, their decision-making authority and their ability to affect financial and operational performance. In addition to performance-related awards, the Committee may make and pay out discretionary awards at any time. Also, the Committee has the discretion to adjust the annual performance targets during the year in the event of acquisitions and divestitures, restructured or discontinued operations, or other extraordinary or unusual issues occurring during the year. The Committee evaluates the allocation factors within the Annual Incentive Plan on an annual basis and has the flexibility to adjust the structure including allocation percentages as needed in order to better align the incentives under the Annual Incentive Plan.

For fiscal year 2009, Annual Incentive Plan target awards for our named executive officers (except Mr. Mullany) were 50% based upon the Company achieving a certain consolidated Adjusted EBITDA performance level goal and 50% based upon the Company achieving a certain consolidated free cash flow performance level goal. For Mr. Mullany, his Annual Incentive Plan target award was 6.25% based upon the Company achieving a certain consolidated Adjusted EBITDA performance level goal (the same goal we used for the four other named executive officers); 6.25% based upon the Company achieving a certain consolidated free cash flow performance level goal (the same goal we used for the four other named executive officers); 21.875% based upon the Company achieving a regional Adjusted EBITDA performance level goal for the two regions in which the hospitals for which he is responsible are located; 21.875% based upon achieving a regional free cash flow performance level goal for the two regions in which the hospitals for which he is responsible are located; and 43.75% based upon the hospitals for

which he is responsible achieving certain specified quality, employee engagement and patient and physician satisfaction goals.

The Committee also set for fiscal 2009 threshold and maximum awards for the named executive officers. For the named executive officers (except for Mr. Mullany) threshold awards of an aggregate of 10% of the target awards were payable upon reaching 91% of the Adjusted EBITDA goal and 91% of the free cash flow goal, with increased awards of 20% to 90% of the target awards payable upon the Company reaching 92% to 99% of the Adjusted EBITDA goal and the free cash flow goal. For the named executive officers (except for Mr. Mullany) maximum awards of an aggregate of 150% of the target awards were payable upon reaching 110% of the Adjusted EBITDA goal and 110% of the free cash flow goal, with increased awards of 105% to 145% of the target awards payable upon the Company reaching 101% to 109% of the Adjusted EBITDA goal and the free cash flow goal. For Mr. Mullany threshold awards of 10% of his target awards for regional Adjusted EBITDA and regional free cash flow were payable upon reaching 91% of the regional Adjusted EBITDA goal and 91% of the regional free cash flow goal, with increased awards of 20% to 90% of the target awards payable upon his regions reaching 92% to 99% of the regional Adjusted EBITDA goal and the regional free cash flow goal. For Mr. Mullany threshold awards of 55% to 99% of some of his target quality awards were payable for achieving a quality score for his hospitals of 55 to 99 (on a 100 point scale) and a threshold award of 50% of his patient satisfaction award was payable if he achieved a certain goal below the target goal in a Press Ganey database. No threshold awards were available to him for his employee engagement goal. Maximum awards of an aggregate of 130% of his salary were payable upon reaching actual regional Adjusted EBITDA and actual regional free cash flow at certain levels above his goals, with other lesser awards available to him also of 1 to 25% of his salary for actual regional Adjusted EBITDA exceeding his goal and 1 to 25% of his salary for actual regional free cash flow exceeding his goal.

The target percentages set for fiscal 2009 and the threshold, target and maximum payments for each of the named executive officers for fiscal 2009 were as follows:

	Charles N. Martin, Jr.	Phillip W. Roe	Keith B. Pitts	Kent H. Wallace	Joseph J. Mullany
Percentage of Base Salary					
Target	100%	70%	90%	90%	80%
Threshold	10%	7%	9%	9%	21.9%
Maximum	150%	105%	135%	135%	130%
Financial Weightings					
Adjusted EBITDA (1)	50%	50%	50%	50%	6.25%
Regional Adjusted EBITDA	–	–	–	–	21.875%
Free cash flow (2)	50%	50%	50%	50%	6.25%
Regional free cash flow	–	–	–	–	21.875%
Hospital Quality/Employee Engagement/Patient Satisfaction	–	–	–	–	43.75%

(1) Adjusted EBITDA is defined by us as income before interest expense (net of interest income), income taxes, depreciation and amortization, minority interests, gain or loss on the disposal of assets, equity method income, stock compensation, monitoring fees and expenses, realized holding loss on investments, impairment loss and discontinued operations, net of taxes. Monitoring fees and expenses represent fees and reimbursed expenses paid to affiliates of The Blackstone Group and Metalmark Subadvisor LLC for advisory and oversight services.

(2) Free cash flow is defined by us as Adjusted EBITDA minus capital expenditures except those construction projects which we are allowed to exclude from our covenant limiting our annual capital expenditures found in our principal credit facility.

All of our five named executive officers earned in excess of their target awards with respect to their financial performance level goals under our Annual Incentive Plan for fiscal year 2009. These awards were approved by the Committee and will be paid to the named executive officers in September 2009 in the individual amounts set forth in the column of the Summary Compensation Table entitled "Non-Equity Incentive Plan Compensation", except for all named executive officers (other than Mr. Mullany) amounts earned in excess of 100% of the target awards are payable as follows: 1/3 in September 2009; 1/3 in September 2010 and 1/3 in September 2011; and for Mr. Mullany only, the amounts he earned in respect of the consolidated Adjusted EBITDA goal and the consolidated free cash flow goal are payable to him 1/3 in September 2009, 1/3 in September 2010 and 1/3 in September 2011.

The Committee has historically attempted to maintain consistency year over year with respect to the difficulty of achieving the performance level goals under our Annual Incentive Plan. The financial performance goals used by

the Committee in recent years for the annual incentive awards for most of our executive officers (Adjusted EBITDA and free cash flow) are identical to or derived from our consolidated annual Adjusted EBITDA and capital expenditures budgets approved at the beginning of each fiscal year by our board of directors. Our annual Adjusted EBITDA budget, and, thus, the annual Adjusted EBITDA financial target, typically increases each year to promote continuous growth consistent with our business plan. Despite such increase, the financial performance targets are designed to be realistic and attainable though slightly aggressive, requiring in each fiscal year strong performance and execution that in our view provides an annual incentive firmly aligned with stockholder interests. This balance is reflected in the fact that none of these named executive officers (except Mr. Mullany) earned any awards under the Plan for fiscal year 2007 when our Company's financial performance was not strong (other than in Mr. Mullany's regions), but they did earn their target awards under the Plan for fiscal years 2008 and 2009 when our Company's financial performance was much stronger.

Long Term Incentive Compensation

The Committee provides equity incentives to executive officers and other key employees in order to directly align their interests with the long term interests of the other equity holders who are principally the Sponsors.

Holdings LLC Units Plan

Holdings acquired Vanguard in the Merger on September 23, 2004. The following contains a summary of the material terms of the Holdings LLC Units Plan, which we refer to as the 2004 Unit Plan, pursuant to which Holdings granted the right to purchase units to members of our management on September 23, 2004 in connection with consummation of the Merger. All of our named executive officers, and certain other members of our management, have been granted the right to purchase units under the 2004 Units Plan.

General

The 2004 Unit Plan permits the grant of the right to purchase Class A Units, Class B Units, Class C Units and Class D Units to employees of Holdings or its affiliates. A maximum of 117,067 Class A Units, 41,945 Class B Units, 41,945 Class C Units and 35,952 Class D Units may be subject to awards under the 2004 Unit Plan. Units covered by awards that expire, terminate or lapse will again be available for option or grant under the 2004 Unit Plan. On September 23, 2004, certain members of management purchased all 117,067 Class A Units for an aggregate purchase price of $117,067,000 and all 41,945 Class B units, all 41,945 Class C Units and all 35,952 of the Class D Units for an aggregate purchase price of $5.7 million.

Administration

The 2004 Unit Plan is administered by a committee of Holdings' board of representatives or, in the board of representatives' discretion, the board of representatives. The committee has the sole discretion to determine the employees to whom awards may be granted under the 2004 Unit Plan, the number and/or class of Units to be covered by an award, the purchase price, if any, of such awards, determine the terms and conditions of any award and determine under what circumstances awards may be settled or cancelled. The committee is authorized to interpret the 2004 Unit Plan, to establish, amend and rescind any rules and regulations relating to the 2004 Unit Plan, and to make any other determinations that it deems necessary or desirable for the administration of the plan. The committee may correct any defect or supply any omission or reconcile any inconsistency in the 2004 Unit Plan in the manner and to the extent the committee deems necessary or desirable.

Adjustments Upon Certain Events

In the event of any changes in the Units by reason of any reorganization, recapitalization, merger, unit exchange or any other similar transaction, the board of representatives, in its sole discretion, may adjust (1) the number or kind of Units or other securities that may be issued or reserved for issuance pursuant to the 2004 Unit Plan or pursuant to any outstanding awards or (2) any other affected terms of such awards.

Amendment and Termination

The Holdings board of representatives may amend or terminate the 2004 Unit Plan at any time, provided that no amendment or termination is permitted that would diminish any rights of a management member pursuant to a previously granted award without his or her consent, subject to the committee's authority to adjust awards upon certain events as described in the previous paragraph. No awards may be made under the 2004 Unit Plan after the tenth anniversary of the effective date of the plan.

Holdings LLC Units Held by Certain of our Managers

The units of Holdings consist of Class A units, Class B units, Class C units and Class D units. As of September 1, 2009, approximately 59.2% of Holdings' Class A Units were held by Blackstone, approximately 20.8% were held by MSCP, approximately 14.9% were held by certain members of our management and approximately 5.1% were held by other investors. The Class B units, Class C units and Class D units are held exclusively by members of our senior management and all such units were purchased on September 23, 2004.

Of our named executive officers, Charles N. Martin, Jr. beneficially owns 40,000 class A units, 8,913 class B units, 8,913 class C units and 7,640 class D units; Phillip W. Roe beneficially owns 3,030 class A units, 2,097 class B units, 2,097 class C units and 1,798 class D units; Keith B. Pitts beneficially owns 11,000 class A units, 5,243 class B units, 5,243 class C units and 4,494 class D units; Kent H. Wallace beneficially owns 850 class A units, 2,622 class B units, 2,622 class C units and 2,247 class D units; and Joseph J. Mullany owns no units. As of September 1, 2009, none of the class C units are vested, but 80% of the Class B and D units are vested; and an additional 20% of such class B and D units will vest on September 23, 2009. See the vesting provisions in respect of the class A, B, C and D units in the discussion immediately below.

Terms of the Holdings' Class A Units, Class B Units, Class C Units and Class D Units

The following is a summary of certain terms of the Holdings' Class A units, Class B units, Class C units and Class D units and certain rights and restrictions applicable to those units.

Class A units have economic characteristics that are similar to those of shares of common stock in a private corporation. Subject to applicable law, only the holders of Class A units are entitled to vote on any matter. Class A units are fully vested. The Class B units, Class C units and Class D units are subject to the vesting provisions described below.

Class B units vest in five equal annual installments on the first five anniversaries of the date of purchase, subject to an employee's continued service with Holdings and its affiliates. However, the Class B units will vest earlier upon a change of control of Holdings. In the event of an employee's termination of employment with Vanguard, other than due to termination by Vanguard for "cause" or by the employee without "good reason", the employee shall be deemed vested in any Class B unit that would otherwise have vested in the calendar year in which such termination of employment occurs. No employee who holds Class B units will receive any distributions until the holders of the Class A units receive the aggregate amount invested for their Class A units. Following return of the aggregate amount invested for the Class A units, the holders of Class B units will be entitled to receive the amount of their investment in the Class B units and, once all the aggregate investment amount invested for all of the units has been returned to their holders, the vested Class B units will share in any distributions pro rata with the Class A units and vested Class C units.

Class C units vest on the eighth anniversary of the date of purchase, subject to the employee's continued service with Holdings and its affiliates. However, the Class C units will vest earlier upon the occurrence of a sale by Blackstone of at least 25.0% of its Class A Units at a price per Class A unit exceeding two and one-half times the price per Class A Unit invested by Blackstone in connection with the Merger. No employee who holds Class C units will receive any distributions until the holders of the Class A units receive the aggregate amount invested for their Class A units. Following return of the aggregate amount invested for the Class A units, the holders of Class C units will be entitled to receive the amount of their investment in the Class C units and, once all the aggregate investment amount invested for all of the units has been returned to their holders, the vested Class C units will share in any distributions pro rata with the Class A units and vested Class B units.

Class D units vest in five equal annual installments on the fifth anniversary of the date of purchase, subject to an employee's continued service with Holdings and its affiliates. However, the Class D units will vest earlier upon a change of control of Holdings. In the event of an employee's termination of employment with Vanguard, other than due to termination by Vanguard for "cause" or by the employee without "good reason", the employee shall be deemed vested in any Class D unit that would otherwise have vested in the calendar year in which such termination of employment occurs. No employee who holds Class D units will receive any distributions until the holders of the Class A units receive the aggregate amount invested for their Class A units. Following return of the aggregate amount invested for the Class A units, the holders of Class D units will be entitled to receive the amount of their investment in the Class D units and, once all the aggregate investment amount invested for all of the units has been returned to their holders and the holders of the Class A units have received an amount representing a 300% return on their aggregate investment along with pro rata distributions to the vested Class B and Class C units, the vested Class D units will share in any distributions pro rata with the Class A units, the vested Class B units and the vested Class C units.

Certain Rights and Restrictions Applicable to the Units Held by Our Managers

The units held by members of our management are not transferable for a limited period of time except in certain circumstances. In addition, the units (other then Class A units) may be repurchased by Holdings, and in certain cases, Blackstone, in the event that the employees cease to be employed by us. Blackstone has the ability to force the employees to sell their units along with Blackstone if Blackstone decides to sell its units.

The employees that hold units are entitled to participate in certain sales by Blackstone. In addition, in the event that Holdings were to make a public offering of its equity securities, the employees would have limited rights to participate in subsequent registered public offerings.

Our 2004 Stock Incentive Plan

General

Since all Units have been granted under the 2004 Unit Plan, we intend for our option program pursuant to our 2004 Stock Incentive Plan to be the primary vehicle currently for offering long-term incentives and rewarding our executive officers, managers and key employees. Because of the direct relationship between the value of an option and the value of our stock, we believe that granting options is the best method of motivating our executive officers to manage our Company in a manner that is consistent with our interests and our stockholders' interests. We also regard our option program as a key retention tool.

We adopted the 2004 Stock Incentive Plan upon consummation of the Merger which permits the grant of non-qualified stock options, incentive stock options, stock appreciation rights, restricted stock and other stock-based awards to our employees or our affiliates' employees. The awards available under the 2004 Stock Incentive Plan, together with Holdings' equity incentive units, represented 20.0% of our fully-diluted equity at the closing of the Merger. Shares covered by awards that expire, terminate or lapse are again available for option or grant under the 2004 Stock Incentive Plan. The total number of shares of our common stock which may be issued under the 2004 Stock Incentive Plan as of September 1, 2009, was 145,611. All of our previous option plans were terminated upon consummation of the Merger on September 23, 2004.

Administration

The 2004 Stock Incentive Plan is administered by a committee of the board of directors or, in the sole discretion of the board of directors, the board of directors. The committee has the sole discretion to determine the employees, representatives and consultants to whom awards may be granted under the 2004 Stock Incentive Plan and the manner in which such awards will vest. Options, stock appreciation rights, restricted stock and other stock-based awards will be granted by the committee to employees, representatives and consultants in such numbers and at such times during the term of the 2004 Stock Incentive Plan as the committee shall determine. The committee is authorized to interpret the 2004 Stock Incentive Plan, to establish, amend and rescind any rules and regulations relating to the 2004 Stock Incentive Plan, and to make any other determinations that it deems necessary or desirable for the administration of the plan. The committee may correct any defect or supply any omission or reconcile any

inconsistency in the 2004 Stock Incentive Plan in the manner and to the extent the committee deems necessary or desirable.

Stock Options and Stock Appreciation Rights

Options granted under the 2004 Stock Incentive Plan are vested and exercisable at such times and upon such terms and conditions as may be determined by the committee, but in no event will an option be exercisable more than 10 years after it is granted. Under the 2004 Stock Incentive Plan, the exercise price per share for any option awarded is determined by the committee, but may not be less than 100% of the fair market value of a share on the day the option is granted with respect to incentive stock options.

Stock option grants under the 2004 Stock Incentive Plan are generally made at the commencement of employment and occasionally following a significant change in job responsibilities or on a periodic basis to meet other special retention or performance objectives. All stock options granted by our board of directors to date under the 2004 Stock Incentive Plan have been granted at or above the fair market value of our common stock at the grant date based upon the most recent appraisal of our common stock. We have not back-dated any option awards.

As a privately-owned company, there has been no market for our common stock. Accordingly, in fiscal year 2007, we had no program, plan or practice pertaining to the timing of stock option grants to executive officers, coinciding with the release of material non-public information.

An option may be exercised by paying the exercise price in cash or its equivalent, and/or, to the extent permitted by the committee, shares, a combination of cash and shares or, if there is a public market for the shares, through the delivery of irrevocable instruments to a broker to sell the shares obtained upon the exercise of the option and to deliver to us an amount equal to the exercise price.

The committee may grant stock appreciation rights independent of or in conjunction with an option. The exercise price of a stock appreciation right is an amount determined by the committee. Generally, each stock appreciation right entitles a participant upon exercise to an amount equal to (i) the excess of (1) the fair market value on the exercise date of one share over (2) the exercise price, times (ii) the number of shares covered by the stock appreciation right. Payment will be made in shares or in cash or partly in shares and partly in cash (any shares valued at fair market value), as determined by the committee.

As of June 30, 2009, options to purchase 102,455 shares of our common stock (the "New Options") were outstanding under the 2004 Stock Incentive Plan. The New Options were granted in part as "time options," and in part as "performance options" which vest and become exercisable ratably on a yearly basis on each of the first five anniversaries following the date of grant (or earlier upon a change of control). 35% of the options granted were time options with an exercise price equal to the greater of the fair market price per share or $1,000 per share at the time of grant (a range of $1,000 to $1,167.50 per share). 30% of the options granted were performance options with an exercise price of $3,000 per share. 35% of the options granted were "liquidity options" with an exercise price equal to greater of the fair market price per share or $1,000 per share at the time of grant (a range of $1,000 to $1,167.50 per share) that become fully vested and exercisable upon the completion of any of certain designated business events ("liquidity events"), and in any event on the eighth anniversary of the date of grant. Any common stock for which such options are exercised are governed by a stockholders agreement, which is described below under "Item 13. Certain Relationships and Related Transactions - Stockholders Agreement."

Of our named executive officers, Mr. Martin has been granted no New Options as of September 1, 2009, Mr. Roe has been granted 3,008 New Options, Mr. Pitts has been granted 1,500 New Options, Mr. Wallace has been granted 13,500 New Options and Mr. Mullany has been granted 5,500 New Options. During fiscal year 2009 the Committee granted 5,000 New Options to Mr. Wallace, but no other named executive officers were granted any New Options.

Other Stock-Based Awards

The committee, in its sole discretion, may grant restricted stock, stock awards, stock appreciation rights, unrestricted stock and other awards that are valued in whole or in part by reference to, or are otherwise based on the

fair market value of our shares. Such other stock-based awards shall be in such form, and dependent on such conditions, as the committee shall determine, including, without limitation, the right to receive, or vest with respect to, one or more shares (or the equivalent cash value of such shares) upon the completion of a specified period of service, the occurrence of an event and/or the attainment of performance objectives.

Adjustments Upon Certain Events

In the event of any stock dividend or split, reorganization, recapitalization, merger, share exchange or any other similar transaction, the committee, in its sole discretion, may adjust (i) the number or kind of shares or other securities that may be issued or reserved for issuance pursuant to the 2004 Stock Incentive Plan or pursuant to any outstanding awards, (ii) the option price or exercise price and/or (iii) any other affected terms of such awards. In the event of a change of control, the committee may, in its sole discretion, provide for the (i) termination of an award upon the consummation of the change of control, but only if such award has vested and been paid out or the participant has been permitted to exercise the option in full for a period of not less than 30 days prior to the change of control, (ii) acceleration of all or any portion of an award, (iii) payment of a cash amount in exchange for the cancellation of an award, which, in the case of options and stock appreciation rights, may equal the excess, if any, of the fair market value of the shares subject to such options or stock appreciation rights over the aggregate option price or grant price of such option or stock appreciation rights, and/or (iv) issuance of substitute awards that will substantially preserve the otherwise applicable terms of any affected awards previously granted hereunder.

Amendment and Termination

The committee may amend or terminate the 2004 Stock Incentive Plan at any time, provided that no amendment or termination shall diminish any rights of a participant pursuant to a previously granted award without his or her consent, subject to the committee's authority to adjust awards upon certain events (described under "Adjustments Upon Certain Events" above). No awards may be made under the 2004 Stock Incentive Plan after the tenth anniversary of the effective date of the plan.

Benefits and Executive Perquisites

The Committee believes that attracting and retaining superior management talent requires an executive compensation program that is competitive in all respects with the programs provided at similar companies. In addition to salaries, incentive bonus and equity awards, competitive executive compensation programs include retirement and welfare benefits and reasonable executive perquisites.

Retirement Benefits

Substantially all of our salaried employees, including our named executive officers, participate in our 401(k) savings plan. Employees are permitted to defer a portion of their income under the 401(k) plan. At our discretion, we may make a matching contribution of either (1) up to 50%, subject to annual limits established under the Internal Revenue Code, of the first 6% of an employee's contributions under this 401(k) plan as determined each year or (2) in respect of a few of our employees who came to us with plans in place having a larger match than this match, a match of 100% of the first 5% of an employee's contributions under this 401(k) plan. Most recently, we authorized such maximum discretionary amounts as a match on employees' aggregate 401(k) Plan contributions for calendar year 2007, including the named executive officers. Employee contributions are fully vested immediately. Our matching contributions vest to the employee's account over time related to the employee's years of service with us, with 20% of our contribution vesting after 2 years of service, 40% after 3 years, 60% after 4 years, 80% after 5 years and 100% after 6 years. Participants may receive distribution of their 401(k) accounts any time after they cease service with us.

We maintain no defined benefit plans.

Other Benefits

All executive officers, including the named executive officers, are eligible for other benefits including: medical, dental, life insurance, and short term disability. The executives participate in these plans on the same basis, terms,

and conditions as other administrative employees. In addition, we provide long-term disability insurance coverage on behalf of the named executive officers at an amount equal to 60% of current base salary (up to $10,000 per month). The named executive officers also participate in our vacation, holiday and sick program which provides paid leave during the year at various amounts based upon the executive's position and length of service.

Perquisites

Our executive officers may have limited use of our corporate plane for personal purposes as well as very modest other usual and customary perquisites. All of such perquisites are reflected in the All Other Compensation column of the Summary Compensation Table and the accompanying footnotes.

Our Employment Agreements with Certain of the Named Executive Officers

We have entered into written employment agreements with all of our named executive officers except Mr. Mullany. On June 1, 1998, we entered into a written employment agreement with our Chief Executive Officer (Mr. Martin) which was amended and restated on September 23, 2004 to extend the term of the employment agreement for five years, and to provide that the Merger did not constitute a change in control under the agreement. On September 1, 1999, we entered into a written employment agreement with Keith B. Pitts to be our Executive Vice President for a term expiring on September 1, 2004. Effective May 31, 2001, Mr. Pitts was promoted to the position of Vice Chairman, and on September 23, 2004, his employment agreement was amended and restated to extend the term of the employment agreement for five years, and to provide that the Merger did not constitute a change in control under the agreement. On November 15, 2007, we entered into written employment agreements with our Chief Operating Officer and our Chief Financial Office (Messrs. Wallace and Roe, respectively) for terms expiring on November 15, 2012.

The term of each employment agreement will renew automatically for additional one-year periods, unless any such agreement is terminated by us or by the named executive officer officer by delivering notice of termination no later than 90 days before the end of the five-year term or any such renewal term. The base salaries of Messrs. Martin, Roe, Pitts and Wallace under such written employment agreements are, effective on and after April 1, 2009, $1,098,079, $525,000, $685,000 and $685,000, respectively. Pursuant to these agreements the officers are eligible to participate in an annual bonus plan giving each of them an opportunity to earn an annual bonus in such amount as our board of directors should determine, as well as pension, medical and other customary employee benefits. The terms of these agreements state that if the officer terminates his employment for Good Reason (as defined in the agreements) or if we terminate the officer's employment without Cause (as defined in the agreements), he will receive within a specified time after the termination a payment of up to three times the sum of (i) his annual salary plus (ii) the average of the bonuses given to him in the two years immediately preceding his termination.

Our Severance Protection Agreements

We provide all of our corporate officers at the Vice President level and above with severance protection agreements granting them severance payments in amounts of 200% to 250% of annual salary and bonus, except for those officers who have written employment agreements with us. Generally, severance payments are due under these agreements if a change in control (as defined in the agreements) should occur and employment of the officer is terminated during the term of the agreement by us (or our successor) without Cause (as defined in the agreements) or by the executive for Good Reason (as defined in the agreement). In addition, these agreements state that in the event of a Potential Change in Control (defined as the time at which an agreement which would result in a change in control is signed, an acquisition attempt relating to us is publicly announced or there is an increase in the number of shares owned by one of our 10% shareholders by 5% or more), the executives have an obligation to remain in our employ until the earliest of (1) six months after the Potential Change in Control; (2) a change in control; (3) a termination of employment by us; or (4) a termination of employment by the employee for Good Reason (treating Potential Change in Control as a change in control for the purposes of determining whether the executive had a Good Reason) or due to death, disability or retirement. On September 23, 2004, all the outstanding severance protection agreements were amended and restated to provide that the Merger did not constitute a change in control under the agreements, and that we would not terminate the agreements prior to the third anniversary of the closing of the Merger.

Stock Ownership

We do not have a formal policy requiring stock ownership by management. Our senior managers, including all of our named executive officers, however, have committed significant personal capital to our Company in connection with the consummation of the Merger. See the beneficial ownership chart below under Item 12, "Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters". Our stock is not publicly traded and is subject to a stockholder agreement that limits a stockholder's ability to transfer his or her shares. See "Holdings Limited Liability Company Agreement" and "Stockholders Agreement" under Item 13, "Certain Relationships and Related Transactions, and Director Independence."

Impact of Tax and Accounting Rules

The forms of our executive compensation are largely dictated by our capital structure and have not been designed to achieve any particular accounting treatment. We do take tax considerations into account, both to avoid tax disadvantages, and obtain tax advantages where reasonably possible consistent with our compensation goals. (Tax advantages for our executives benefit us by reducing the overall compensation we must pay to provide the same after-tax income to our executives.) Thus our severance pay plans are designed or are being reviewed to take account of and avoid "parachute" excise taxes under Section 280G of the Internal Revenue Code. Similarly we have taken steps to structure and assure that our executive compensation program is applied in compliance with Section 409A of the Internal Revenue Code. Since we currently have no publicly traded common stock, we are not currently subject to the $1,000,000 limitation on deductions for certain executive compensation under Section 162(m) of the Internal Revenue Code, though that rule will be considered if our common stock becomes publicly traded. Incentives paid to executives under our annual incentive plan are taxable at the time paid to our executives.

The expenses associated with the stock options issued by us to our executive officers and other key employees are reflected in our consolidated financial statements. In the first quarter of the fiscal year ended June 30, 2007, we began accounting for these stock-based payments in accordance with the requirements of SFAS 123(R), which requires all share-based payments to employees, including grants of employee stock options, to be recognized as expense in the consolidated financial statements based on their fair values. For further discussion see "ITEM 8, Note 2-Summary of Critical and Significant Accounting Policies" under the heading "Stock-Based Compensation." We previously accounted for these awards under the provisions of SFAS 123, which allowed us to estimate the fair value of options using the minimum value method.

Recovery of Certain Awards

We do not have a formal policy for recovery of annual incentives paid on the basis of financial results which are subsequently restated. Under the Sarbanes-Oxley Act, our chief executive officer and chief financial officer must forfeit incentive compensation paid on the basis of financial statements for which they were responsible and which have to be restated. In that event we would expect to recover such bonuses and incentive compensation. If and when the situation arises in other events, we would consider our course of action in light of the particular facts and circumstances, including the culpability of the individuals involved.

Compensation Committee Report

The Committee has reviewed and discussed the Compensation Discussion and Analysis with management. Based upon the review and discussions, the Committee directed that the Compensation Discussion and Analysis be included in this annual report on Form 10-K.

Compensation Committee:

Michael Dal Bello
M. Fazle Husain
Charles N. Martin, Jr.
Alan M. Muney, M.D.
James A. Quella
Michael J. Parsons
Neil P. Simpkins

Summary Compensation Table

The following table sets forth, for the fiscal years ended June 30, 2009, 2008 and 2007, the compensation earned by the Chief Executive Officer and Chief Financial Officer and the three other most highly compensated executive officers of the registrant, Vanguard, at the end of Vanguard's last fiscal year ended June 30, 2009. We refer to these persons as our named executive officers.

Name and Principal Position	Year	Salary ($)	Bonus($)	Non-Equity Incentive Plan Compensation ($)(a)	Option Awards($)(b)	All Other Compensation ($)(c)	Total ($)
Charles N. Martin, Jr. Chairman of the Board & Chief Executive Officer	2009	1,062,238	–	1,454,956	–	13,758	2,530,952
	2008	1,050,291	–	1,050,291	–	13,608	2,114,190
	2007	1,050,291	–	–	–	10,164	1,060,455
Phillip W. Roe Executive Vice President, Chief Financial Officer & Treasurer	2009	487,500	–	486,939	99,437	7,640	1,081,516
	2008	440,192	–	332,500	50,859	7,620	831,171
	2007	350,000	–	–	17,462	7,410	374,872
Keith B. Pitts Vice Chairman	2009	652,633	–	816,864	46,905	8,142	1,524,544
	2008	641,845	100,000	577,661	19,004	7,992	1,346,502
	2007	641,845	–	–	–	7,410	649,255
Kent H. Wallace President & Chief Operating Officer	2009	621,250	–	816,864	333,776	8,142	1,780,032
	2008	600,000	100,000	540,000	197,141	7,992	1,445,133
	2007	600,000	–	–	124,292	230,212	954,504
Joseph J. Mullany Senior Vice President-Operations	2009	483,800	–	571,289	171,983	60,900	1,287,972
	2008	450,000	–	351,500	113,530	60,810	975,840
	2007	400,000	–	251,260	69,067	72,847	793,174

(a) The Compensation Committee has determined the amount of the Annual Incentive Plan compensation that was earned by each of these named executive officers for fiscal year 2009. This amount will be paid to the named executive officers in September 2009, except for Messrs. Martin, Roe, Pitts and Wallace amounts earned in excess of 100% of the target awards are payable as follows: 1/3 in September 2009; 1/3 in September 2010 and 1/3 in September 2011; and except for Mr. Mullany, the target amounts earned by him in respect of the consolidated Adjusted EBITDA and consolidated free cash flow goals are payable to him 1/3 in September 2009, 1/3 in September 2010 and 1/3 in September 2011. See "Compensation Discussion and Analysis – Annual Incentive Compensation" for more details in respect of the incentive plan awards.

(b) Option Awards reflect the compensation expense recognized in our financial statements for fiscal years 2009, 2008 and 2007 in accordance with SFAS 123(R) with respect to options to purchase shares of our common stock which have been awarded under our 2004 Stock Incentive Plan in our 2006, 2008 and 2009 fiscal years to four of our named executive officers. See Note 12 to our consolidated financial statements for assumptions used in calculation of these amounts. The actual number of Option Awards granted in fiscal year 2009 is shown in the "Grants of Plan Based Awards in Fiscal Year 2009" table included below in this report. Because these amounts represent expense for financial reporting purposes, they are not representative of the actual value that the named executive officer would receive upon exercise of these options.

(c) The amounts disclosed under All Other Compensation in the Summary Compensation Table represent for the named executive officers in fiscal 2009 (i) the following amounts of our matching contributions made under our 401(k) Plan: Mr. Martin: $6,900; Mr. Roe: $6,900; Mr. Pitts: $6,900; Mr. Wallace $6,900; and Mr. Mullany: $6,900; and (ii) the following amounts of insurance premiums paid by Vanguard with respect to group term life insurance: Mr. Martin: $6,858; Mr. Roe: $740; Mr. Pitts: $1,242 Mr. Wallace: $1,242; and Mr. Mullany: $0. The amounts in this column also include for Mr. Mullany in fiscal 2009 $54,000, consisting of a $4,500 monthly housing allowance in connection with his relocation of his residence to Massachusetts from his residence in Tennessee after he joined us in September 2005. No amounts for perquisites and other personal benefits, or property, have been included in this column for 2009 for Messrs. Martin, Roe, Pitts and Wallace because the aggregate value thereof for each of these named executive officers was below the $10,000 reporting threshold established by the Securities and Exchange Commission for this column.

Grants of Plan-Based Awards in Fiscal Year 2009

Name	Grant Date	Estimated Future Payouts Under Non-Equity Incentive Plan Awards (a) Threshold ($)	Target ($)	Maximum ($)	All Other Option Awards: Number of Securities Underlying Options (b)(#)	Exercise or Base Price of Option Awards ($/Sh)(b)	Grant Date Fair Value of Option Awards ($)(b)
Charles N. Martin, Jr.	n/a	109,808	1,098,079	1,647,119			
Phillip W. Roe	n/a	36,750	367,500	551,250			
Keith B. Pitts	n/a	61,650	616,500	924,750			
Kent H. Wallace	n/a	61,650	616,500	924,750			
	5/5/09				1,750	1,057.41	740,565
	5/5/09				1,750	1,057.41	877,153
	5/5/09				1,500	3,000.00	0
Joseph J. Mullany	n/a	111,690	408,000	663,000			

(a) The threshold, target and maximum amounts in these columns have been provided in accordance with Item 402(d) of Regulation S-K and show the range of payouts targeted for fiscal 2009 for performance under the Annual Incentive Plan. For fiscal year 2009, each of the named executive officers earned non-equity incentive plan awards, the Committee approved them and they were paid in cash to the named executive officers in September 2009 (except for certain portions thereof payable in September 2010 and September 2011, as disclosed in footnote (a) of the Summary Compensation Table,) and the full amounts of the awards are reflected in the Summary Compensation Table under the column labeled "Non-Equity Incentive Plan Compensation." See "Compensation Discussion and Analysis – Annual Incentive Compensation" for a detailed description of our Annual Incentive Plan.

(b) These are stock options awarded under the 2004 Stock Incentive Plan by the Committee as part of the named executive officer's long term equity incentive compensation. None of these options were granted with exercise prices below the fair market value of the underlying common stock on the date of grant. Since we are a privately-held company, the Committee determines the fair market value of our common stock primarily from an independent appraisal of our common stock which we obtain no less frequently than annually. The terms of these option awards are described in more detail under "Compensation Discussion and Analysis – Long Term Incentive Compensation – Our 2004 Stock Incentive Plan." We utilize a Black-Scholes-Merton model to estimate the fair value of options granted. The compensation expense recognized in our financial statements for fiscal year 2009 in accordance with SFAS 123(R) with respect to these option grants is reflected in the "Option Awards" column of the Summary Compensation Table.

Outstanding Equity Awards at Fiscal 2009 Year-End

The following table summarizes the outstanding equity awards held by each named executive officer at June 30, 2009. The table reflects options to purchase common stock of Vanguard which were granted under the Vanguard Health Systems, Inc. 2004 Stock Incentive Plan.

Name	Number of Securities Underlying Unexercised Options (#) Exercisable(a)	Number of Securities Underlying Unexercised Options (#) Unexercisable(b)	Option Exercise Price ($)(c)	Option Expiration Date
Charles N. Martin, Jr.	–	–	–	–
Phillip W. Rae	213(d)	140(d)	1,150.37	11/3/15
	–	353(e)	1,150.37	11/3/15
	182(d)	120(d)	3,000.00	11/3/15
	140(f)	560(f)	1,000.00	2/5/18
	–	700(g)	1,000.00	2/5/18
	120(f)	480(f)	3,000.00	2/5/18
Keith B. Pitts	105(f)	420(f)	1,000.00	2/5/18
	–	525(g)	1,000.00	2/5/18
	90(f)	360(f)	3,000.00	2/5/18
Kent H. Wallace	516(d)	342(d)	1,150.37	11/3/15
	–	858(e)	1,150.37	11/3/15
	442(d)	294(d)	3,000.00	11/3/15
	956(h)	636(h)	1,150.37	11/28/15
	–	1,592(i)	1,150.37	11/28/15
	819(h)	545(h)	3,000.00	11/28/15
	105(f)	420(f)	1,000.00	2/5/18
	–	525(g)	1,000.00	2/5/18
	90(f)	360(f)	3,000.00	2/5/18
	–	1,750(j)	1,057.41	5/5/19
	–	1,750(k)	1,057.41	5/5/19
	–	1,500(j)	3,000.00	5/5/19
Joseph J. Mullany	1,050(l)	700(l)	1,000.00	9/19/15
	–	1,750(m)	1,000.00	9/19/15
	900(l)	600(l)	3,000.00	9/19/15
	35(f)	140(f)	1,000.00	2/5/18
	–	175(g)	1,000.00	2/5/18
	30(f)	120(f)	3,000.00	2/5/18

(a) This column represents the number of stock options that had vested and were exercisable as of June 30, 2009.

(b) This column represents the number of stock options that had not vested and were not exercisable as of June 30, 2009.

(c) The exercise price for the options was never less than the grant date fair market value of a share of Vanguard common stock as determined by the Compensation Committee.

(d) 20% of the options represented by this option grant vest and become exercisable on each of the first five anniversaries of the November 3, 2005 grant date of these options (or earlier upon a change of control). 60% of this option grant was vested as of June 30, 2009.

(e) 100% of the options represented by this option grant vest and become exercisable on the eighth anniversary of the November 3, 2005 grant date of these options (or earlier upon a liquidity event).

(f) 20% of the options represented by this option grant vest and become exercisable on each of the first five anniversaries of the February 5, 2008 grant date of these options (or earlier upon a change of control). 20% of this option grant was vested as of June 30, 2009.

(g) 100% of the options represented by this option grant vest and become exercisable on the eighth anniversary of the February 5, 2008 grant date of these options (or earlier upon a liquidity event).

(h) 20% of the options represented by this option grant vest and become exercisable on each of the first five anniversaries of the November 28, 2005 grant date of these options (or earlier upon a change of control). 60% of this option grant was vested as of June 30, 2009.

(i) 100% of the options represented by this option grant vest and become exercisable on the eighth anniversary of the November 28, 2005 grant date of these options (or earlier upon a liquidity event).

(j) 20% of the options represented by this option grant vest and become exercisable on each of the first five anniversaries of the May 5, 2009 grant date of these options (or earlier upon a change of control). None of this option grant was vested as of June 30, 2009.

(k) 100% of the options represented by this option grant vest and become exercisable on the eighth anniversary of the May 5, 2009 grant date of these options (or earlier upon a liquidity event).

(l) 20% of the options represented by this option grant vest and become exercisable on each of the first five anniversaries of the September 19, 2005 grant date of these options (or earlier upon a change of control). 60% of this option grant was vested as of June 30, 2009.

(m) 100% of the options represented by this option grant vest and become exercisable on the eighth anniversary of the September 19, 2005 grant date of these options (or earlier upon a liquidity event).

Option Exercises and Stock Vested

No named executive officer exercised any stock options of Vanguard during fiscal 2009 nor were any restricted stock awards vested during fiscal 2009. Vanguard has made no restricted stock awards of its common stock since the Merger.

Pension Benefits

Vanguard maintains a 401(k) plan as previously discussed in the Compensation Discussion and Analysis. Vanguard maintains no defined benefit plans.

Nonqualified Deferred Compensation

None of the named executive officers receive nonqualified deferred compensation benefits.

Employment and Severance Protection Agreements

As discussed above, we have entered into definitive employment or severance protection agreements with four of the named executive officers (Messrs. Martin, Roe, Pitts and Wallace). The terms of these agreements are described above under Compensation Discussion and Analysis.

Potential Payments Upon Termination or Change of Control

The following table describes the potential payments and benefits under our compensation and benefit plans and arrangements to which the named executive officers would be entitled upon a termination of their employment under their employment agreement, if they have an employment agreement, or if they do not have an employment agreement, under their severance protection agreement. In accordance with SEC disclosure rules, dollar amounts below assume a termination of employment on June 30, 2009 (the last business day of our last completed fiscal year).

Current	Cash Severance Payment ($)	Continuation of Medical/Welfare Benefits (present value) ($)	Total Termination Benefits ($)
Charles N. Martin, Jr.			
·Voluntary retirement	0	0	0
·Involuntary termination	4,296,740	23,463	4,320,203
·Involuntary or Good Reason termination after change in control	6,445,110	23,463	6,468,573
Phillip W. Roe			
·Voluntary retirement	0	0	0
·Involuntary termination	1,715,000	23,463	1,738,463
·Involuntary or Good Reason termination after change in control	2,572,500	23,463	2,595,963
Keith B. Pitts			
·Voluntary retirement	0	0	0
·Involuntary termination	2,525,322	23,463	2,548,785
·Involuntary or Good Reason termination after change in control	3,787,983	23,463	3,811,446
Kent H. Wallace			
·Voluntary retirement	0	0	0
·Involuntary termination	2,450,000	23,463	2,473,463
·Involuntary or Good Reason termination after change in control	3,675,000	23,463	3,698,463
Joseph J. Mullany			
·Voluntary retirement	0	0	0
·Involuntary termination	0	0	0
·Involuntary or Good Reason termination after change in control	2,295,000	27,041	2,322,041

Accrued Pay and Regular Retirement Benefits. The amounts shown in the table above do not include payments and benefits to the extent they are provided on a non-discriminatory basis to salaried employees generally upon termination of employment. These include:

- Accrued salary and vacation pay and earned but unpaid bonus.
- Distributions of plan balances under our 401(k) plan.

Death and Disability. A termination of employment due to death or disability does not entitle the named executive officers to any payments or benefits that are not available to salaried employees generally.

Involuntary Termination and Change-in-Control Severance Pay Program. As described above under "—Our Employment Agreements," all of the named executive officers (except for Mr. Mullany who has no employment agreement with us) are entitled to severance pay in the event that their employment is terminated by us without Cause or if the named executive officer terminates the agreement as a result of our breach of his employment agreement. Additionally, they are entitled to severance pay under their employment agreements in the event they terminate the agreements after a change in control if their termination is for Good Reason.

As described above under "—Our Severance Protection Agreements", Mr. Mullany is entitled to severance pay in the event that his employment is terminated by us after a change of control without Cause. Additionally, he may terminate his agreement and be entitled to severance pay after a change in control if his termination is for Good Reason.

Under our executive severance pay program, no payments due in respect of a change of control are "single trigger", that is, payments of severance due to the named executive officers merely upon a change of control. All of our change of control payments are "double trigger", due to the executive only subsequent to a change of control and after a termination of employment has occurred.

Under their employment agreements, all of our named executive officers (except Mr. Mullany) owe the following obligations to us:

- Not to disclose our confidential business information;
- Not to solicit for employment any of our employees for a period expiring two years after the termination of their employment; and
- Not to accept employment with or consult with, or have any ownership interest in, any hospital or hospital management entity for a period expiring two years after the termination of their employment, except there shall be not such prohibitions if (1) we terminate the executive under his employment agreement or (2) the executive terminates his agreement for Good Reason or because we have breached his agreement.

The amounts shown in the table are for such involuntary or Good Reason terminations for the named executive officers and are based on the following assumptions and provisions in the employment agreements.

• *Covered terminations following a Change in Control.* Eligible terminations for Messrs. Martin, Roe, Pitts and Wallace include an involuntary termination for reasons other than Cause both before and following a change of control, or a voluntary resignation by the executive as a result of Good Reason following a change in control. Eligible terminations for Mr. Mullany include an involuntary termination for reasons other the Cause following a change of control, or a voluntary resignation as a result of Good Reason following a change of control.

• *Definitions of Cause and Good Reason*

A termination of a named executive officer by us is for Cause if it is for any of the following reasons:

(a) the conviction of the executive of a criminal act classified as a felony;

(b) the willful failure by the executive to substantially perform the executive's duties with us (other than any such failure resulting from the executive's incapacity due to physical or mental illness); or

(c) the willful engaging by the executive in conduct which is materially injurious to us monetarily or otherwise.

A termination by the named executive officer is for Good Reason if it results from, after a change of control has occurred, one of the following events:

(a) a material diminution in the executive's base compensation;

(b) a material diminution in the executive's authority, duties or responsibilities;

(c) a material diminution in the authority, duties or responsibilities of the supervisor to whom the executive is required to report, including a requirement that the executive's supervisor report to a corporate officer or employee instead of reporting directly to our Board of Directors;

(d) a material diminution in the budget over which the executive retains authority;

(e) a material change in the geographic location at which the executive must perform services, except for required travel on our business to an extent substantially consistent with his business travel obligations prior to the change in control; or

(f) any other action or inaction that constitutes a material breach by us of the terms of the employment agreement.

• *Cash severance payments; Timing.* Represents, for each of Messrs. Martin, Roe, Pitts and Wallace, (1) if it relates to an involuntary termination without Cause by us prior to a change of control, a payment of 2 times the named executive officer's base salary and average annual incentive actually paid during the last two years plus an additional amount equal to such officer's pro rata annual target incentive for the year of termination and (2) if it relates to an involuntary termination without cause by us or a Good Reason termination by the executive after a change of control, payment of 3 times the named executive officer's base salary and average annual incentive actually paid during the last two years plus an additional amount equal to such officer's pro rata annual target incentive for the year of termination. Represents, for Mr. Mullany, if it relates to either an involuntary termination without cause by us or a Good Reason termination by the executive after a change of control, payment of 2.5 times Mr. Mullany's base salary and target incentive plus an additional amount equal to Mr. Mullany's pro rata annual incentive for the year of termination. All of these severance payments are "lump sum" payments by us to the named executive officers due within 5 days of termination of employment, except that the amounts of severance described above payable to Messrs. Martin, Roe, Pitts and Wallace in respect of a termination of their employment prior to a change of control are payable monthly in equal monthly installments starting with the month after employment terminates and ending with the month that their 5-year employment agreements terminate (which is September 2010 for Messrs. Martin and Pitts and November 2012 for Messrs. Roe and Wallace).

• *Continuation of health, welfare and other benefits.* Represents the value of coverage for 18 months following a covered termination equivalent to our current active employee medical, dental, life, long-term disability insurances and other covered benefits.

Director Compensation

During fiscal 2009, our directors who are either our employees or affiliated with our private equity Sponsors did not receive any fees or other compensation services as our directors. As described in the table below, Michael J. Parsons, a director who is not our employee or an affiliate of our Sponsors, receives our current standardized director compensation plan for our independent directors of $60,000 per annum in cash plus an initial grant, upon election to our board of directors, of 85 stock options pursuant to our 2004 Stock Incentive Plan, as described in this Item under the caption "Our 2004 Stock Incentive Plan". We do, however, reimburse all of our directors for travel expenses and other out-of-pocket costs incurred in connection with attendance at meetings of the board.

The following table summarizes all compensation for our non-employee directors for our fiscal year ended June 30, 2009.

Name	Fees Earned or Paid in Cash(1) ($)	Stock Awards ($)	Option Awards(2)(3) ($)	Non-Equity Incentive Plan Compensation ($)	Change in Pension Value and Nonqualified Deferred Compensation Earnings	All Other Compensation ($)	Total ($)
Michael J. Parsons	60,000	–	2,812	–	–	–	62,812

(1) The director compensation in the above table reflects an annual cash retainer paid to each independent, non-employee director of $60,000. The employee director and the Sponsor-affiliated directors receive no additional compensation for serving on the board and, as a result, are not listed in the above table.

(2) The amount in this column reflects the dollar amount recorded for financial statement reporting purposes for the fiscal year ended June 30, 2009, in accordance with FAS 123(R), relating to Mr. Parsons' option award on May 6, 2008 granted pursuant to our 2004 Stock Option Plan. Assumptions used in the calculation of this amount are included in Note 12 of the Notes to our consolidated financial statements for the fiscal year ended June 30, 2009 included in this report.

(3) This represents a grant of 85 stock options on May 6, 2008 under our 2004 Stock Option Plan. 20% of such options (11 options) were exercisable on June 30, 2009. 30 of the options had an option exercise price of $1,000 per share and become exercisable 20% on each of the first five anniversaries of their May 6, 2008 grant date (or earlier upon a change of control). 30 of the options also had an option exercise price of $1,000 per share and become exercisable on the eighth anniversary of the May 6, 2008 grant date (or earlier upon a liquidity event). 25 of the options had an option exercise price of $3,000 per share and become exercisable 20% on each of the first five anniversaries of their May 6, 2008 grant date (or earlier upon a change of control). The exercise price for the options is not less than the fair market value of a share of our common stock as determined by the Compensation Committee. All of these 85 options have an expiration date of May 6, 2018. For more information about options granted under our 2004 Stock Option Plan, see information in this Item under the caption "Our 2004 Stock Incentive Plan".

Compensation Committee Interlocks and Insider Participation

During fiscal 2009, we had no compensation committee of our board of directors. Charles N. Martin, Jr., one of our named executive officers, participated in deliberations of our board of directors concerning executive officer compensation during fiscal 2009. Also, during fiscal 2009, Keith B. Pitts, one of our named executive officers, served on the board of directors of SouthernCare, Inc., one of whose executive officers, Michael J. Parsons, served on our board of directors. Both our board of directors and the board of directors of SouthernCare, Inc. act as the compensation committees for each such entity, each such entity having no such standing compensation committee or other committee performing similar functions.

Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters.

As of September 1, 2009, VHS Holdings LLC ("Holdings") directly owned 624,550 of the outstanding shares of the common stock of Vanguard (representing a 83.3% ownership interest), certain investment funds affiliated with Blackstone directly owned 125,000 of the outstanding shares of the common stock of Vanguard (representing a 16.7% ownership interest) and no other person or entity had a direct beneficial ownership interest in the common stock of Vanguard, except for certain key employees who held an aggregate of 27,804 exercisable options into 27,804 shares of the common stock of Vanguard as of such date. However, ignoring only the direct ownership of Holdings in the common stock of Vanguard, the following table sets forth information with respect to the direct or indirect beneficial ownership of the common stock of Vanguard as of September 1, 2009 by (1) each person (other than Holdings) known to own beneficially more than 5.0% of the common stock of Vanguard, (2) each named executive officer, (3) each of our directors and (4) all executive officers and directors as a group. The indirect beneficial ownership of the common stock of Vanguard reflects the direct beneficial ownership of all Class A units and all vested Class B and D units of Holdings. None of the shares listed in the table are pledged as security pursuant to any pledge arrangement or agreement. Additionally, there are no arrangements with respect to the share, the operation of which may result in a change in control of Vanguard.

Notwithstanding the beneficial ownership of the common stock of Vanguard presented below, the limited liability company agreement of Holdings governs the holders' exercise of their voting rights with respect to election

of Vanguard's directors and certain other material events. See "Item 13. Certain Relationships and Related Transactions - Holdings Limited Liability Company Agreement."

Name of Beneficial Owner	Beneficial Ownership	Ownership Percentage
Blackstone Funds(1)	494,930	66.0%
MSCP Funds(2)	130,000	17.3%
Charles N. Martin Jr.(3)	56,553	7.4%
Phillip W. Roe(4)	7,580	1.0%
Keith B. Pitts(5)	20,932	2.8%
Kent H. Wallace(6)	8,647	1.1%
Joseph J. Mullany(7)	2,665	*
M. Fazle Husain(8)	126,750	16.9%
James A. Quella(1)	494,930	66.0%
Neil P. Simpkins (1)	494,930	66.0%
Michael A. Dal Bello	-(9)	-(9)
Alan M. Muney, M.D.	-(9)	-(9)
Michael J. Parsons (10)	11	*
All directors and executive officers as a group (29 persons) (11)	773,854	94.8%

* Less than 1% of shares of common stock outstanding (excluding, in the case of all directors and executive officers as a group, shares beneficially owned by Blackstone and by the MSCP Funds).

(1) Includes common stock interests directly and indirectly owned by each of Blackstone FCH Capital Partners IV L.P., Blackstone FCH Capital Partners IV-A L.P., Blackstone FCH Capital Partners IV-B L.P., Blackstone Capital Partners IV-A L.P., Blackstone Family Investment Partnership IV-A L.P., Blackstone Health Commitment Partners L.P. and Blackstone Health Commitment Partners-A L.P. (the "Blackstone Funds"), for which Blackstone Management Associates IV L.L.C. ("BMA") is the general partner having voting and investment power over the membership interests in Holdings and the shares in Vanguard held or controlled by each of the Blackstone Funds. Messrs. Quella and Simpkins are members of BMA, but disclaim any beneficial ownership of the membership interests or the shares beneficially owned by BMA. Mr. Stephen A. Schwarzman is the founding member of BMA and as such may be deemed to share beneficial ownership of the membership interests or shares held or controlled by the Blackstone Funds. Mr. Schwarzman disclaims beneficial ownership of such membership interests and shares. The address of BMA and the Blackstone Funds is c/o The Blackstone Group L.P., 345 Park Avenue, New York, New York 10154

(2) The MSCP Funds consist of the following six funds: Morgan Stanley Capital Partners III, L.P., MSCP III 892 Investors, L.P., Morgan Stanley Capital Investors, L.P., Morgan Stanley Dean Witter Capital Partners IV, L.P., MSDW IV 892 Investors, L.P., and Morgan Stanley Dean Witter Capital Investors IV, L.P. The address of each of Morgan Stanley Capital Partners III, L.P., MSCP III 892 Investors, L.P., Morgan Stanley Dean Witter Capital Partners IV, L.P. and MSDW IV 892 Investors, L.P. is c/o Metalmark Capital LLC, 1177 Avenue of the Americas, New York, New York 10036. The address of each of Morgan Stanley Capital Investors, L.P. and Morgan Stanley Dean Witter Capital Investors IV, L.P. is c/o Morgan Stanley, 1585 Broadway, New York, New York 10036. Metalmark Capital LLC shares investment and voting power with Morgan Stanley Capital Partners III, L.P., MSCP III 892 Investors, L.P., Morgan Stanley Dean Witter Capital Partners IV, L.P. and MSDW IV 892 Investors, L.P. over 126,750 of these 130,000 shares of Vanguard common stock indirectly owned by these four funds.

(3) Includes 8,913 B units and 7,640 D units in Holdings which are vested or vest within 60 days of September 1, 2009. Also, includes 5,000 A units in Holdings owned by the Charles N. Martin, Jr. 2008 Irrevocable Grantor Retained Annuity Trust u/a/d December 5, 2008, of which Mr. Martin is Trustee and one of its beneficiaries.

(4) Includes 655 options on Vanguard common stock and 2,097 B units and 1,798 D units in Holdings which are vested or vest within 60 days of September 1, 2009.

(5) Includes 195 options on Vanguard common stock and 5,243 B units and 4,494 D units in Holdings which are vested or vest within 60 days of September 1, 2009.

(6) Includes 2,928 options on Vanguard common stock and 2,622 B units and 2,247 D units in Holdings which are vested or vest within 60 days of September 1, 2009. Also, includes 850 A units in Holdings owned by the 2008 Kent H. Wallace Trust u/a/d October 10, 2008, of which Mr. Wallace is sole beneficiary. The 2,622 B units and the 2,247 D units in Holding are also owed by the Trust.

(7) Includes solely 2,665 options on Vanguard common stock which are vested or vest within 60 days of September 1, 2009.

(8) Mr. Husain is a Managing Director of Metalmark Capital LLC and exercises shared voting or investment power over the membership interests in Holdings owned by Morgan Stanley Capital Partners III, L.P., MSCP III 892 Investors, L.P., Morgan Stanley Dean Witter Capital Partners IV, L.P., and MSDW IV 892 Investors, L.P. and, as a result, may be deemed to be the beneficial owner of such membership interests and the 126,750 shares of Vanguard common stock indirectly owned by these four funds. Mr. Husain disclaims beneficial ownership of such membership interests and shares of common stock as a result of his employment arrangements with Metalmark, except to the extent of his pecuniary interest therein ultimately realized. Metalmark Capital does not have investment and voting

power with respect to 3,250 shares of Vanguard common stock indirectly owned by Morgan Stanley Capital Investors, L.P. and Morgan Stanley Dean Witter Capital Investors IV, L.P. and these 3,250 shares are not included in the 126,750 shares contained in this table for Mr. Husain.

(9) Mr. Dal Bello and Mr. Muney are employees of Blackstone, but do not have investment or voting control over the shares beneficially owned by Blackstone.

(10) Includes solely 11 options in Vanguard common stock which are vested or vest within 60 days of September 1, 2009.

(11) Includes 13,445 options in Vanguard and 28,574 B units and 24,492 D units in Holdings which have vested or vest within 60 days of September 1, 2009.

Equity Compensation Plan Information

The following table gives information about our common stock that may be issued upon the exercise of options, warrants and rights under all of Vanguard's existing equity compensation plans as of June 30, 2009.

	Equity Compensation Plan Information		
Plan Category	Number of securities to be issued upon exercise of outstanding options, warrants and rights (a)	Weighted-average exercise price of outstanding options, warrants and rights (b)	Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a)) (c)
Equity compensation plans approved by security holders	102,455(1)	$1,643	2,652 (1)
Equity compensation plans not approved by security holders	0	$ 0	0
Total	102,455	$1,643	2,652

(1) The material features of the equity compensation plan under which these options were issued are set forth in this report under "Item 11. Executive Compensation – Our 2004 Stock Incentive Plan."

Item 13. Certain Relationships and Related Transactions, and Director Independence.

Holdings Limited Liability Company Agreement

In the Merger, Blackstone invested, and MSCP, Baptist and the Rollover Management Investors re-invested, in our company by subscribing for and purchasing Class A membership units in Holdings. In addition, at the closing of the Merger, the board of representatives of Holdings issued to certain Rollover Management Investors Class B, C and D membership units in Holdings as part of a new equity incentive program.

Under the limited liability company agreement of Holdings, the board of representatives of Holdings consists of the same five individuals who constitute the sole members of our board of directors. At Blackstone's election, the size of the board of representatives may be increased to nine members, with two additional representatives to be designated by Blackstone and two additional representatives to be independent representatives identified by our chief executive officer and acceptable to Blackstone. If at any time our chief executive officer is not Charles N. Martin, Jr., the Rollover Management Investors shall have the right to designate one representative to the board (the "Manager Representative") so long as the Rollover Management Investors continue to own not less than 50% of the Class A units held by them immediately after the completion of the Merger. MSCP will continue to be entitled to nominate and elect one representative so long as MSCP continues to own not less than 50% of the Class A units it held immediately after the completion of the Merger.

The limited liability company agreement of Holdings also has provisions relating to restrictions on transfer of securities, rights of first refusal, tag-along, drag-along, preemptive rights and affiliate transactions. At the

completion of the Merger, the Company issued Class B, C and D warrants to Holdings, exercisable for the proportional percentage of equity represented by the related classes of membership units in Holdings. With respect to the Class B, C and D units only, the limited liability company agreement also has call provisions applicable in the event of certain termination events relating to a Rollover Management Investor's employment.

Stockholders Agreement

Recipients of options to purchase the Company's common stock are required to enter into a stockholders agreement governing such grantees' rights and obligations with respect to the common stock underlying such options. The provisions of the stockholders agreement are, with limited exceptions, similar to those set forth in the limited liability company agreement of Holdings, including certain restrictions on transfer of shares of common stock, rights of first refusal, call rights, tag-along rights and drag-along rights. The transfer restrictions apply until the earlier of the fifth anniversary of the date the stockholder becomes a party to the stockholders agreement, or a change in control of the Company. The right of first refusal provision gives the Company a right of first refusal at any time after the fifth anniversary of the date the stockholder became a party to the stockholders agreement and prior to the earlier of a change in control of the Company or a registered public offering of our common stock meeting certain specified criteria. The call provisions provide rights with respect to the shares of our common stock held by the stockholder, whether or not such shares were acquired upon the exercise of a New Option, except for shares received upon conversion of or in redemption for Class A membership units in Holdings pursuant to the limited liability company agreement of Holdings. Such call rights are applicable in the event of certain termination events relating to the grantee's employment with the Company.

Transaction and Monitoring Fee Agreement

In connection with the Merger, Vanguard entered into a transaction and monitoring fee agreement with affiliates of Blackstone and with Metalmark Subadvisor LLC ("Metalmark SA") pursuant to which these entities provide certain structuring, advisory and management services to Vanguard. Under this agreement, Vanguard paid to Blackstone Management Partners IV L.L.C. ("BMP") upon the closing of the Merger a transaction fee of $20.0 million. In consideration for ongoing consulting and management advisory services, Vanguard is required to pay to BMP an annual fee of $4.0 million. In consideration for on-going consulting and management services Vanguard is required to pay to Metalmark SA an annual fee of $1.2 million for the first five years and thereafter an annual fee of $600,000. In the event or in anticipation of a change of control or initial public offering, BMP may elect at any time to have Vanguard pay to BMP and Metalmark SA lump sum cash payments equal to the present value (using a discount rate equal to the yield to maturity on the date of notice of such event of the class of outstanding U.S. government bonds having a final maturity closest to the tenth anniversary of such written notice) of all then-current and future fees payable to each of BMP and Metalmark SA under the agreement (assuming that the agreement terminates on the tenth anniversary of the closing of the Merger). In the event that BMP receives any additional fees in connection with an acquisition or disposition involving Vanguard, Metalmark SA will receive an additional fee equal to 15.0% of such fees paid to BMP or, if both parties provide equity financing in connection with the transaction, Metalmark SA will receive a portion of the aggregate fees payable by Vanguard, if any, based upon the amount of equity financing provided by Metalmark SA. The transaction and monitoring fee agreement also requires Vanguard to pay or reimburse BMP and Metalmark SA for reasonable out-of-pocket expenses in connection with, and indemnify them for liabilities arising from, the engagement of BMP and Metalmark SA of independent professionals pursuant to and the performance by BMP and Metalmark SA of the services contemplated by the transaction and monitoring fee agreement. The transaction and monitoring fee agreement will remain in effect with respect to each of BMP and Metalmark SA until the earliest of (1) BMP and Metalmark SA, as the case may be, beneficially owning less than 5.0% of Vanguard's common equity on a fully diluted basis, (2) the completion of a lump-sum payout as described above or (3) termination of the agreement upon the mutual consent of BMP and/or Metalmark SA, as the case may be, and Vanguard. Upon termination of Metalmark SA as a party to the agreement, Metalmark SA will be entitled to the excess, if any, of 15.0% of the aggregate amount of fees paid to date to BMP under the agreement minus any monitoring fees already paid to Metalmark SA.

Under the transaction and monitoring fee agreement during fiscal year 2009, Vanguard paid to BMP the annual $4.0 million fee referred to above. BMP is an affiliate of the Blackstone Funds which own 66.0% of the equity of Vanguard. Four of our seven directors, Messrs. Dal Bello, Muney, Quella and Simpkins, are employed by affiliates of BMP.

Under the transaction and monitoring fee agreement during fiscal year 2009, Vanguard paid to Metalmark SA the annual $1.2 million fee referred to above. Metalmark SA is an affiliate of Metalmark Capital LLC which manages the MSCP Funds and the MSCP Funds own 17.3% of the equity of Vanguard.

Registration Rights Agreement

In connection with the Merger, the Company entered into a registration rights agreement with Blackstone, MSCP and other investors and the Rollover Management Investors, pursuant to which Blackstone and MSCP are entitled to certain demand registration rights and pursuant to which Blackstone, MSCP and other investors and the Rollover Management Investors are entitled to certain piggyback registration rights.

Employer Health Program Agreement with a Blackstone Affiliate, Equity Healthcare LLC

Effective July 1, 2008, the Company entered into an Employer Health Program Agreement with Equity Healthcare LLC ("Equity Healthcare"). Equity Healthcare negotiates with providers of standard administrative services for health benefit plans as well as other related services for cost discounts and quality of service monitoring capability by Equity Healthcare. Because of the combined purchasing power of its client participants, Equity Healthcare is able to negotiate pricing terms for providers that are believed to be more favorable than the companies could obtain for themselves on an individual basis.

In consideration for Equity Healthcare's provision of access to these favorable arrangements and its monitoring of the contracted third parties' delivery of contracted services to the Company, Equity Healthcare receives from the Company a fee of $2 per employee per month ("PEPM Fee"). As of June 30, 2009, the Company has approximately 11,750 employees enrolled in its health and welfare benefit plans.

Equity Healthcare may also receive a fee from one or more of the health plans contracted with Equity Healthcare ("Health Plan Fees") if the total number of employees from Blackstone portfolio companies joining such health plans exceeds specified thresholds. If and when Equity Healthcare reaches the point at which the aggregate of its receipts from the PEPM Fee and the Health Plan Fees have covered all of its allocated costs, it will apply the incremental revenues derived from all such fees to (a) reduce the PEPM Fee; (b) avoid or reduce an increase in the PEPM Fee that might otherwise have occurred on contract renewal; or (c) arrange for additional services to the Company at no cost or reduced cost.

Equity Healthcare is an affiliate of Blackstone, with whom Michael A. Dal Bello, Alan M. Muney, James A. Quella and Neil P. Simpkins, members of our Board, are affiliated and in which they may have an indirect pecuniary interest.

Commercial Transactions with Sponsor Portfolio Companies

Blackstone, MSCP and Metalmark each sponsor private equity funds which have ownership interests in a broad range of companies. We have entered into commercial transactions in the ordinary course of our business with some of these companies, including the sale of goods and services and the purchase of goods and services. None of these transactions or arrangements is of great enough value to be considered material to us.

Policy on Transactions with Related Persons

The Vanguard board of directors recognizes the fact that transactions with related persons present a heightened risk of conflicts of interests and/or improper valuation (or the perception thereof). In February 2007, the board of directors adopted a written policy reflecting existing practices to be followed in connection with any transaction between the Company and a "related person."

Any transaction with the Company in which a director, executive officer or beneficial holder of more than 5% of the total equity of the Company, or any immediate family member of the foregoing (each, a "related person") has a direct or indirect material interest, and where the amount involved exceeds $120,000, must be specifically disclosed by the Company in its public filings. Any such transaction would be subject to the Company's written policy respecting the review, approval or ratification of related person transactions.

Under this policy:

- the Company or any of its subsidiaries may employ a related person in the ordinary course of business consistent with the Company's policies and practices with respect to the employment of non-related persons in similar positions; and

- any other related person transaction that would be required to be publicly disclosed must be approved or ratified by the board of directors, a committee thereof or if it is impractical to defer consideration of the matter until a board or committee meeting, by a non-management director who is not involved in the transaction.

If the transaction involves a related person who is a director or an immediate family member of a director, that director may not participate in the deliberations or vote. In approving or ratifying a transaction under this policy, the board of directors, the committee or director considering the matter must determine that the transaction is fair to the Company and may take into account, among other factors deemed appropriate, whether the transaction is on terms not less favorable than terms generally available to an unaffiliated third-party under the same or similar circumstances and the extent of the related person's interest in the transaction.

During fiscal year 2009, there were no transactions between the Company and a related person requiring approval under this policy, except for the Employer Health Program Agreement with Equity Healthcare.

Director Independence

Our board of directors has not made a formal determination as to whether each director is "independent" because we have no equity securities listed for trading on a national securities exchange or in an automated inter-dealer quotation system of a national securities association, which has requirements that a majority of its board of directors be independent. Six of our seven directors have either been appointed by our equity Sponsors or are employed by us (Mr. Martin, our chairman and chief executive officer). Our seventh director (Michael J. Parsons) is neither our employee or otherwise affiliated with us in any significant way. Thus, we do not believe any of our directors would be considered independent under the New York Stock Exchange's definition of independence, except for Mr. Parsons.

Item 14. Principal Accounting Fees and Services.

Fees Paid to the Independent Auditor

The following table presents fees for professional services rendered by Ernst & Young LLP for the audit of Vanguard's annual financial statements for 2008 and 2009, and fees billed for audit-related services, tax services and all other services rendered by Ernst & Young LLP for 2008 and 2009.

	2008	2009
Audit fees[1]	$ 856,929	$ 852,712
Audit-related fees	1,500	1,995
Audit and audit-related fees	858,429	854,707
Tax fees[2]	64,263	133,384
All other fees[3]	1,108,072	1,002,563
Total fees[4]	$ 2,030,764	$ 1,990,654

(1) Audit fees for 2008 and 2009 include fees for the audit of the annual consolidated financial statements, reviews of the condensed consolidated financial statements included in Vanguard's quarterly reports and statutory audits.

(2) Tax fees for 2008 and 2009 consisted principally of fees for tax advisory services.

(3) All other fees for 2008 and 2009 consisted of assistance in identification of Medicaid eligible days for inclusion in the Medicare cost reports for Medicare disproportionate share reimbursement; assistance in validating average wage rates in our markets used in Medicare reimbursement; assistance in preparing reports for us relating to payer matters; and assistance in preparing occupational mix survey data in accordance with CMS requirements.

(4) Ernst & Young LLP full time, permanent employees performed all of the professional services described in this chart.

Pre-Approval Policies and Procedures

In February 2004, our board of directors first adopted an audit and non-audit services pre-approval policy and in November 2004 and May 2006 the board amended and restated this policy. This policy sets forth the Board's procedures and conditions pursuant to which services proposed to be performed by the Company's regular independent auditor (and those other independent auditors for whom pre-approvals are legally necessary) are presented to the Board for pre-approval. Normally, the policy would have been approved by the audit committee and ratified by the board of directors, but in February 2004, November 2004 and May 2006 we had no audit committee and, as a result, the full board of directors has the responsibility for all matters that are usually the responsibility of the audit committee.

The policy provides that the board of directors shall pre-approve audit services, audit-related services, tax services and those other services that it believes to be routine and recurring services that do not impair the independence of the auditor. Under the policy, our Chief Accounting Officer is responsible for determining whether services provided by the independent auditor are included as part of those services already pre-approved or whether separate approval from the board of directors is required. All services performed for us by Ernst & Young LLP, our independent registered public accounting firm, subsequent to the adoption of the policy have been pre-approved by the board of directors. The board of directors has concluded that the audit-related services, tax services and other non-audit services provided by Ernst & Young LLP in fiscal year 2009 were compatible with the maintenance of the firm's independence in the conduct of its auditing functions. In addition, to safeguard the continued independence of the independent auditors, the policy prevents our independent auditors from providing services to us that are prohibited under Section 10A(g) of the Securities Exchange Act of 1934, as amended.

PART IV

Item 15. Exhibits and Financial Statement Schedules.

(a) List of documents filed as part of this report.

(1) Financial Statements. The accompanying index to financial statements on page **XX** of this report is provided in response to this item.

(2) Financial Statement Schedules. All schedules are omitted because the required information is either not present, not present in material amounts or presented within the consolidated financial statements.

(3) Exhibits. The exhibits filed as part of this report are listed in the Exhibit Index which is located at the end of this report.

(b) Exhibits.
See Item 15(a)(3) of this report.

(c) Financial Statement Schedules.
See Item 15(a)(2) of this report.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

VANGUARD HEALTH SYSTEMS, INC. — Date

By: /s/ Charles N. Martin, Jr. — September 2, 2009
Charles N. Martin, Jr.
Chairman of the Board & Chief Executive Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/s/ Charles N. Martin, Jr. Charles N. Martin, Jr.	Chairman of the Board & Chief Executive Officer; Director (Principal Executive Officer)	September 2, 2009
/s/ Phillip W. Roe Phillip W. Roe	Executive Vice President, Chief Financial Officer & Treasurer (Principal Financial Officer)	September 2, 2009
/s/ Gary D. Willis Gary D. Willis	Senior Vice President, Controller & Chief Accounting Officer (Principal Accounting Officer)	September 2, 2009
/s/ Michael A. Dal Bello Michael A. Dal Bello	Director	September 2, 2009
/s/ M. Fazle Husain M. Fazle Husain	Director	September 2, 2009
_____ Alan M. Muney, M.D.	Director	September 2, 2009
/s/ Michael J. Parsons Michael J. Parsons	Director	September 2, 2009
_____ James A. Quella	Director	September 2, 2009
/s/ Neil P. Simpkins Neil P. Simpkins	Director	September 2, 2009

Supplemental Information to be Furnished With Reports Filed Pursuant to Section 15(d) of the Act by Registrants Which Have Not Registered Securities Pursuant to Section 12 of the Act.

No annual report or proxy material has been sent to security holders.

EXHIBIT INDEX

Exhibit No.	Description
2.1	Agreement and Plan of Merger, dated as of July 23, 2004, among VHS Holdings LLC, Health Systems Acquisition Corp. and Vanguard Health Systems, Inc.(1)
2.2	First Amendment to the Agreement and Plan of Merger, dated as of September 23, 2004, among VHS Holdings LLC, Health Systems Acquisition Corp. and Vanguard Health Systems, Inc.(1)
2.3	Indemnification Agreement, dated as of July 23, 2004, among VHS Holdings LLC, Vanguard Health Systems, Inc., and the stockholders and holders of options set forth therein(1)(3)
3.1	Amended and Restated Certificate of Incorporation of Vanguard Health Systems, Inc.(1)
3.2	By-Laws of Vanguard Health Systems, Inc.(7)
4.1	Indenture, relating to the 9% Senior Subordinated Notes, dated as of September 23, 2004, among Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the Guarantors party thereto and the Trustee(1)
4.2	First Supplemental Indenture, dated as of November 5, 2004, among Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the Guarantors party thereto and the Trustee(1)
4.3	Indenture, relating to the 11 1/4% Senior Discount Notes, dated as of September 23, 2004, among Vanguard Health Holding Company I, LLC, Vanguard Holding Company I, Inc, Vanguard Health Systems, Inc. and the Trustee(1)
4.4	Registration Rights Agreement relating to the 9% Senior Subordinated Notes, dated as of September 23, 2004, among Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the Guarantors party thereto, Citigroup Global Markets Inc., Banc of America Securities LLC, Bear Stearns & Co., Inc., J.P. Morgan Securities Inc., Merrill Lynch, Pierce, Fenner & Smith Incorporated, Wachovia Capital Markets, LLC and ABN AMRO Incorporated(1)
4.5	Registration Rights Agreement, relating to the 11 1/4% Senior Discount Notes, dated as of September 23, 2004, among Vanguard Health Holding Company I, LLC, Vanguard Holding Company I, Inc., Vanguard Health Systems, Inc., Citigroup Global Markets Inc., Banc of America Securities LLC, Bear Stearns & Co., Inc., J.P. Morgan Securities Inc., Merrill Lynch, Pierce, Fenner & Smith Incorporated, Wachovia Capital Markets, LLC and ABN AMRO Incorporated(1)
4.6	Registration Rights Agreement, concerning Vanguard Health Systems, Inc., dated as of September 23, 2004(1)
4.7	Second Supplemental Indenture, dated as of March 28, 2005, among Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the Guarantors party thereto and the Trustee (5)
4.8	Third Supplemental Indenture, dated as of July 13, 2006, among Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the Guarantors party thereto and the Trustee (11)
4.9	Fourth Supplemental Indenture, dated as of June 25, 2007, among Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the Guarantors party thereto and the Trustee(13)

4.10	Fifth Supplemental Indenture, dated as of July 1, 2007, among Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the Guarantors party thereto and the Trustee(13)
4.11	Sixth Supplemental Indenture, dated as of October 2, 2007, among Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the Guarantors party thereto and the Trustee (14)
4.12	Seventh Supplemental Indenture, dated as of November 3, 2008, among Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the Guarantors party thereto and the Trustee (18)
4.13	Eighth Supplemental Indenture, dated as of March 24, 2009, among Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the Guarantors party thereto and the Trustee (19)
10.1	Credit Agreement, dated as of September 23, 2004, among Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., Vanguard Health Holding Company I, LLC, the lenders party thereto, Bank of America, N.A. as administrative agent, Citicorp North America, Inc., as syndication agent, the other agents named therein, and Banc of America Securities LLC and Citigroup Global Markets Inc., as joint lead arrangers and book runners(1)
10.2	Security Agreement, dated as of September 23, 2004, made by each assignor party thereto in favor of Bank of America, N.A., as collateral agent(1)
10.3	Vanguard Guaranty, dated as of September 23, 2004, made by and among Vanguard Health Systems, Inc. in favor of Bank of America, N.A., as administrative agent(1)
10.4	Subsidiaries Guaranty, dated as of September 23, 2004, made by and among each of the guarantors party thereto in favor of Bank of America, N.A., as administrative agent(1)
10.5	Pledge Agreement, dated as of September 23, 2004, among each of the pledgors party thereto and Bank of America, N.A., as collateral agent(1)
10.6	Transaction and Monitoring Fee Agreement, dated as of September 23, 2004, among Vanguard Health Systems, Inc., Blackstone Management Partners IV L.L.C., and Metalmark Management LLC(1)
10.7	Amended and Restated Limited Liability Company Operating Agreement of VHS Holdings LLC, dated as of September 23, 2004(1)
10.8	Vanguard Health Systems, Inc. 2004 Stock Incentive Plan(1)(3)
10.9	VHS Holdings LLC 2004 Unit Plan(1)(3)
10.10	Vanguard Health Systems, Inc. 2001 Annual Incentive Plan(2)(3)
10.11	Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Charles N. Martin, Jr., dated as of September 23, 2004(1)(3)
10.12	Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Joseph D. Moore, dated as of September 23, 2004(1)(3)
10.13	Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Ronald P. Soltman, dated as of September 23, 2004(1)(3)

10.14 Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Keith B. Pitts, dated as of September 23, 2004(1)(3)

10.15 Form of Amended and Restated Severance Protection Agreement of Vanguard Health Systems, Inc. dated as of September 23, 2004 for Vice Presidents and above (1)(3)

10.16 Amended and Restated Agreement Between the Shareholders of VHS Acquisition Subsidiary Number 5, Inc. executed on September 8, 2004, but effective as of September 1, 2004(1)

10.17 Certificate of Designations, Preferences and Rights of Series A Preferred Stock of VHS Acquisition Subsidiary Number 5, Inc., dated as of September 8, 2004(1)

10.18 License Agreement between Baptist Health System and VHS San Antonio Partners, L.P. dated as of January 1, 2003(4)

10.19 Form of Performance Option Under 2004 Stock Incentive Plan(1)(3)

10.20 Form of Time Option Under 2004 Stock Incentive Plan(1)(3)

10.21 Form of Liquidity Event Option Under 2004 Stock Incentive Plan(1)(3)

10.22 Stockholders Agreement Concerning Vanguard Health Systems, Inc., dated as of November 4, 2004, by and among Vanguard Health Systems, Inc., VHS Holdings LLC, Blackstone FCH Capital Partners IV L.P. and its affiliates identified on the signature pages thereto and the employees identified on the signature pages thereto(1)

10.23 Amendment No. 1 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Charles N. Martin, Jr., dated as of December 1, 2004(1)(3)

10.24 Amendment No. 1 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Joseph D. Moore, dated as of December 1, 2004(1)(3)

10.25 Amendment No. 1 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Ronald P. Soltman, dated as of December 1, 2004(1)(3)

10.26 Amendment No. 1 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Keith B. Pitts, dated as of December 1, 2004(1)(3)

10.27 First Amendment of VHS Holdings LLC 2004 Unit Plan(3)(7)

10.28 First Amendment to Credit Agreement, dated as of August 15, 2005, among Vanguard Health Holding Company I, LLC, Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the lenders party to the Credit Agreement referred to therein, and Bank of America, N.A. as administrative agent(6)

10.29 First Amendment to Credit Agreement, dated as of August 15, 2005, among Vanguard Health Holding Company I, LLC, Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the lenders party to the Credit Agreement referred to therein, and Bank of America, N.A. as administrative agent(8)

10.30 Amendment No. 2 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Charles N. Martin, Jr., dated as of December 1, 2005(3)(9)

10.31 Amendment No. 2 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Joseph D. Moore , dated as of December 1, 2005(3)(9)

10.32	Amendment No. 2 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Ronald P. Soltman, dated as of December 1, 2005(3)(9)
10.33	Amendment No. 2 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Keith B. Pitts, dated as of December 1, 2005(3)(9)
10.34	Amendment No. 1, dated as of November 3, 2005, to Amended and Restated Limited Liability Company Operating Agreement of VHS Holdings LLC(9)
10.35	Amendment Number 1 to the Vanguard Health Systems, Inc. 2004 Stock Incentive Plan, effective November 28, 2005(3)(9)
10.36	Amendment Number 2 to the Vanguard Health Systems, Inc. 2004 Stock Incentive Plan, effective February 15, 2006(3)(10)
10.37	Amendment Number 3 to the Vanguard Health Systems, Inc. 2004 Stock Incentive Plan, effective April 15, 2006(3)(10)
10.38	Amendment Number 4 to the Vanguard Health Systems, Inc. 2004 Stock Incentive Plan, effective November 13, 2006(3)(12)
10.39	Amendment No. 3 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Charles N. Martin, Jr., dated as of October 1, 2007(3)(15)
10.40	Amendment No. 3 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Keith B. Pitts, dated as of October 1, 2007(3)(15)
10.41	Amendment No. 3 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Joseph D. Moore, dated as of October 1, 2007(3)(15)
10.42	Amendment No. 4 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Joseph D. Moore, dated as of November 7, 2007(3)(15)
10.43	Amendment No. 3 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Ronald P. Soltman, dated as of October 1, 2007(3)(15)
10.44	Employment Agreement between Vanguard Health Systems, Inc. and Kent H. Wallace dated as of November 15, 2007(3)(15)
10.45	Employment Agreement between Vanguard Health Systems, Inc. and Phillip W. Roe dated as of November 15, 2007(3)(15)
10.46	Form of Amendment No. 1 to Severance Protection Agreement dated as of October 1, 2007, entered into between Vanguard Health Systems, Inc. and each of its executive officers (other than Messrs. Martin, Pitts, Moore, Soltman, Wallace and Roe who each have entered into employment agreements with the registrant)(3)(15)
10.47	Amendment Number 5 to the Vanguard Health Systems, Inc. 2004 Stock Incentive Plan, effective May 6, 2008(3)(16)
10.48	Letter dated May 13, 2008, from the Arizona Health Care Cost Containment System to VHS Phoenix Health Plan, LLC, countersigned by VHS Phoenix Health Plan, LLC on May 13, 2008 awarding Contract No. YH09-0001-07(17)

10.49 Waiver No. 1 dated as of May 22, 2008, to Amended and Restated Limited Liability Company Operating Agreement of VHS Holdings LLC, dated as of September 23, 2004, as amended by Amendment No. 1, dated as of November 3, 2005(20)

10.50 Amendment No. 5 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Joseph D. Moore, dated as of June 30, 2008(3)(20)

10.51 Form of Severance Protection Agreement of Vanguard Health Systems, Inc. in current use for Vice Presidents and above(3)(20)

10.52 Arizona Health Care Cost Containment System Administration RFP re Contract No. YH09-0001-07 with VHS Phoenix Health Plan, LLC awarded May 13, 2008(20)

10.53 Solicitation Amendments to RFP numbers One, Two, Three, Four and Five dated February 29, 2008, March 14, 2008, March 26, 2008, March 28, 2008 and April 10, 2008, respectively, to Arizona Health Care Cost Containment System Administration Contract No. YH09-0001-07 with VHS Phoenix Health Plan, LLC(20)

10.54 Contract Amendment Number 1, executed on September 23, 2008, but effective as of October 1, 2008, to the Arizona Health Care Cost Containment System Administration Contract No. YH09-0001-07 between VHS Phoenix Health Plan, LLC and the Arizona Health Care Cost Containment System(21)

10.55 Contract Amendment Number 2, executed on January 16, 2009, but effective as of January 15, 2009, to the Arizona Health Care Cost Containment System Administration Contract No. YH09-0001-07 between VHS Phoenix Health Plan, LLC and the Arizona Health Care Cost Containment System(18)

10.56 Contract Amendment Number 3, executed on April 6, 2009, but effective as of May 1, 2009, to the Arizona Health Care Cost Containment System Administration Contract No. YH09-0001-07 between VHS Phoenix Health Plan, LLC and the Arizona Health Care Cost Containment System(19)

10.57 Contract Amendment Number 4, executed on July 7, 2009, but effective as of August 1, 2009, to the Arizona Health Care Cost Containment System Administration Contract No. YH09-0001-07 between VHS Phoenix Health Plan, LLC and the Arizona Health Care Cost Containment System

10.58 Contract Amendment Number 5, executed on July 7, 2009, but effective as of August 1, 2009, to the Arizona Health Care Cost Containment System Administration Contract No. YH09-0001-07 between VHS Phoenix Health Plan, LLC and the Arizona Health Care Cost Containment System

10.59 Amendment Number 6 to the Vanguard Health Systems, Inc. 2004 Stock Incentive Plan, effective February 13, 2009(3)(19)

10.60 Form of Indemnification Agreement between the Company and each of its directors and executive officers (3)(22)

10.61 Amendment No. 4 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Charles N. Martin, Jr., dated as of May 5, 2009(3)

10.62 Amendment No. 4 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Keith B. Pitts, dated as of May 5, 2009(3)

10.63 Amendment No. 4 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Ronald P. Soltman, dated as of May 5, 2009(3)

10.64	Amendment No. 1 to Employment Agreement between Vanguard Health Systems, Inc. and Kent H. Wallace, dated as of May 5, 2009(3)
10.65	Amendment No. 1 to Employment Agreement between Vanguard Health Systems, Inc. and Phillip W. Roe, dated as of May 5, 2009(3)
10.66	Employment Agreement between Vanguard Health Systems, Inc. and Mark R. Montoney, M.D. dated as of December 31, 2008(3)
10.67	Amendment No. 1 to Employment Agreement between Vanguard Health Systems, Inc. and Mark R. Montoney, M.D. dated as of May 5, 2009(3)
10.68	Employment Agreement between Vanguard Health Systems, Inc. and Bradley A. Perkins dated as of July 1, 2009(3)
10.69	Vanguard Health Systems, Inc. 2009 Long Term Incentive Plan (3)(23)
10.70	Amendment No. 7 to Vanguard Health Systems, Inc. 2004 Stock Incentive Plan (3)(23)
12.1	Computation of Ratios of Earnings to Fixed Charges
21.1	Subsidiaries of Vanguard Health Systems, Inc.
31.1	Certification of CEO pursuant to Rule 13a-14(a)/15d-14(a) as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
31.2	Certification of CFO pursuant to Rule 13a-14(a)/15d-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
32.1	Certification of CEO pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
32.2	Certification of CFO pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002

(1) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Registration Statement on Form S-4 first filed on November 12, 2004 (Registration No. 333-120436).

(2) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Registration Statement on Form S-1 first filed on October 19, 2001 (Registration No. 333-71934).

(3) Management compensatory plan or arrangement.

(4) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Current Report on Form 8-K dated January 14, 2003, File No. 333-71934.

(5) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended March 31, 2005, File No. 333-71934.

(6) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Current Report on Form 8-K dated August 26, 2005, File No. 333-71934.

(7) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Annual Report on Form 10-K for the annual period ended June 30, 2005, File No. 333-71934.

(8) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Current Report on Form 8-K dated September 27, 2005, File No. 333-71934.

(9) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended December 31, 2005, File No. 333-71934.

(10) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended March 31, 2006, File No. 333-71934.

(11) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Annual Report on Form 10-K for the annual period ended June 30, 2006, File No. 333-71934.

(12) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended December 31, 2006, File No. 333-71934.

(13) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Annual Report on Form 10-K for the annual period ended June 30, 2007, File No. 333-71934.

(14) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended September 30, 2007, File No. 333-71934.

(15) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended December 31, 2007, File No. 333-71934.

(16) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Current Report on Form 8-K dated May 9, 2008, File No. 333-71934.

(17) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Current Report on Form 8-K dated May 16, 2008, File No. 333-71934.

(18) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended December 31, 2008, File No. 333-71934.

(19) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended March 31, 2009, File No. 333-71934.

(20) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Annual Report on Form 10-K for the annual period ended June 30, 2008, File No. 333-71934.

(21) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended September 30, 2008, File No. 333-71934.

(22) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Current Report on Form 8-K dated May 6, 2009, File No. 333-71934.

(23) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Current Report on Form 8-K dated August 21, 2009, File No. 333-71934.

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, D.C. 20549

FORM 10-K

(Mark One)

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the fiscal year ended June 30, 2008

OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from _____ to _____

Commission File Number: 333-71934

VANGUARD
HEALTH SYSTEMS

VANGUARD HEALTH SYSTEMS, INC.

(Exact name of registrant as specified in its charter)

Delaware	**62-1698183**
(State or other jurisdiction of incorporation or organization)	*(I.R.S. Employer Identification No.)*

20 Burton Hills Boulevard, Suite 100
Nashville, TN 37215
(Address and zip code of principal executive offices)

(615) 665-6000
(Registrant's telephone number, including area code)

Securities Registered Pursuant to Section 12(b) of the Act: None
Securities Registered Pursuant to Section 12(g) of the Act: None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. ☐Yes ☒No

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. ☒Yes ☐No

Indicate by check mark whether the registrant (1) has filed all reports required to be filed under Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports) and (2) has been subject to such filing requirements for the past 90 days. ☒Yes ☐No

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of the registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendments to this Form 10-K. ☒

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer or a smaller reporting company. See the definitions of "large accelerated filer", "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☐	Accelerated filer ☐
Non-accelerated filer ☒ (Do not check if a smaller reporting company)	Smaller reporting company ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). ☐Yes ☒No

There were 749,550 shares of registrant's common stock outstanding as of September 15, 2008 (all of which are privately owned and not traded on a public market).

Documents incorporated by reference: None

VANGUARD HEALTH SYSTEMS, INC.
ANNUAL REPORT ON FORM 10-K
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VANGUARD HEALTH SYSTEMS, INC.

CAUTIONARY STATEMENT REGARDING FORWARD-LOOKING STATEMENTS

This annual report on Form 10-K contains "forward-looking statements" within the meaning of the federal securities laws that are intended to be covered by safe harbors created thereby. Forward-looking statements are those statements that are based upon management's plans, objectives, goals, strategies, future events, future revenue or performance, capital expenditures, financing needs, plans or intentions relating to acquisitions, business trends and other information that is not historical information. These statements are based upon estimates and assumptions made by the Company's management that, although believed to be reasonable, are subject to numerous factors, risks and uncertainties that could cause actual outcomes and results to be materially different from those projected. When used in this annual report on Form 10-K, the words "estimates," "expects," "anticipates," "projects," "plans," "intends," "believes," "forecasts," "continues," or future or conditional verbs, such as "will," "should," "could" or "may," and variations of such words or similar expressions are intended to identify forward-looking statements.

These factors, risks and uncertainties include, among other things, statements relating to:

- Our high degree of leverage
- Our ability to incur substantially more debt
- Operating and financial restrictions in our debt agreements
- Our ability to successfully implement our business strategies
- Our ability to successfully integrate our recent and any future acquisitions
- The highly competitive nature of the healthcare industry
- Governmental regulation of the industry, including Medicare and Medicaid reimbursement levels
- Pressures to contain costs by managed care organizations and other insurers and our ability to negotiate acceptable terms with these third party payers
- Our ability to attract and retain qualified management and healthcare professionals, including physicians and nurses
- Potential federal or state reform of healthcare
- Future governmental investigations
- Potential management information systems failures and the significant costs of systems integrations
- The availability of capital to fund our corporate growth strategy
- Potential lawsuits or other claims asserted against us
- Our ability to maintain or increase patient membership and control costs of our managed healthcare plans
- Changes in general economic conditions including risks associated with investments we may hold from time to time
- Our exposure to the increased amounts of and collection risks associated with uninsured accounts and the co-pay and deductible portions of insured accounts
- Cost of professional and general liability insurance and increases in the quantity and severity of professional liability claims
- Our ability to maintain and increase patient volumes and control the costs of providing services, including salaries and benefits, supplies and bad debts
- Our failure to comply, or allegations of our failure to comply, with applicable laws and regulations
- The geographic concentration of our operations
- Technological and pharmaceutical improvements that increase the cost of providing, or reduce the demand for, healthcare services
- Potential substantial liabilities arising from unfavorable retrospective reviews by governmental or other payers of the medical necessity of medical procedures performed at our hospitals
- Lost future revenues from payer contract terminations resulting from their unfavorable retrospective reviews of the medical necessity of medical procedures performed at our hospitals

See "Item 1A – Risk Factors" for further discussion. We assume no obligation to update any forward-looking statements.

PART I

Item 1. Business.

Company Overview

We own and operate acute care hospitals and complementary outpatient facilities principally located in urban and suburban markets. We currently operate 15 acute care hospitals which, as of June 30, 2008, had a total of 4,181 beds in the following four locations:

- San Antonio, Texas
- metropolitan Phoenix, Arizona
- metropolitan Chicago, Illinois
- Massachusetts

Historically, we have concentrated our operations in markets with high population growth and median income in excess of the national average. Our objective is to provide high-quality, cost effective healthcare services through an integrated delivery platform serving the needs of the communities in which we operate. During the year ended June 30, 2008, we generated revenues from continuing operations of $2,790.7 million. During this period 83.9% of our total revenues were derived from acute care hospitals and complementary outpatient facilities.

Our general acute care hospitals offer a variety of medical and surgical services including emergency services, general surgery, internal medicine, cardiology, obstetrics, orthopedics and neurology. In addition, certain of our facilities provide on-campus and off-campus services including outpatient surgery, physical therapy, radiation therapy, diagnostic imaging and laboratory services. We also own three strategically important managed care health plans: a Medicaid managed health plan, Phoenix Health Plan, that served approximately 103,400 members as of June 30, 2008 in Arizona; Abrazo Advantage Health Plan, a managed Medicare and dual-eligible health plan that served approximately 3,200 members as of June 30, 2008 in Arizona; and MacNeal Health Providers a preferred provider network that served approximately 43,000 member lives in metropolitan Chicago as of June 30, 2008 under capitated contracts covering only outpatient and physician services.

We are a Delaware corporation formed in July 1997. Our principal executive offices are located at 20 Burton Hills Boulevard, Suite 100, Nashville, Tennessee, 37215 and our telephone number at that address is (615) 665-6000. Our corporate website address is www.vanguardhealth.com. Information contained on our website does not constitute part of this Annual Report on Form 10-K. The terms "we", "our", "the Company", "us", "registrant" and "Vanguard" as used in this report refer to Vanguard Health Systems, Inc. and its subsidiaries as a consolidated entity, except where it is clear from the context that such terms mean only Vanguard Health Systems, Inc. "Subsidiaries" means direct and indirect corporate subsidiaries of Vanguard Health Systems, Inc. and partnerships, joint ventures and limited liability companies in which such subsidiaries are partners or members.

The Merger

On July 23, 2004, Vanguard executed an agreement and plan of merger (the "Merger Agreement") with VHS Holdings LLC ("Holdings") and Health Systems Acquisition Corp., a newly formed Delaware corporation ("Acquisition Corp."), pursuant to which on September 23, 2004 Acquisition Corp. merged with and into Vanguard, with Vanguard being the surviving corporation (the "Merger"). In the Merger, holders of the outstanding Vanguard capital stock, options to acquire Vanguard common stock and other securities convertible into Vanguard common stock received aggregate consideration of approximately $1,248.6 million.

The Blackstone Group, together with its affiliates (collectively, "Blackstone"), funded the Merger in part by subscribing for and purchasing approximately $494.9 million aggregate amount of (1) Class A membership units in Holdings and (2) common stock of Acquisition Corp. (merged with and into Vanguard), in an amount equal to $125.0 million of such common stock. In addition, Morgan Stanley Capital Partners, together with its affiliates

(collectively, "MSCP"), subscribed for and purchased Class A membership units in Holdings by contributing to Holdings a number of shares of Vanguard common stock equal to (1) $130.0 million divided by (2) the per share consideration payable for each share of Vanguard common stock in connection with the Merger. Certain senior members of management and certain other stockholders of Vanguard (the "Rollover Management Investors") subscribed for and purchased Class A membership units in Holdings, having an aggregate purchase price of approximately $119.1 million, by (a) paying cash using the proceeds of consideration received in connection with the Merger and/or (b) contributing shares of Vanguard common stock in the same manner as MSCP. Baptist Health Services ("Baptist"), the former owner of our division, Baptist Health System of San Antonio, also purchased $5.0 million of Class A membership units in Holdings. Immediately after completion of the Merger in September 2004, Blackstone, MSCP (together with Baptist) and the Rollover Management Investors held approximately 66.1%, 18.0% and 15.9%, respectively, of the common equity of Vanguard (most of which is indirectly held through the ownership of the Class A membership units in Holdings). Certain members of senior management also purchased $5.7 million of the equity incentive units in Holdings.

Our Competitive Strengths

Concentrated Local Market Positions in Attractive Markets

We believe that our markets are attractive because of their favorable demographics, competitive landscape, payer mix and opportunities for expansion. Ten of our 15 hospitals are located in markets with population growth rates in excess of the national average and all of our acute care hospitals are located in markets in which the median household income is above the national average. For the fiscal year ended June 30, 2008, we derived approximately 65% of our total revenues from the high-growth markets of San Antonio and metropolitan Phoenix, in which we own five hospitals each. Our facilities in these markets primarily serve Bexar County, Texas, which encompasses most of the metropolitan San Antonio area and Maricopa County, Arizona, which encompasses most of the metropolitan Phoenix area. Our strong market positions provide us with opportunities to offer integrated services to patients, receive more favorable reimbursement terms from a broader range of third party payers and realize regional operating efficiencies. The U.S. Census Bureau projects that the number of individuals aged 65 and older will increase by an average of 3.0% each year during the years 2010 to 2020 so that those individuals aged 65 and older would represent approximately 18.6% of the total U.S. population by 2020. Our presence in high growth markets combined with the general aging of the United States population and expected longer life expectancies should result in higher demand for healthcare services and provide growth opportunities for us well into the future.

Strong Management Team with Significant Equity Investment

Our senior management has an average of more than 20 years of experience in the healthcare industry at various organizations, including OrNda Healthcorp, HCA Inc. and HealthTrust, Inc. Many of our senior managers have been with Vanguard since its founding in 1997, and 12 of our 18 members of senior management have worked together managing healthcare companies for up to 20 years, either continuously or from time to time. In connection with consummation of the Merger, the Rollover Management Investors purchased Class A membership units in Holdings having an aggregate purchase price of approximately $119.1 million which then represented approximately 15.9% of our equity interests.

Proven Ability to Complete and Integrate Acquisitions

Including our first acquisition in 1998, we have selectively acquired 18 hospitals, 12 of which were formerly not-for-profit hospitals. We have subsequently sold 3 of these hospitals and ceased acute care operations in another. We believe our success in completing acquisitions is due in large part to our disciplined approach to making acquisitions. Prior to completing an acquisition, we carefully review the operations of the target facility and develop a strategic plan to improve performance. We have routinely rejected acquisition candidates that did not meet our financial and operational criteria.

We believe our historical performance demonstrates our ability to identify underperforming facilities and improve the operations of acquired facilities. When we acquire a hospital, we generally implement a number of measures to lower costs, and we often make significant investments in the facility to expand existing services and introduce new services, strengthen the medical staff and improve our overall market position. We expect to continue

to grow revenues and profitability in the markets in which we operate by improving quality of care, increasing the depth and breadth of services provided and through the implementation of additional operational enhancements.

Our Business Strategy

The key elements of our business strategy include the following:

Continue our Commitment to Quality of Care

We have implemented and continue to implement various programs to improve the quality of care we provide. Our quality of care initiatives focus on engaging all of the stakeholders in the healthcare delivery process – the physicians, nurses, payers and most importantly the patients themselves. Establishing a commitment to quality of care that starts at the top and spreads down through the entire hospital organization is the first step in achieving a culture of quality. This culture fosters successful outcomes through continuous communication with physicians, discussing treatment plans with patients and reporting quality measurements with payers.

We have invested significant resources to develop clinical information systems to allow us to standardize compliance reporting of multiple quality indicators across our facilities, and we currently conduct a monthly review of 30 quality indicators set forth by CMS. We have developed training programs for our staff and share information among our hospital management teams to implement best practices and assist in complying with regulatory requirements. Corporate support is provided to each hospital to assist with accreditation reviews.

All hospitals conduct patient, physician and staff satisfaction surveys to help identify methods of improving the quality of care. We have appointed licensed physicians in each of our markets to the position of chief medical officer charged with driving best practices and clinical quality to improve the level of satisfaction among physicians and patients and promote cost-efficient provision of care. We have established rapid response teams and hourly nursing rounds in all of our hospitals to improve patient care. By the end of our fiscal year 2008, we had established Physician Advisory Councils at most of our hospitals to align the quality goals of our hospitals with the physicians who practice at our hospitals.

We believe quality of care has become an increasingly important factor in governmental and managed care reimbursement. We continuously review patient care evaluations and maintain other quality assurance programs to support and monitor quality of care standards and to meet and exceed Medicare and Medicaid accreditation and regulatory requirements. Many payers, including Medicare and several large managed care organizations, currently require providers to report certain quality measures in order to receive the full amount of payment increases that were awarded automatically in the past. For federal fiscal year 2009, Medicare expanded the number of quality measures to be reported to 42 from 30 during federal fiscal year 2008 and from 21 during federal fiscal year 2007. These measures include risk-adjusted outcomes measures such as 30-day mortality measures for patients who suffered a heart attack, heart failure or pneumonia; additional measures related to patients who undergo surgical procedures such as hospital-acquired infections data; and several patient satisfaction indicators. Many large managed care organizations have developed quality measurement criteria that are similar to or even more stringent than these Medicare requirements. We have invested and will continue to invest significant capital to upgrade our clinical information systems to enable us to report these quality measures.

We believe that pay for performance reimbursement will continue to evolve, and that the quality measures themselves will determine reimbursement as evidenced by CMS' new reforms effective October 1, 2008 that would take the first steps toward preventing Medicare from making additional payments to hospitals for treating patients that acquire one of eleven identified hospital-acquired conditions during a hospital stay. Our ability to meet our quality goals requires not only information systems to monitor compliance with quality indicators, but more importantly requires clinical programs and physician integration to improve quality.

Expand Services to Increase Revenues and Profitability

We will continue to invest in our facilities to expand the range and improve the quality of services provided based on our understanding of the needs of the communities we serve. Our local management teams work closely with patients, payers, physicians and other medical personnel to identify and prioritize the healthcare needs of individual communities. We intend to increase our revenues and profitability by expanding the range of services we offer at certain of our hospitals. We plan to:

- expand emergency room and operating room capacity;
- improve the convenience, quality and breadth of our outpatient services;
- upgrade and expand select specialty services, including cardiology, oncology, neurosurgery, orthopedics, and women's services;
- update our medical equipment technology, including diagnostic and imaging equipment and robotics; and
- continue evaluating the construction of new facilities in underserved areas of the community.

We believe that our disciplined expansion strategy will grow volumes, increase acuity mix, improve managed care pricing and enhance operating margins at our existing facilities, and at the same time reduce patient out-migration and satisfy unmet demand within our existing markets.

Improve Operating Margins and Efficiency

We seek to position ourselves as a cost effective provider of healthcare services in each of our markets. We intend to generate operational efficiencies and improve operating margins by:

- implementing more efficient care management, supply utilization and inventory management
- improving our billing and collection processes;
- capitalizing on purchasing efficiencies;
- targeting our capital expenditures on high demand service lines that will achieve higher returns; and
- implementing programs to reduce nurse turnover to minimize utilization of contract labor.

Recruit New Physicians and Maintain Strong Relationships with Existing Physicians

We recruit both primary care and specialty physicians who can provide services that we believe are currently underserved and in demand in the communities we serve. A core group of primary care physicians serves as the initial contact point for members of those communities. Having a quality group of specialty physicians available to provide such services as general surgery, cardiovascular services, orthopedics and obstetrics/gynecology, among others, enables members of the community to obtain necessary healthcare services locally without traveling to other communities. We increased the number of employed physicians at our hospitals by more than 50 during fiscal 2008, primarily through our physician recruiting initiatives. During fiscal 2009, we plan to further increase the number of primary care and specialty physicians who practice in our communities by more than 140 physicians through both employment and non-employment initiatives. We added significant corporate resources during fiscal 2008 in order to implement our physician recruiting strategies and to manage the practices of our employed physicians. We believe our hospitals provide an attractive setting for physicians to practice based on the following strategies and initiatives we have in place:

- continually seeking to improve quality of care and engaging physicians in these programs;
- providing physicians with access to efficiently designed facilities and modern technologies;
- providing a broad array of services within the integrated health network;
- offering quality training programs;
- obtaining physician support for the long-term vision of our hospitals;
- providing remote access to clinical information; and
- arranging for convenient medical office space adjacent to our facilities.

Continue to Develop Favorable Managed Care Relationships

We plan to increase the number of patients at our facilities and improve our profitability by negotiating more favorable terms with managed care plans. We believe that we are attractive to managed care plans because of the geographic and demographic coverage of our facilities in their respective markets, the quality and breadth of our services and the expertise of our physicians. Further, we believe that as we increase our presence and improve our competitive position in our markets, particularly as we develop our networks of hospitals, we will be even better positioned to negotiate more favorable managed care contracts.

Grow Through Selective Acquisitions

We will continue to pursue acquisitions and enter into partnerships or affiliations with other healthcare service providers that either expand our network and presence in our existing markets or allow us to enter new urban and suburban markets. We intend to selectively pursue acquisitions of networks of hospitals and other complementary facilities or single-well positioned facilities where we believe we can improve operating performance and profitability and increase market share. We maintain a disciplined approach whereby we ensure that potential acquisition targets fit within our corporate mission and long-term strategic goals while also providing benefit in the short-term. We believe that we will continue to have substantial acquisition opportunities as other healthcare providers choose to divest facilities and as independent hospitals, particularly not-for-profit hospitals, seek to capitalize on the benefits of becoming part of a larger hospital company.

The Markets We Serve

San Antonio, Texas

In the San Antonio market, as of June 30, 2008, we owned and operated 5 hospitals with a total of 1,741 licensed beds and related outpatient service locations complementary to the hospitals. We acquired these hospitals in January 2003 from the non-profit Baptist Health Services (formerly known as Baptist Health System) and continue to operate the hospitals as the Baptist Health System. The acquisition followed our strategy of acquiring a significant market share in a growing market, San Antonio, Texas. Our facilities primarily serve the residents of Bexar County which encompasses most of the metropolitan San Antonio area. According to estimates by the U.S. Census Bureau, the population in Bexar County grew by 11.7% from 2000 to 2006 and is expected to grow by another 13.9% by 2020. These growth rates are well above the national average.

During the years ended June 30, 2007 and 2008, we generated approximately 31.2% and 32.1% of our total revenues, respectively, in this market. In our acquisition agreement for the Baptist Health System we committed to fund not less than $200.0 million in capital expenditures in respect of the acquired businesses in the San Antonio metropolitan area during the first six years of our ownership, with $75.0 million of such expenditures being required in the first two years. By the end of our fiscal year ended June 30, 2005, we had funded or committed to fund all $200.0 million of this capital commitment.

Metropolitan Phoenix, Arizona

In the Phoenix market, as of June 30, 2008, we owned and operated 5 hospitals with a total of 996 licensed beds and related outpatient service locations complementary to the hospitals, a prepaid Medicaid managed health plan, Phoenix Health Plan ("PHP"), and a managed Medicare and dual-eligible health plan, Abrazo Advantage Health Plan ("AAHP"). Phoenix is the fifth largest city in the U.S. and has been one of the fastest growing major metropolitan areas in recent years. Our facilities primarily serve the residents of Maricopa County, which encompasses most of the metropolitan Phoenix area. According to estimates by the U.S. Census Bureau, the population in Maricopa County grew by 22.7% from 2000 to 2006 and is expected to grow by another 38.3% by 2020. These growth rates are also well above the national average.

During the years ended June 30, 2007 and 2008, exclusive of PHP and AAHP, we generated approximately 19.5% and 18.8% of our total revenues, respectively, in this market. Three of our hospitals in this market were formerly not-for-profit hospitals. We believe that payers will choose to contract with us in order to give their enrollees a comprehensive choice of providers in the western and northern Phoenix areas. Recently, we have

negotiated improvements in our payer rates at our Phoenix hospitals generally, and Arizona's state Medicaid program remains strong. We believe our network strategy will position us to continue to negotiate favorable rate increases with managed care payers and to build upon our network's comprehensive range of integrated services. In addition, our ownership of PHP and AAHP will allow us to enroll eligible patients, who would not otherwise be able to pay for healthcare services, into our health plan or into other state-approved plans.

Metropolitan Chicago, Illinois

In the Chicago metropolitan area, as of June 30, 2008, we owned and operated 2 hospitals with 784 licensed beds, and related outpatient service locations complementary to the hospitals. These hospitals, MacNeal Hospital and Weiss Hospital, are located in areas serving relatively well-insured populations. Weiss Hospital is operated by us in a consolidated joint venture corporation in which we own 80.1% and the University of Chicago Hospitals owns 19.9% of the equity interests. During the years ended June 30, 2007 and 2008, we generated approximately 15.6% and 14.9%, respectively, of our total revenues in this market.

We chose MacNeal and Weiss Hospitals, both former not-for-profit facilities, as our first two entries into the largely not-for-profit metropolitan Chicago area. Both MacNeal and Weiss Hospitals are large, well-equipped, university-affiliated hospitals with strong reputations and medical staffs. We believe we have captured a large share of the patients in MacNeal Hospital's immediate surrounding service area, which encompasses the cities of Berwyn and Cicero, Illinois. MacNeal offers tertiary services such as open heart surgery that patients would otherwise have to travel outside the local community to receive. We have also established a fully-integrated healthcare system at MacNeal and Weiss Hospitals by operating free-standing primary care and occupational medicine centers and a large commercial reference laboratory and by employing 68 physicians on our medical staffs there, including 30 primary care physicians. Our network of 17 primary care and occupational medicine centers allows us to draw patients to MacNeal and Weiss Hospital from around the metropolitan Chicago area. Both hospitals partner with various medical schools, the most significant being the University of Chicago Medical School and the University of Illinois Medical School, to provide medical training through residency programs in multiple specialties. In addition, MacNeal Hospital runs a successful free-standing program in family practice, one of the oldest such programs in the state of Illinois, and Weiss Hospital also runs a successful free-standing residency program in internal medicine. Our medical education programs help us to attract quality physicians to both the hospitals and our network of primary care and occupational medicine centers.

Massachusetts

In Massachusetts, as of June 30, 2008, we owned and operated 3 hospitals with a total of 660 licensed beds and related healthcare services complementary to the hospitals. These hospitals include Saint Vincent Hospital located in Worcester and MetroWest Medical Center, a two-campus hospital system comprised of Framingham Union Hospital in Framingham and Leonard Morse Hospital in Natick. These hospitals were acquired by us on December 31, 2004. We believe that opportunities for growth through increased market share exist in the Massachusetts area through the possible addition of new services, partnerships and the implementation of a strong primary care physician strategy. During the years ended June 30, 2007 and 2008, the Massachusetts facilities represented 19.8% and 19.7% of our total revenues, respectively.

Saint Vincent Hospital, located in Worcester, is a 321-bed teaching hospital with a strong residency program. Worcester is located in central Massachusetts and is the second largest city in Massachusetts. The service area is characterized by a patient base that is older, more affluent and well-insured. Saint Vincent Hospital is focused on strengthening its payer relationships, developing its primary care physician base and expanding its offerings in cardiology, orthopedics, radiology and minimally-invasive surgery capabilities.

MetroWest Medical Center's two campus system has a combined total of 339 licensed beds with locations in Framingham and Natick, in the suburbs west of Boston. These facilities serve communities that are generally well-insured. We are seeking to develop strong ambulatory care capabilities in these service areas, as well as expansion of oncology, radiology, women's services and cardiology services.

Our Facilities

We owned and operated 15 acute care hospitals as of June 30, 2008. The following table contains information concerning our hospitals:

Hospital	City	Licensed Beds	Date Acquired
Texas			
Baptist Medical Center	San Antonio	636	January 1, 2003
Northeast Baptist Hospital	San Antonio	367	January 1, 2003
North Central Baptist Hospital	San Antonio	268	January 1, 2003
Southeast Baptist Hospital	San Antonio	175	January 1, 2003
St. Luke's Baptist Hospital	San Antonio	295	January 1, 2003
Arizona			
Maryvale Hospital	Phoenix	232	June 1, 1998
Arrowhead Hospital	Glendale	220	June 1, 2000
Phoenix Baptist Hospital	Phoenix	236	June 1, 2000
Paradise Valley Hospital	Phoenix	151	November 1, 2001
West Valley Hospital (1)	Goodyear	157	September 4, 2003
Illinois			
MacNeal Hospital	Berwyn	427	February 1, 2000
Louis A. Weiss Memorial Hospital (2)	Chicago	357	June 1, 2002
Massachusetts			
MetroWest Medical Center – Leonard Morse Hospital	Natick	141	December 31, 2004
MetroWest Medical Center - Framingham Union Hospital	Framingham	198	December 31, 2004
Saint Vincent Hospital at Worcester Medical Center	Worcester	321	December 31, 2004
Total Licensed Beds		4,181	

(1) This hospital was constructed, not acquired.

(2) This hospital is operated by us in a consolidated joint venture corporation in which we own 80.1% of the equity interests and the University of Chicago Hospitals owns 19.9% of the equity interests.

In addition to the hospitals listed in the table above, as of June 30, 2008, we owned certain outpatient service locations complementary to our hospitals and two surgery centers in California. We also own and operate a limited number of medical office buildings in conjunction with our hospitals which are primarily occupied by physicians practicing at our hospitals.

Our Hospital Operations

Acute Care Services

Our hospitals typically provide the full range of services commonly available in acute care hospitals, such as internal medicine, general surgery, cardiology, oncology, neurosurgery, orthopedics, obstetrics, diagnostic and emergency services, as well as select tertiary services such as open-heart surgery and level II and III neonatal intensive care. Our hospitals also generally provide outpatient and ancillary healthcare services such as outpatient surgery, laboratory, radiology, respiratory therapy and physical therapy. We also provide outpatient services at our

imaging centers and ambulatory surgery centers. Certain of our hospitals have a limited number of psychiatric, skilled nursing and rehabilitation beds.

Management and Oversight

Our senior management team has extensive experience in operating multi-facility hospital networks and focuses on strategic planning for our facilities. A hospital's local management team is generally comprised of a chief executive officer, chief operating officer, chief financial officer and chief nursing officer. Local management teams, in consultation with our corporate staff, develop annual operating plans setting forth revenue growth strategies through the expansion of offered services and the recruitment of physicians in each community, as well as plans to improve operating efficiencies and reduce costs. We believe that the ability of each local management team to identify and meet the needs of our patients, medical staffs and the community as a whole is critical to the success of our hospitals. We base the compensation for each local management team in part on its ability to achieve the goals set forth in the annual operating plan, including both quality of care and financial measures.

Boards of trustees at each hospital, consisting of local community leaders, members of the medical staff and the hospital administrator, advise the local management teams. Members of each board of trustees are identified and recommended by our local management teams and serve three-year staggered terms. The boards of trustees establish policies concerning medical, professional and ethical practices, monitor these practices and ensure that they conform to our high standards. We have recently formed Physician Advisory Councils at each of our hospitals that focus on quality of care and other issues important to physicians and make recommendations to the boards of trustees as necessary. We maintain company-wide compliance and quality assurance programs and use patient care evaluations and other assessment methods to support and monitor quality of care standards and to meet accreditation and regulatory requirements.

We also provide support to the local management teams through our corporate resources including areas such as revenue cycle, business office, legal, managed care, case management, physician services and other administrative functions. These resources also allow for sharing best practices and standardization of policies and processes among all of our hospitals.

Attracting Patients

We believe that the most important factors affecting a patient's choice in hospitals are the reputation of the hospital's nursing staff for delivering quality care, the availability and expertise of physicians caring for patients at the facility and the location and convenience of the hospital. Other factors that affect utilization include local demographics and population growth, local economic conditions and the hospital's success in contracting with a wide range of local payers.

Operating Statistics

The following table sets forth certain operating statistics from continuing operations for the periods indicated. Acute care hospital operations are subject to fluctuations due to seasonal cycles of illness and weather, including increased patient utilization during the cold weather months and decreases during holiday periods.

	Year Ended June 30,				
	2004	2005	2006	2007	2008
Number of hospitals at end of period (a)	12	15	15	15	15
Number of licensed beds at end of period (b)	3,133	3,907	3,937	4,143	4,181
Discharges (c)	126,356	147,798	162,446	166,873	169,668
Adjusted discharges - hospitals (d)	186,464	231,322	261,056	264,698	270,076
Average length of stay (days) (e)	4.1	4.2	4.3	4.3	4.3
Average daily census (f)	1,420	1,708	1,921	1,978	2,008
Net patient revenue per adjusted hospital discharge (g)	$ 6,455	$ 6,859	$ 7,319	$ 7,766	$ 8,110
Total surgeries (h)	83,996	101,368	113,043	113,833	110,877
Member lives (i)	142,200	146,700	146,200	145,600	149,600

(a) The number of hospitals at the end of each period represents hospitals included in continuing operations.

(b) Licensed beds are those beds for which a facility has been granted approval to operate from the applicable state licensing agency.

(c) Represents the total number of patients discharged (in the facility for an overnight stay) from our hospitals and is used by management and certain investors as a general measure of inpatient volumes.

(d) Adjusted discharges-hospitals is used by management and certain investors as a general measure of combined inpatient and outpatient volumes and is computed by multiplying discharges by the sum of gross hospital inpatient and outpatient revenues and then dividing the result by gross hospital inpatient revenues. This computation enables management to assess hospital volumes by a combined measure of inpatient and outpatient volumes.

(e) Average length of stay represents the average number of days admitted patients stay in our hospitals.

(f) Average daily census represents the average number of patients in our hospitals each day during our ownership.

(g) Net revenue per adjusted hospital discharge is calculated by dividing hospital net patient revenues by hospital adjusted discharges and measures the average net payment expected to be received for a patient's hospital stay.

(h) Total surgeries represent the sum of inpatient surgeries and outpatient surgeries performed at our hospitals or ambulatory surgery centers.

(i) Member lives represents the total number of enrollees in our Arizona prepaid managed health plans and our Chicago capitated health plan as of the end of the respective period.

Outpatient Services

The healthcare industry has experienced a general shift during the past few years from inpatient services to outpatient services as Medicare, Medicaid and managed care payers have sought to reduce costs by shifting lower-acuity cases to an outpatient setting. Advances in medical equipment technology and pharmacology have supported the shift to outpatient utilization, which has resulted in an increase in the acuity of inpatient admissions. However, we expect inpatient admissions to recover over the long-term as the baby boomer population reaches ages where inpatient admissions become more prevalent. We have responded to the shift to outpatient services through our ambulatory surgery centers in Orange County, California, our interests in diagnostic imaging centers in San Antonio, Texas, our outpatient diagnostic imaging centers in metropolitan Phoenix, Arizona and our network of primary care and occupational medicine centers in metropolitan Chicago, Illinois, along with continued expansion of emergency and outpatient services at our acute hospitals. We continually upgrade our resources, including quality physicians and nursing staff and technologically advanced equipment, to support our comprehensive service offerings to capture inpatient volumes from the baby boomers and have focused on core services including cardiology, neurology, oncology, orthopedics and women's services. We also operate sub-acute units such as rehabilitation, skilled nursing facilities and psychiatric services, where appropriate, to meet the needs of our patients while increasing volumes and increasing care management efficiencies.

Our Health Plan Operations

Phoenix Health Plan

In addition to our hospital operations, we own three health plans. PHP is a prepaid Medicaid managed health plan that currently serves Maricopa, Pinal and Gila counties in the Phoenix, Arizona area. We acquired PHP in May 2001. We are able to enroll eligible patients in our hospitals into PHP or other local Medicaid managed health plans who otherwise would not be able to pay for their hospital expenses. We believe the volume of patients generated through our health plans will help attract quality physicians to the communities our hospitals serve.

For the year ended June 30, 2008, we derived approximately $353.3 million of our total revenues from PHP. PHP had approximately 103,400 enrollees as of June 30, 2008, and derives substantially all of its revenues through a contract with the Arizona Health Care Cost Containment System ("AHCCCS"), which is Arizona's state Medicaid program. The contract requires PHP to arrange for healthcare services for enrolled Medicaid patients in exchange for monthly capitation payments and supplemental payments from AHCCCS. PHP subcontracts with physicians, hospitals and other healthcare providers to provide services to its enrollees. These services are provided regardless of the actual costs incurred to provide these services. We receive reinsurance and other supplemental payments from AHCCCS to cover certain costs of healthcare services that exceed certain thresholds.

As part of its contract with AHCCCS, PHP is required to maintain a performance guarantee in the amount of $22.0 million. Vanguard maintains this performance guarantee on behalf of PHP in the form of surety bonds totaling $22.0 million with independent third party insurers that expire on October 1, 2008. We were also required to arrange for $2.9 million in letters of credit to collateralize our $22.0 million in surety bonds with the third party insurers. The amount of the performance guaranty that AHCCCS requires is based upon the membership in the health plan and the related capitation amounts paid to us. As a result of PHP's new AHCCCS contract which commences on October 1, 2008, as discussed below, we currently expect a significant increase in the amount of the performance guarantee during our fiscal year ending June 30, 2009.

Our current contract with AHCCCS commenced on October 1, 2003 and covers members in three Arizona counties: Gila, Maricopa and Pinal. In September 2007, AHCCCS executed its final one-year renewal option that effectively extended the contract through September 30, 2008. In May 2008, PHP was awarded a new contract with AHCCCS effective for the three-year period beginning October 1, 2008 and ending September 30, 2011. AHCCCS has the option to renew the new contract, in whole or in part, for two additional one-year periods commencing on October 1, 2011 and on October 1, 2012. The new contract will cover the existing three counties under the current contract plus an additional six Arizona counties: Apache, Coconino, Mohave, Navajo, Pima and Yavapai. We expect a significant increase in PHP membership under the new contract but are unable to determine the impact of the new contract on our future operations and cash flows at this time.

Abrazo Advantage Health Plan

Effective January 1, 2006, AAHP became a Medicare Advantage Prescription Drug Special Needs Plan provider under a contract with the Centers for Medicare & Medicaid Services ("CMS"). This allows AAHP to offer Medicare and Part D drug benefit coverage for Medicare members and dual-eligible members (those that are eligible for Medicare and Medicaid). PHP has historically served dual-eligible members through its AHCCCS contract. As of June 30, 2008, approximately 3,200 members were enrolled in AAHP, most of whom were previously enrolled in PHP. For the year ended June 30, 2008, we derived approximately $39.2 million of our total revenues from AAHP.

MacNeal Health Providers

The operations of MHP are somewhat integrated with our MacNeal Hospital in Berwyn, Illinois. For the year ended June 30, 2008, we derived approximately $57.7 million of our total revenues from MHP. MHP generates revenues from its contracts with health maintenance organizations from whom it took assignment of capitated member lives as well as third party administration services for other providers. As of June 30, 2008, MHP had contracts in effect covering approximately 43,000 capitated member lives. Such capitation is limited to physician services and outpatient ancillary services and does not cover inpatient hospital services. We try to utilize MacNeal Hospital and its medical staff as much as possible for the physician and outpatient ancillary services that are

required by such capitation arrangements. Revenues of MHP are dependent upon health maintenance organizations in the metropolitan Chicago area continuing to assign capitated-member lives to health plans like MHP as opposed to entering into direct fee-for-service arrangements with healthcare providers.

Competition

The hospital industry is highly competitive. We currently face competition from established, not-for-profit healthcare companies, investor-owned hospital companies, large tertiary care centers, specialty hospitals and outpatient service providers. In the future, we expect to encounter increased competition from companies, like ours, that consolidate hospitals and healthcare companies in specific geographic markets. Continued consolidation in the healthcare industry will be a leading factor contributing to increased competition in our current markets and markets we may enter in the future. Due to the shift to outpatient care and more stringent payer-imposed pre-authorization requirements during the past few years, most hospitals have significant unused capacity resulting in increased competition for patients. Many of our competitors are larger than us and have more financial resources available than we do. Other not-for-profit competitors have endowment and charitable contribution resources available to them and can purchase equipment and other assets on a tax-free basis.

One of the most important factors in the competitive position of a hospital is its location, including its geographic coverage and access to patients. A location convenient to a large population of potential patients or a wide geographic coverage area through hospital networks can make a hospital significantly more competitive. Another important factor is the scope and quality of services a hospital offers, whether at a single facility or a network of facilities, compared to the services offered by its competitors. A hospital or network of hospitals that offers a broad range of services and has a strong local market presence is more likely to obtain favorable managed care contracts. We intend to evaluate changing circumstances in the geographic areas in which we operate on an ongoing basis to ensure that we offer the services and have the access to patients necessary to compete in these managed care markets and, as appropriate, to form our own, or join with others to form, local hospital networks.

A hospital's competitive position also depends in large measure on the quality and scope of the practices of physicians associated with the hospital. Physicians refer patients to a hospital primarily on the basis of the quality and scope of services provided by the hospital, the quality of the medical staff and employees affiliated with the hospital, the hospital's location and the availability of modern equipment and facilities. Although physicians may terminate their affiliation with our hospitals, we seek to retain physicians of varied specialties on our medical staffs and to recruit other qualified physicians by maintaining and improving our level of care and providing quality facilities, equipment, employees and services for physicians and their patients.

Another major factor in the competitive position of a hospital is the ability of its management to obtain contracts with managed care plans and other group payers. The importance of obtaining managed care contracts has increased in recent years due primarily to consolidations of health plans and is expected to continue to increase as private and government payers and others increasingly turn to managed care organizations to help control rising healthcare costs. Our markets have experienced significant managed care penetration. The revenues and operating results of our hospitals are significantly affected by our hospitals' ability to negotiate favorable contracts with managed care plans. Health maintenance organizations and preferred provider organizations use managed care contracts to encourage patients to use certain hospitals in exchange for discounts from the hospitals' established charges. Traditional health insurers and large employers also are interested in containing costs through similar contracts with hospitals.

The hospital industry and our hospitals continue to have significant unused capacity. Inpatient utilization, average lengths of stay and average occupancy rates have historically been negatively affected by payer-required pre-admission authorization, utilization review and payer pressure to maximize outpatient and alternative healthcare delivery services for less acutely ill patients. Admissions constraints, payer pressures and increased competition are expected to continue. We endeavor to meet these challenges by expanding many of our facilities to include outpatient centers, offering discounts to private payer groups, upgrading facilities and equipment and offering new or expanded programs and services.

Employees and Medical Staff

As of June 30, 2008, we had approximately 18,500 employees, including approximately 2,000 part-time employees. Approximately 1,600 of our full-time employees at our three Massachusetts hospitals are unionized. Overall, we consider our employee relations to be good. While some of our non-unionized hospitals experience union organizing activity from time to time, we do not expect these efforts to materially affect our future operations. Our hospitals, like most hospitals, have experienced labor costs rising faster than the general inflation rate.

In the industry as a whole, and particularly in our Phoenix and San Antonio service areas, there is currently a shortage of nurses and other medical support personnel. Often these nursing shortages result in our using more contract labor resources to meet increased demand especially during the peak winter months. To address the nursing shortage, we have implemented comprehensive recruiting and retention plans for nurses. As part of this plan, we have expanded our nursing school in San Antonio to attract new students and to provide options for current nurses to advance their careers. We also increased our involvement with other colleges, participated in more job fairs and recruited nurses from abroad. Our recruiting and retention plan also focuses on mentoring, flexible work hours, performance leadership training, quality of care and patient safety and competitive pay and benefits. We anticipate that demand for nurses will continue to exceed supply especially as the baby boomer population reaches the ages where inpatient stays become more frequent. However, we expect our initiatives to help stabilize our nursing resources over time.

Our hospitals grant staff privileges to licensed physicians who may serve on the medical staffs of multiple hospitals, including hospitals not owned by us. A physician who is not an employee can terminate his or her affiliation with our hospital at any time. Although we employ a limited number of physicians, a physician does not have to be an employee of ours to be a member of the medical staff of one of our hospitals. Any licensed physician may apply to be admitted to the medical staff of any of our hospitals, but admission to the staff must be approved by each hospital's medical staff and board of trustees in accordance with established credentialing criteria.

Compliance Program

We voluntarily maintain a company-wide compliance program designed to ensure that we maintain high standards of ethics and conduct in the operation of our business and implement policies and procedures so that all our employees act in compliance with all applicable laws, regulations and company policies. The organizational structure of our compliance program includes oversight by our board of directors and a high-level corporate management compliance committee. The board of directors and compliance committee are responsible for ensuring that the compliance program meets its stated goals and remains up-to-date to address the current regulatory environment and other issues affecting the healthcare industry. Our Senior Vice President of Compliance and Ethics reports jointly to our Chairman and Chief Executive Officer and to our board of directors, serves as Chief Compliance Officer and is charged with direct responsibility for the day-to-day management of our compliance program. Other features of our compliance program include Regional Compliance Officers who report to our Chief Compliance Officer in all four of our operating regions, initial and periodic ethics and compliance training and effectiveness reviews, a toll-free hotline for employees to report, without fear of retaliation, any suspected legal or ethical violations, annual "fraud and abuse" audits to examine all of our payments to physicians and other referral sources and annual "coding audits" to make sure our hospitals bill the proper service codes for reimbursement from the Medicare program.

Our compliance program also oversees the implementation and monitoring of the standards set forth by the Health Insurance Portability and Accountability Act ("HIPAA") for privacy and security. To facilitate reporting of potential HIPAA compliance concerns by patients, family or employees, we established a second toll-free hotline dedicated to HIPAA and other privacy matters. Corporate HIPAA compliance staff monitors all reports to the privacy hotline and each phone call is responded to appropriately. Ongoing HIPAA compliance also includes self-monitoring of HIPAA policy and procedure implementation by each of our healthcare facilities and corporate compliance oversight.

Our Information Systems

We believe that our information systems must cost-effectively meet the needs of our hospital management, medical staff and nurses in the following areas of our business operations:

- patient accounting, including billing and collection of revenues;
- accounting, financial reporting and payroll;
- coding and compliance;
- laboratory, radiology and pharmacy systems;
- medical records and document storage;
- remote physician access to patient data;
- quality indicators;
- materials and asset management; and
- negotiating, pricing and administering our managed care contracts.

Although we map the financial information systems from each of our hospitals to one centralized database, we do not automatically standardize our financial information systems among all of our hospitals. We carefully review existing systems at the hospitals we acquire and, if a particular information system is unable to cost-effectively meet the operational needs of the hospital, we will convert or upgrade the information system at that hospital to one of several standardized information systems that can cost-effectively meet these needs.

Professional and General Liability Insurance

As is typical in the healthcare industry, we are subject to claims and legal actions by patients and others in the ordinary course of business. For claims incurred on or after June 1, 2002 through May 31, 2006, our wholly owned captive subsidiary insured our professional and general liability risks at a $10.0 million retention level. For professional and general liability claims incurred on or after June 1, 2006, we self-insure the first $9.0 million of each claim, and the captive subsidiary insures the next $1.0 million. We maintain excess coverage from independent third-party carriers for individual claims exceeding $10.0 million per occurrence up to $75.0 million, but limited to total annual payments of $65.0 million in the aggregate. The captive insurance subsidiary funds its portion of claims costs from proceeds of premium payments received from us.

The malpractice insurance environment remains volatile. Some states in which we operate, including Texas and Illinois, have passed in recent years tort reform legislation to place limits on non-economic damages. However, in November 2007 a judge in the Illinois Cook County Circuit Court declared that these Illinois malpractice limits were unconstitutional under state law. While such ruling is being considered in an appeal to the Illinois Supreme Court, we understand that the trial courts are not enforcing the non-economic damages limits under that Illinois tort reform statute. Additionally, in Texas an action has been brought to declare its tort reform legislation unconstitutional under federal law. Thus, while we have taken multiple steps at our facilities to reduce our professional liability exposures, absent significant legislation (not later declared unconstitutional) to curb the size of malpractice judgments in the states in which we operate, our insurance costs may increase in the future.

Sources of Revenues

Hospital revenues depend upon inpatient occupancy levels, the medical and ancillary services ordered by physicians and provided to patients, the volume of outpatient procedures and the charges or payment rates for such services. Charges and reimbursement rates for inpatient services vary significantly depending on the type of payer, the type of service (e.g., acute care, intensive care or subacute) and the geographic location of the hospital. Inpatient occupancy levels fluctuate for various reasons, many of which are beyond our control.

We receive payment for patient services from:

- the federal government, primarily under the Medicare program;
- state Medicaid programs; and
- health maintenance organizations, preferred provider organizations, managed Medicare providers, managed Medicaid providers, other private insurers and individual patients.

The table below presents the approximate percentage of net patient revenues we received from the following sources for the periods indicated:

	Year ended June 30,		
Payer Source	**2006**	**2007**	**2008**
Medicare	28%	26%	26%
Medicaid	7	9	8
Managed Medicare[1]	N/A	13	14
Managed Medicaid[1]	N/A	7	7
Other managed care plans[1]	52	32	35
Self-pay	9	10	9
Commercial	4	3	1
Total	100%	100%	100%

(1) For the year ended June 30, 2006, managed care revenues include revenues from managed Medicare, managed Medicaid and other governmental managed plans in addition to commercial managed care plans.

Medicare is a federal program that provides certain hospital and medical insurance benefits to persons age 65 and over, some disabled persons and persons with end-stage renal disease. Medicaid is a federal-state program, administered by the states, which provides hospital and medical benefits to qualifying individuals who are unable to afford health care. All of our general, acute care hospitals located in the United States are certified as health care services providers for persons covered under the Medicare and Medicaid programs. Amounts received under the Medicare and Medicaid programs are generally significantly less than established hospital gross charges for the services provided.

Our hospitals offer discounts from established charges to certain group purchasers of healthcare services, including private insurance companies, employers, health maintenance organizations, preferred provider organizations and other managed care plans. These discount programs limit our ability to increase net revenues in response to increasing costs. Patients generally are not responsible for any difference between established hospital charges and amounts reimbursed for such services under Medicare, Medicaid, some private insurance plans, health maintenance organizations or preferred provider organizations, but are generally responsible for exclusions, deductibles and coinsurance features of their coverages. Due to rising healthcare costs, many payers have increased the number of excluded services and the levels of deductibles and coinsurance resulting in a higher portion of the contracted rate due from the individual patients. Collecting amounts due from individual patients is typically more difficult than collecting from governmental or private managed care plans.

Medicare

Inpatient Acute Care

Under a prospective payment system, a hospital receives a fixed payment based on the patient's assigned diagnosis related group ("DRG") for acute care hospital inpatient services. The DRG classifies categories of illnesses according to the estimated intensity of hospital resources necessary to furnish care for each principal diagnosis. The DRG rates for acute care hospitals are based upon a statistically normal distribution of severity. When treatments for patients fall well outside the normal distribution, providers may receive additional payments known as outlier payments. The DRG payments do not consider a specific hospital's actual costs but are adjusted for geographic area wage differentials. Inpatient capital costs for acute care hospitals are reimbursed on a prospective system based on DRG weights multiplied by geographically adjusted federal weights.

Pursuant to regulation, the DRG rates are supposed to be adjusted each federal fiscal year for inflation, but such adjustment has often been affected by new federal legislation. The index used to adjust the DRG rates, known as the "market basket index," gives consideration to the inflation experienced by hospitals and entities outside of the healthcare industry in purchasing goods and services, but the percentage increases in the DRG rates have generally been lower than the actual projected increase in the cost of goods and services purchased by hospitals. Moreover,

often federal legislation has lowered or potentially lowered the annual percentage increase to the DRG rates below the annual amount indicated by the "market basket index" for the year. Thus, while federal legislation provided for DRG rate increases for federal fiscal years 2007, 2008 and 2009 at the full market basket, the increases were or will be paid only if the facility has submitted data for 21 patient care quality indicators to the Secretary of Health and Human Services in federal fiscal year 2007, 30 in federal fiscal year 2008 and 42 in federal fiscal year 2009. We currently have the ability to monitor our compliance with the quality indicators and have submitted or intend to submit the quality data required to receive the full market basket pricing updates during federal fiscal years 2007, 2008 and 2009. Those hospitals not submitting data on the quality indicators received or will receive an increase equal to the market basket rate minus 2% in federal fiscal years 2007, 2008 or 2009. Consistent with federal law, CMS issued final rules in August 2006, 2007 and 2008 that increased the hospital DRG payment rates by the full market basket of 3.40% for federal fiscal year 2007, the full market basket of 3.30% for federal fiscal year 2008 and the full market basket of 3.60% for federal fiscal year 2009 for those hospitals submitting data on the required quality indicators. While we will endeavor to comply with all data submission requirements as additional requirements continue to be added, our submissions may not be deemed timely or sufficient to entitle us to the full market basket adjustment for all of our hospitals.

In August 2006, CMS changed the methodology used to recalibrate the DRG weights from charge-based weights to cost relative weights under a three-year transition period beginning in federal fiscal year 2007. The adoption of the cost relative weights is not anticipated to have a material financial impact on us. On August 22, 2007, CMS published a final rule which adopts a two-year implementation of Medicare-Severity Diagnostic-Related Groups ("MS-DRGs"), a severity-adjusted DRG system. This change represents a refinement to the existing DRG system, and its impact on our revenues has not been significant. Additionally, CMS has imposed a documentation and coding adjustment to account for changes in payments under the new MS-DRG system that are not related to changes in case mix. Through legislative refinement, the documentation and coding adjustments for federal fiscal years 2008 and 2009 are reductions to the base payment rate of 0.6% and 0.9%, respectively. However, Congress has given CMS the ability to retrospectively determine if the documentation and coding adjustment levels for federal fiscal years 2008 and 2009 were adequate to account for changes in payments not related to changes in case mix. If the levels are found to have been inadequate, CMS can impose an adjustment to payments for federal fiscal years 2010, 2011 and 2012.

Beginning in federal fiscal year 2009, Medicare will not pay hospitals additional amounts for the treatment of certain preventable adverse events, also know as hospital-acquired conditions. The Deficit Reduction Act of 2005 required CMS to select at least two hospital-acquired conditions for which hospitals will not receive additional payment unless the conditions were present on admission to the hospital. In a final rule published on August 22, 2007, CMS selected eight such hospital-acquired conditions, three of which are classified as "serious preventable events" or "never events." Effective October 1, 2008, cases with any of these eight hospital-acquired conditions will not be paid at a higher DRG unless the condition was present at admission. The Act also provides that CMS may revise the list of conditions from time to time, and, thus, CMS sought comment in April 2008 on adding nine additional proposed conditions. In a final rule announced on July 31, 2008, CMS selected only three of the nine proposed additional hospital-acquired conditions to be added to the eight previously selected, bringing the total to 11 hospital-acquired conditions for which, effective October 1, 2008, it will not make additional payments to hospitals. Additionally, CMS has recently issued a report proposing a value-based purchasing system, which would phase out the current quality reporting system, making a portion of hospital payments contingent on actual performance against specified measures. It is uncertain whether such a program will be implemented.

Further realignments in the DRG system could also reduce the payments we receive for certain specialties, including cardiology and orthopedics. The greater proliferation of specialty hospitals in recent years has caused CMS to focus on payment levels for such specialties. Changes in the payments received for specialty services could have an adverse effect on our revenues.

In addition to DRG inpatient payments, in certain high-cost situations CMS makes additional payments to acute care hospitals, commonly referred to as "outlier payments", for those DRG cases where the cost of the case exceeds the total DRG payments plus a fixed threshold amount. Historically, the Medicare program has set aside 5.1% of Medicare inpatient payments to pay for outlier cases. During federal fiscal years 2001, 2002 and 2003, the CMS payments for outlier cases far exceeded the 5.1% set aside. As a result CMS increased the threshold amount from $16,350 at the end of federal fiscal year 2001 to as high as $33,560 for 2003. Additionally, on June 9, 2003,

CMS published a final rule substantially modifying the methodology for determining Medicare outlier payments in order to ensure that only the highest cost cases are entitled to receive additional payments under the inpatient prospective payment system. For discharges occurring on or after October 1, 2003, outlier payments are based on either a provider's most recent tentatively settled cost report or the most recent settled cost report, whichever is from the latest cost reporting period. Previously, outlier payments had been based on the most recent settled cost report, resulting in excessive outlier payments for some hospitals. The final rule requires, in most cases, the use of hospital-specific cost to charge ratios instead of a statewide ratio. Further, outlier payments may be adjusted retroactively to recoup any past outlier overpayments plus interest or to return any underpayments plus interest. We believe that these 2003 changes to the outlier payment methodology have not and will not have a material adverse effect on our business, financial position or results of operations. Indeed, we believe that as a result of these 2003 changes to the outlier payment methodology, CMS has generally reduced the outlier threshold amounts in each year after 2003. Thus, CMS decreased the threshold in federal fiscal year 2008 to $22,650 and decreased it in federal fiscal year 2009 to $20,185. Decreasing the outlier threshold amounts has and will increase both the number of our cases that qualify for outlier payments and the amount of payments for qualifying outlier cases, compared to the "peak" year of federal fiscal year 2003 when the threshold amount was $33,560. The most recent cost reports filed for each of our facilities as of June 30, 2006, 2007 and 2008 reflected outlier payments of $5.9 million, $5.8 million and $4.3 million for those respective cost report periods.

Outpatient

CMS reimburses hospital outpatient services and certain Medicare Part B services furnished to hospital inpatients who have no Part A coverage on a prospective payment system basis. CMS has continued to use existing fee schedules to pay for physical, occupational and speech therapies, durable medical equipment, clinical diagnostic laboratory services and nonimplantable orthotics and prosthetics. Freestanding surgery centers and independent diagnostic testing facilities are also reimbursed on a fee schedule.

All services paid under the prospective payment system for hospital outpatient services are classified into groups called ambulatory payment classifications ("APCs"). Services in each APC are similar clinically and in terms of the resources they require. A payment rate is established for each APC. Depending on the services provided, a hospital may be paid for more than one APC for a patient visit. The APC payment rates were updated for calendar years 2006 and 2007 by the full market baskets of 3.70% and 3.40%, respectively. However, as a result of the expiration of additional payments for drugs that were being paid in calendar year 2005, for calendar year 2006 there was an effective 2.25% reduction to the market basket of 3.70%, resulting in a net market basket of 1.45%. This reduction was not applied in calendar years 2007 and 2008. In November 2007, CMS published a final rule to update outpatient prospective payment system payments for calendar year 2008 by 3.30%, which is the full market basket. In this final rule, CMS outlined the requirements for hospitals to submit quality data relating to outpatient care in order to receive the full market basket increase under the outpatient prospective payment system beginning in calendar year 2009. CMS requires that data on seven quality measures be submitted according to a data submission schedule. Hospitals that fail to submit such data will receive the market basket update minus two percentage points for the outpatient prospective payment system. We intend to submit the necessary quality data to qualify to receive the full market basket update in 2009.

Disproportionate Share Payments

Hospitals that treat a disproportionately large number of low-income patients (Medicare and Medicaid patients eligible to receive supplemental Social Security income) currently receive additional payments from the federal government in the form of disproportionate share payments. CMS has recommended changes to the present formula used to calculate these payments. One recommended change would give greater weight to the amount of uncompensated care provided by a hospital than it would to the number of low-income patients treated. During fiscal year 2008 all of our hospitals qualified for disproportionate share payments. During the year ended June 30, 2008, we recognized revenues of approximately $59.4 million or 2.1% of total revenues from Medicare disproportionate share reimbursement.

Rehabilitation Units

CMS reimburses inpatient rehabilitation hospitals and designated units pursuant to a prospective payment system. Under this prospective payment system, patients are classified into case mix groups based upon impairment, age, comorbidities and functional capability. Inpatient rehabilitation facilities and units are paid a predetermined amount per discharge that reflects the patient's case mix group and is adjusted for area wage levels, low-income patients, rural areas and high-cost outliers. For federal fiscal year 2008, CMS originally updated the payment rate for inpatient rehabilitation facilities and units by the full market basket rate of 3.2%. However, subsequently, Congress passed the Medicare, Medicaid, and SCHIP Extension Act of 2007 which set the inflation update for inpatient rehabilitation facilities and units at zero percent for federal fiscal years 2008 and 2009, effective for discharges beginning on or after April 1, 2008. As of June 30, 2008, we operated three inpatient rehabilitation units within our acute care hospitals.

Skilled Nursing Units

Medicare has established a prospective payment system for Medicare skilled nursing units, under which the units are paid a federal per diem rate for virtually all covered services. The effect of the new payment system generally has been to significantly reduce reimbursement for skilled nursing services, which has led many hospitals to close such units. We will monitor closely and evaluate the few remaining skilled nursing units in our hospitals and related facilities to determine whether it is feasible to continue to offer such services under this reimbursement system. For federal fiscal years 2008 and 2009, CMS updated the payment rate for skilled nursing units by the full market basket of 3.3% and 3.4%, respectively. As of June 30, 2008, we operated two skilled nursing units within our acute care hospitals.

Psychiatric Units

On November 15, 2004 CMS published a final regulation to implement a new Medicare prospective payment system for inpatient psychiatric hospitals and units. The new system replaced a cost-based payment system with a per diem prospective payment system for reporting periods beginning on or after January 1, 2005. The new system is a per diem prospective payment system with adjustments to account for certain patient and facility characteristics. The final rule included several provisions to ease the transition to the new payment system. For example, CMS phased in the new system over a three-year period so that full payment under the new system did not begin until cost report periods beginning on or after January 1, 2008. Additionally, CMS has included in the final rule a stop-loss provision, an "outlier" policy authorizing additional payments for extraordinarily costly cases and an adjustment to the base payment if the facility maintains a full-service emergency department which all of our units qualified for. CMS increased payments to our units by 3.2% for each of the psychiatric rate years of July 1, 2007 to June 30, 2008 and July 1, 2008 to June 30, 2009.

At the current time we continue to believe that the new psychiatric payment system will not materially negatively impact our Medicare reimbursement in respect of our psychiatric units. As of June 30, 2008, we operated seven psychiatric units within our acute care hospitals.

Home Health

CMS reimburses home health agencies through a prospective payment system. Home health payment rates have been historically updated annually by either the full home health market basket, or by the home health market basket as adjusted by Congress. The increase in payment rates for calendar year 2008 was the full home health market basket increase of 3.0%. The 2008 increase, however, provides for an adjustment to the payment rates for the non-reporting of certain quality data. Home health agencies that submit the quality data as required will receive payments based on the full home health market basket update of 3.0% for calendar year 2008. If a home health agency does not submit the required quality data, the home health market basket percentage increase will be reduced by 2.0% and the home health agency will only receive a 1.0% update during calendar year 2008. We currently submit, and plan to continue to submit, the necessary quality data to receive the full market basket update. As of June 30, 2008, we operated two entities providing home health services.

Contractor Reform

CMS has a significant initiative underway that could affect the administration of the Medicare program and impact how hospitals bill and receive payment for covered Medicare services. In accordance with the Medicare Modernization Act, CMS has begun implementation of contractor reform whereby CMS will competitively bid the Medicare fiscal intermediary and Medicare carrier functions to 15 Medicare Administrative Contractors ("MACs"). Hospital management companies like Vanguard will have the option to work with the selected MAC in the jurisdiction where a given hospital is located or to use the MAC in the jurisdiction where our home office is located. For hospital management companies, either all hospitals in the system must choose to stay with the MAC chosen for their locality or all hospitals must opt to use the home office MAC. We have filed a request for our single home office MAC to serve all of our hospitals. CMS awarded one MAC contract in 2006, and from August 2007 to June 2008 CMS awarded seven MAC contracts.

The remaining seven MAC contracts are expected to be awarded in the second half of calendar 2008 with all implementations occurring by July 2009. All of these changes could impact claims processing functions and the resulting cash flow; however, we are unable to predict the impact that these changes could have, if any, to our cash flows.

Wage Index

Under Medicare's prospective payment system, the payment rates are adjusted for the area differences in wage levels by a factor ("wage index") reflecting the relative wage level in the geographic area compared to the national average wage level. In federal fiscal years 2007 and 2008, CMS adjusted 100% of the wage index factor for occupational mix. The redistributive impact of wage index changes was not materially adverse to our results of operations in our fiscal year ended June 30, 2008.

Recovery Audit Contractors

In 2005, CMS began using recovery audit contractors ("RACs") to detect Medicare overpayments not identified through existing claims review mechanisms. The RAC program relies on private auditing firms to examine Medicare claims filed by healthcare providers. Fees to the RACs are paid on a contingency basis. The RAC program began as a demonstration project in 2005 in three states (New York, California and Florida) which was expanded into the three additional states of Arizona, Massachusetts and South Carolina in July 2007. No RAC audits, however, were initiated at our Arizona or Massachusetts hospitals during the demonstration project. The program was made permanent by the Tax Relief and Health Care Act of 2006 enacted in December 2006. CMS announced in March 2008 the end of the demonstration project and the commencement of the permanent program by the expansion of the RAC program to additional states beginning in the summer and fall 2008 and its plans to have RACs in place in all 50 states by 2010. Also, in March 2008 CMS initiated a process for selecting the four permanent RACs for the permanent program which are expected to be selected by CMS by September or October 2008.

In a report issued in July 2008 CMS reported that the RACs corrected over $1 billion of Medicare improper payments from 2005 through March 2008. Roughly 96% of the improper payments ($992.7 million) were overpayments collected from providers, while the remaining 4% ($37.8 million) were underpayments repaid to providers. Of the overpayments, 85% were collected from inpatient hospital providers, and the other principal collections were 6% from inpatient rehabilitation facilities, and 4% from outpatient hospital providers.

RACs perform post-discharge audits of medical records to identify Medicare overpayments resulting from incorrect payment amounts, non-covered services, incorrectly coded services, and duplicate services. CMS has given RACs the authority to look back at claims up to three years old, provided that the claim was paid on or after October 1, 2007. Claims identified as overpayments will be subject to the Medicare appeals process.

RACs are paid a contingency fee based on the overpayments they identify and collect. Therefore, we expect that the RACs will look very closely at claims submitted by our facilities in an attempt to identify possible overpayments. Although we believe the claims for reimbursement submitted to the Medicare program by our facilities have been accurate, we cannot predict whether, once our facilities are subject to RAC audits in the future,

what the result of such audits might be, but it is reasonably possible that the aggregate payments that our facilities are required to return to the Medicare program pursuant to these RAC audits may have a material adverse effect on our business, financial position, results of operations or cash flows.

Managed Medicare

Managed Medicare plans relate to situations where a private company contracts with CMS to provide members with Medicare benefits. Managed Medicare plans can be structured as health maintenance organizations, preferred provider organizations or private fee-for-service plans. The Medicare Modernization Act increased reimbursement to managed Medicare plans and included provisions limiting, to some extent, the financial risk to the companies offering the plans. Following these changes, the number of beneficiaries choosing to receive their Medicare benefits through such plans has increased significantly.

Medicaid

Medicaid programs are funded jointly by the federal government and the states and are administered by states under approved plans. Most state Medicaid program payments are made under a prospective payment system or are based on negotiated payment levels with individual hospitals. Medicaid reimbursement is less than Medicare reimbursement for the same services and is often less than a hospital's cost of services. The federal government and many states have recently adopted or are currently considering reducing the level of Medicaid funding (including upper payment limits) or program eligibility that could adversely affect future levels of Medicaid reimbursement received by our hospitals. As permitted by law, certain states in which we operate have adopted broad-based provider taxes to fund their Medicaid programs. Since states must operate with balanced budgets and since the Medicaid program is often the state's largest program, states can be expected to adopt or consider adopting legislation designed to reduce their Medicaid expenditures.

As to recent federal action, the Deficit Reduction Act of 2005 included Medicaid cuts in federal funding of approximately $4.8 billion over five years. Additionally, on May 29, 2007, CMS published a final rule entitled "Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership" which is estimated to reduce federal Medicaid funding from $12 to $20 billion over five years. Congress has enacted two moratoria in respect of this rule. First, Congress delayed its implementation totally until May 2008. Secondly, in June 2008 Congress delayed six of seven proposed Medicaid regulations in this final CMS rule until April 1, 2009, with only the seventh regulation concerning certain outpatient services and imposing severe restrictions on states covering children with family income levels beyond 250% of the federal poverty level under the Children's Health Insurance Program not being delayed by this second moratorium. As a result of the moratorium on implementing the final rule, the impact on us of the final rule has not been quantified.

Certain states in which we operate provide disproportionate share payments to hospitals that treat a disproportionately large number of low-income patients as part of their state Medicaid programs, similar to disproportionate share payments received from Medicare. During the year ended June 30, 2008, we recognized revenues of approximately $20.2 million or 0.7% of total revenues related to Medicaid disproportionate share reimbursement. These states continually assess the level of expenditures for disproportionate share reimbursement and may reduce these payments or restructure this portion of their Medicaid programs.

The states have also adopted, or are considering, legislation designed to reduce coverage and program eligibility, enroll Medicaid recipients in managed care programs and/or impose additional taxes on hospitals to help finance or expand the states' Medicaid systems.

Future federal or state legislation or other changes in the administration or interpretation of government health programs by the federal government or by the states in which we operate could have a material, adverse effect on our financial position and results of operations.

Managed Medicaid

Managed Medicaid programs relate to situations where states contract with one or more entities for patient enrollment, care management and claims adjudication. The states usually do not give up program responsibilities for financing, eligibility criteria and core benefit plan design. We generally contract directly with one of the designated entities, usually a managed care organization. The provisions of these programs are state-specific.

Annual Cost Reports

All hospitals participating in the Medicare and Medicaid programs are required to meet specific financial reporting requirements. Federal and, where applicable, state regulations require submission of annual cost reports identifying medical costs and expenses associated with the services provided by each hospital to Medicare beneficiaries and Medicaid recipients. Moreover, annual cost reports required under the Medicare and Medicaid programs are subject to routine audits, which may result in adjustments to the amounts ultimately determined to be due to us under these reimbursement programs. The audit process takes several years to reach the final determination of allowable amounts under the programs. Providers also have the right of appeal, and it is common to contest issues raised in audits of prior years' reports.

Many prior year cost reports of our facilities are still open. If any of our facilities are found to have been in violation of federal or state laws relating to preparing and filing of Medicare or Medicaid cost reports, whether prior to or after our ownership of these facilities, we and our facilities could be subject to substantial monetary fines, civil and criminal penalties and exclusion from participation in the Medicare and Medicaid programs. If an allegation is lodged against one of our facilities for a violation occurring during the time period before we acquired the facility, we may have indemnification rights against the seller of the facility to us. In each of our acquisitions, we have negotiated customary indemnification and hold harmless provisions for any damages we may incur in these areas.

Managed Care and Other Private Insurers

Managed care providers, including health maintenance organizations, preferred provider organizations, other private insurance companies and employers, are organizations that provide insurance coverage and a network of healthcare providers to members for a fixed monthly premium. To attract additional volume, most of our hospitals offer discounts from established charges or prospective payment systems to these large group purchasers of healthcare services. These discount programs often limit our ability to increase charges in response to increasing costs. However, as part of our business strategy, we have been able to renegotiate payment rates on many of our managed care contracts to improve our operating margin. While we generally received annual average payment rate increases of 5 to 16 percent from non-governmental managed care payers during fiscal year 2008, there can be no assurance that we will continue to receive increases in the future and that patient volumes from these payers will not be adversely affected by rate negotiations. While the majority of our admissions and revenues are generated from patients covered by managed care plans, the percentage may decrease in the future due to increased Medicare utilization associated with the aging U.S. population. We experienced a slight increase in managed care utilization of inpatient days as a percentage of total inpatient days during the year ended June 30, 2008 compared to the year ended June 30, 2007.

Self-Pay Patients

Self-pay patients are patients who do not qualify for government programs payments, such as Medicare and Medicaid, and who do not have some form of private insurance, and are, therefore, responsible for their own medical bills. We also include in our self-pay accounts those unpaid coinsurance and deductible amounts for which payment has been received from the primary payer. A significant portion of our self-pay patients are admitted through our hospitals' emergency departments and often require high-acuity treatment. High-acuity treatment is more costly to provide and, therefore, results in higher billings, which are the least collectible of all accounts. We believe self-pay patient volumes and revenues have been impacted during the last two years due to a combination of broad economic factors, including reductions in state Medicaid budgets, increasing numbers of individuals and employers who choose not to purchase insurance and an increased burden of coinsurance and deductibles to be made by patients instead of insurers.

Self-pay accounts pose significant collectibility problems. At June 30, 2008, approximately 23.5% of our accounts receivable, prior to the allowance for doubtful accounts, contractual allowances and the charity care allowance, was comprised of self-pay accounts. The majority of our provision for doubtful accounts relates to self-pay patients. While our allowance for doubtful accounts and charity care allowance cover over 95% of our collecibility risks associated with self-pay receivables, we remain vulnerable to further increased self-pay utilization. We are taking multiple actions in an effort to mitigate the effect on us of the high number of uninsured patients and the related economic impact. These initiatives include conducting detailed reviews of intake procedures in hospitals facing the greatest pressures and enhancing and updating intake best practices for all of our hospitals. We developed hospital-specific reports detailing collection rates by type of patient to help the hospital management teams better identify areas of vulnerability and opportunities for improvement. Also, we completely redesigned our self-pay collection workflows, enhanced technology and improved staff training in an effort to increase collections.

We do not pursue collection of amounts due from uninsured patients that qualify for charity care under our guidelines (currently those uninsured patients whose incomes are equal to or less than 200% of the current federal poverty guidelines set forth by the Department of Health and Human Services). We exclude charity care accounts from revenues when we determine that the account meets our charity care guidelines. We provide expanded discounts from billed charges and alternative payment structures for uninsured patients who do not qualify for charity care but meet certain other minimum income guidelines, primarily those uninsured patients with incomes between 200% and 500% of the federal poverty guidelines. During the fiscal years ended June 30, 2006, 2007 and 2008, we deducted $71.1 million, $86.1 million and $86.1 million of charity care from gross charges, respectively.

Government Regulation and Other Factors

Overview

All participants in the healthcare industry are required to comply with extensive government regulation at the federal, state and local levels. In addition, these laws, rules and regulations are extremely complex and the healthcare industry has had the benefit of little or no regulatory or judicial interpretation of many of them. Although we believe we are in compliance in all material respects with such laws, rules and regulations, if a determination is made that we were in material violation of such laws, rules or regulations, our business, financial condition or results of operations could be materially adversely affected. If we fail to comply with applicable laws and regulations, we can be subject to criminal penalties and civil sanctions, our hospitals can lose their licenses and their ability to participate in the Medicare and Medicaid programs.

Licensing, Certification and Accreditation

Healthcare facility construction and operation is subject to federal, state and local regulations relating to the adequacy of medical care, equipment, personnel, operating policies and procedures, fire prevention, rate-setting and compliance with building codes and environmental protection laws. Our facilities also are subject to periodic inspection by governmental and other authorities to assure continued compliance with the various standards necessary for licensing and accreditation. We believe that all of our operating healthcare facilities are properly licensed under appropriate state healthcare laws.

All of our operating hospitals are certified under the Medicare program and are accredited by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"), the effect of which is to permit the facilities to participate in the Medicare and Medicaid programs. If any facility loses its accreditation by JCAHO, or otherwise loses its certification under the Medicare program, then the facility will be unable to receive reimbursement from the Medicare and Medicaid programs. We intend to conduct our operations in compliance with current applicable federal, state, local and independent review body regulations and standards. The requirements for licensure, certification and accreditation are subject to change and, in order to remain qualified, we may need to make changes in our facilities, equipment, personnel and services.

Certificates of Need

In some states, the construction of new facilities, acquisition of existing facilities or addition of new beds or services may be subject to review by state regulatory agencies under a Certificate of Need program. Illinois and

Massachusetts are the only states in which we currently operate that require approval under a Certificate of Need program. These laws generally require appropriate state agency determination of public need and approval prior to the addition of beds or services or other capital expenditures. Failure to obtain necessary state approval can result in the inability to expand facilities, add services, acquire a facility or change ownership. Further, violation of such laws may result in the imposition of civil sanctions or the revocation of a facility's license.

Utilization Review

Federal law contains numerous provisions designed to ensure that services rendered by hospitals to Medicare and Medicaid patients meet professionally recognized standards and are medically necessary and that claims for reimbursement are properly filed. These provisions include a requirement that a sampling of admissions of Medicare and Medicaid patients be reviewed by quality improvement organizations that analyze the appropriateness of Medicare and Medicaid patient admissions and discharges, quality of care provided, validity of diagnosis related group classifications and appropriateness of cases of extraordinary length of stay or cost. Quality improvement organizations may deny payment for services provided, assess fines and recommend to the Department of Health and Human Services that a provider not in substantial compliance with the standards of the quality improvement organization be excluded from participation in the Medicare program. Most non-governmental managed care organizations also require utilization review.

Federal Healthcare Program Statutes and Regulations

Participation in any federal healthcare program, such as the Medicare and Medicaid programs, is regulated heavily by statute and regulation. If a hospital provider fails to substantially comply with the numerous conditions of participation in the Medicare or Medicaid program or performs specific prohibited acts, the hospital's participation in the Medicare program may be terminated or civil or criminal penalties may be imposed upon it under provisions of the Social Security Act and other statutes.

Anti-Kickback Statute

A section of the Social Security Act known as the federal Anti-Kickback Statute prohibits providers and others from soliciting, receiving, offering or paying, directly or indirectly, any remuneration with the intent of generating referrals or orders for services or items covered by a federal healthcare program. Violation of this statute is a felony, including criminal penalties of imprisonment or criminal fines up to $25,000 for each violation, but it also includes civil money penalties of up to $50,000 per violation, damages up to three times the total amount of the improper payment to the referral source and exclusion from participation in Medicare, Medicaid or other federal healthcare programs.

The Office of the Inspector General of the Department of Health and Human Services (the "OIG") has published final safe harbor regulations that outline categories of activities that are deemed protected from prosecution under the Anti-Kickback Statute. Currently there are safe harbors for various activities, including the following: investment interests, space rental, equipment rental, practitioner recruitment, personal services and management contracts, sale of practice, referral services, warranties, discounts, employees, group purchasing organizations, waiver of beneficiary coinsurance and deductible amounts, managed care arrangements, obstetrical malpractice insurance subsidies, investments in group practices, ambulatory surgery centers and referral agreements for specialty services.

The fact that conduct or a business arrangement does not fall within a safe harbor does not automatically render the conduct or business arrangement illegal under the Anti-Kickback Statute. The conduct or business arrangement, however, does increase the risk of scrutiny by government enforcement authorities. We may be less willing than some of our competitors to take actions or enter into business arrangements that do not clearly satisfy the safe harbors. As a result, this unwillingness may put us at a competitive disadvantage.

The OIG, among other regulatory agencies, is responsible for identifying and eliminating fraud, abuse and waste. The OIG carries out this mission through a nationwide program of audits, investigations and inspections. In order to provide guidance to healthcare providers, the OIG has from time to time issued "fraud alerts" that, although they do not have the force of law, identify features of a transaction that may indicate that the transaction could

violate the Anti-Kickback Statute or other federal healthcare laws. The OIG has identified several incentive arrangements as potential violations, including:

- payment of any incentive by the hospital when a physician refers a patient to the hospital;
- use of free or significantly discounted office space or equipment for physicians in facilities usually located close to the hospital;
- provision of free or significantly discounted billing, nursing or other staff services;
- free training for a physician's office staff, including management and laboratory techniques;
- guarantees that provide that, if the physician's income fails to reach a predetermined level, the hospital will pay any portion of the remainder;
- low-interest or interest-free loans, or loans which may be forgiven if a physician refers patients to the hospital;
- payment of the costs of a physician's travel and expenses for conferences or a physician's continuing education courses;
- coverage on the hospital's group health insurance plans at an inappropriately low cost to the physician;
- rental of space in physician offices, at other than fair market value terms, by persons or entities to which physicians refer;
- payment of services which require few, if any, substantive duties by the physician, or payment for services in excess of the fair market value of the services rendered; or
- "gain sharing," the practice of giving physicians a share of any reduction in a hospital's costs for patient care attributable in part to the physician's efforts.

Also, the OIG has encouraged persons having information about hospitals who offer the above types of incentives to physicians to report such information to the OIG.

The OIG also issues "Special Advisory Bulletins" as a means of providing guidance to healthcare providers. These bulletins, along with other "fraud alerts", have focused on certain arrangements between physicians and providers that could be subject to heightened scrutiny by government enforcement authorities, including, "suspect" joint ventures where physicians may become investors with the provider in a newly formed joint venture entity where the investors refer their patients to this new entity, and are paid by the entity in the form of "profit distributions." These subject joint ventures may be intended not so much to raise investment capital legitimately to start a business, but to lock up a stream of referrals from the physician investors and to compensate them indirectly for these referrals. Because physician investors can benefit financially from their referrals, unnecessary procedures and tests may be ordered or performed, resulting in unnecessary Medicare expenditures.

Similarly, in a Special Advisory Bulletin issued in April 2003, the OIG focused on "questionable" contractual arrangements where a healthcare provider in one line of business (the "Owner") expands into a related healthcare business by contracting with an existing provider of a related item or service (the "Manager/Supplier") to provide the new item or service to the Owner's existing patient population, including federal healthcare program patients (so called "suspect Contractual Joint Ventures"). The Manager/Supplier not only manages the new line of business, but may also supply it with inventory, employees, space, billing, and other services. In other words, the Owner contracts out substantially the entire operation of the related line of business to the Manager/Supplier – otherwise a potential competitor – receiving in return the profits of the business as remuneration for its federal program referrals. The Bulletin lists the following features of these "questionable" contractual relationships. First, the Owner expands into a related line of business, which is dependent on referrals from, or other business generated by, the Owner's existing business. Second, the Owner neither operates the new business itself nor commits

substantial financial, capital or human resources to the venture. Instead, it contracts out substantially all the operations of the new business. The Manager/Supplier typically agrees to provide not only management services, but also a range of other services, such as the inventory necessary to run the business, office and healthcare personnel, billing support, and space. Third, the Manager/Supplier is an established provider of the same services as the Owner's new line of business. In other words, absent the contractual arrangement, the Manager/Supplier would be a competitor of the new line of business, providing items and services in its own right, billing insurers and patients in its own name, and collecting reimbursement. Fourth, the Owner and the Manager/Supplier share in the economic benefit of the Owner's new business. The Manager/Supplier takes its share in the form of payments under the various contracts with the Owner; the Owner receives its share in the form of the residual profit from the new business. Fifth, aggregate payments to the Manager/Supplier typically vary with the value or volume of business generated for the new business by the Owner. We monitor carefully our contracts with other healthcare providers and attempt to not allow our facilities to enter into these suspect Contractual Joint Ventures.

In addition to issuing fraud alerts and Special Advisory Bulletins, the OIG from time to time issues compliance program guidance for certain types of healthcare providers. In January 2005, the OIG published a Supplemental Compliance Guidance for Hospitals, supplementing its 1998 guidance for the hospital industry. In the supplemental guidance, the OIG identifies a number of risk areas under federal fraud and abuse statutes and regulations. These areas of risk include compensation arrangements with physicians, recruitment arrangements with physicians and joint venture relationships with physicians.

We have a variety of financial relationships with physicians who refer patients to our hospitals. As of June 30, 2008, physicians owned interests in two of our free-standing surgery centers in California and seven of our diagnostic imaging centers in Texas. We may sell ownership interests in certain other of our facilities to physicians and other qualified investors in the future. We also have contracts with physicians providing for a variety of financial arrangements, including employment contracts, leases and professional service agreements. We have provided financial incentives to recruit physicians to relocate to communities served by our hospitals, including income and collection guarantees and reimbursement of relocation costs, and will continue to provide recruitment packages in the future. Although we have established policies and procedures to ensure that our arrangements with physicians comply with current law and available interpretations, we cannot assure you that regulatory authorities that enforce these laws will not determine that some of these arrangements violate the Anti-Kickback Statute or other applicable laws. An adverse determination could subject us to liabilities under the Social Security Act, including criminal penalties, civil monetary penalties and exclusion from participation in Medicare, Medicaid or other federal healthcare programs, any of which could have a material adverse effect in our business, financial condition or results of operations.

Other Fraud and Abuse Provisions

The Social Security Act also imposes criminal and civil penalties for submitting false claims to Medicare and Medicaid. False claims include, but are not limited to, billing for services not rendered, misrepresenting actual services rendered in order to obtain higher reimbursement and cost report fraud. Like the Anti-Kickback Statute, these provisions are very broad. Further, the Social Security Act contains civil penalties for conduct including improper coding and billing for unnecessary goods and services. Careful and accurate preparation and submission of claims for reimbursement must be performed in order to avoid liability.

The Health Insurance Portability and Accountability Act of 1996 broadened the scope of the fraud and abuse laws by adding several criminal provisions for healthcare fraud offenses that apply to all health benefit programs. This act also created new enforcement mechanisms to combat fraud and abuse, including the Medicaid Integrity Program and an incentive program under which individuals can receive up to $1,000 for providing information on Medicare fraud and abuse that leads to the recovery of at least $100 of Medicare funds. In addition, federal enforcement officials now have the ability to exclude from Medicare and Medicaid any investors, officers and managing employees associated with business entities that have committed healthcare fraud. Additionally, this Act establishes a violation for the payment of inducements to Medicare or Medicaid beneficiaries in order to influence those beneficiaries to order or receive services from a particular provider or practitioner.

Some of these provisions, including the federal Civil Monetary Penalty Law, require a lower burden of proof than other fraud and abuse laws, including the Anti-kickback Statute. Civil monetary penalties that may be

imposed under the federal Civil Monetary Penalty Law range from $10,000 to $50,000 per act, and in some cases may result in penalties of up to three times the remuneration offered, paid, solicited or received. In addition, a violator may be subject to exclusion from federal and state healthcare programs. Federal and state governments increasingly use the federal Civil Monetary Penalty Law, especially where they believe they cannot meet the higher burden of proof requirements under the Anti-kickback Statute.

The Stark Law

The Social Security Act also includes a provision commonly known as the "Stark Law." This law prohibits physicians from referring Medicare and (to an extent) Medicaid patients to entities with which they or any of their immediate family members have a financial relationship for the provision of certain designated health services that are reimbursable by Medicare or Medicaid, including inpatient and outpatient hospital services. The law also prohibits the entity from billing the Medicare program for any items or services that stem from a prohibited referral. Sanctions for violating the Stark Law include denial of payment, refunding amounts received for services provided pursuant to prohibited referrals, civil money penalties up to $15,000 per item or service improperly billed and exclusion from the federal healthcare programs. The statute also provides for a penalty of up to $100,000 for a circumvention scheme. There are a number of exceptions to the self-referral prohibition, including an exception for a physician's ownership interest in an entire hospital as opposed to an ownership interest in a hospital department. There are also exceptions for many of the customary financial arrangements between physicians and providers, including employment contracts, leases, professional services agreements, non-cash gifts having an annual value of no more than $338 in calendar 2008 and recruitment agreements. Unlike safe harbors under the Anti-kickback Statute with which compliance is voluntary, an arrangement must comply with every requirement of a Stark Law exception or the arrangement is in violation of the Stark Law.

CMS has issued three phases of final regulations implementing the Stark Law, which became effective on January 4, 2002, July 26, 2004 and December 4, 2007, respectively, and which created several additional exceptions and many technical changes and nuanced details. Also, as part of its annual physician fee schedule update, on July 2, 2007, CMS released a number of proposed and potentially far-reaching changes to the Stark Law regulations apparently resulting from CMS's frustration with what it perceived as a growing number of hospital/physician joint venture arrangements that permitted physicians to profit from their referrals of ancillary services, while side-stepping or working around existing Stark Law restrictions. On July 31, 2008, CMS issued the final hospital inpatient prospective payment system rule for federal fiscal year 2009 which, in part, finalized and responded to public comments regarding some of its July 2007 proposed major changes to the Stark Law regulations to undermine many common hospital/physician joint venture models. The most far-reaching of the changes made in this final July 2008 rule will effectively prohibit, as of a delayed effective date of October 1, 2009, both "under arrangements" ventures between a hospital and any of its physicians and unit-of-service-based "per click" compensation and percentage-based compensation in office space and equipment leases between a hospital and its physicians. Hospitals will need to examine all of their "under arrangements" ventures and their space and equipment leases with physicians to identify those arrangements which violate these new Stark regulations and restructure or terminate those arrangements so identified prior to October 1, 2009. In addition, in this July 2008 final rule CMS indicated that it will continue to enact further regulations tightening aspects of the Stark Law that it perceives allow for Medicare program abuse, especially those regulations that still permit physicians to profit from their referrals of ancillary services. There can be no assurance that the arrangements entered into by us and our facilities will be found to be in compliance with the Stark Law, as it ultimately may be implemented or interpreted.

Similar State Laws, etc.

Many of the states in which we operate also have adopted laws that prohibit payments to physicians in exchange for referrals similar to the federal Anti-Kickback Statute or that otherwise prohibit fraud and abuse activities. Many states also have passed self-referral legislation, similar to the Stark Law, prohibiting the referral of patients to entities with which the physician has a financial relationship. Often these state laws are broad in scope and they may apply regardless of the source of payment for care. These statutes typically provide criminal and civil penalties, as well as loss of licensure. Little precedent exists for the interpretation or enforcement of these state laws.

Certain Implications of these Fraud and Abuse Laws or New Laws

Our operations could be adversely affected by the failure of our arrangements to comply with the Anti-Kickback Statute, the Stark Law, billing laws and regulations, current state laws or other legislation or regulations in these areas adopted in the future. We are unable to predict whether other legislation or regulations at the federal or state level in any of these areas will be adopted, what form such legislation or regulations may take or how they may impact our operations. We are continuing to enter into new financial arrangements with physicians and other providers in a manner structured to comply in all material respects with these laws. We cannot assure you, however, that governmental officials responsible for enforcing these laws will not assert that we are in violation of them or that such statutes or regulations ultimately will be interpreted by the courts in a manner consistent with our interpretation.

The Federal False Claims Act and Similar Laws

Another trend affecting the healthcare industry today is the increased use of the federal False Claims Act, and, in particular, actions being brought by individuals on the government's behalf under the False Claims Act's "*qui tam*" or whistleblower provisions. Whistleblower provisions allow private individuals to bring actions on behalf of the government alleging that the defendant has defrauded the federal government. If the government intervenes in the action and prevails, the party filing the initial complaint may share in any settlement or judgment. If the government does not intervene in the action, the whistleblower plaintiff may pursue the action independently, and may receive a larger share of any settlement or judgment. When a private party brings a *qui tam* action under the False Claims Act, the defendant generally will not be made aware of the lawsuit until the government makes a determination whether it will intervene.

When a defendant is determined by a court of law to be liable under the False Claims Act, the defendant must pay three times the actual damages sustained by the government, plus mandatory civil penalties of between $5,500 to $11,000 for each separate false claim. Settlements entered into prior to litigation usually involve a less severe calculation of damages. There are many potential bases for liability under the False Claims Act. Although liability often arises when an entity knowingly submits a false claim for reimbursement to the federal government, the False Claims Act defines the term "knowingly" broadly. Thus, simple negligence will not give rise to liability under the False Claims Act, but submitting a claim with reckless disregard to its truth or falsity can constitute "knowingly" submitting a false claim and result in liability. In some cases, whistleblowers or the federal government have taken the position that providers who allegedly have violated other statutes, such as the Anti-Kickback Statute or the Stark Law, have thereby submitted false claims under the False Claims Act.

A number of states, including states in which we operate, have adopted their own false claims provisions as well as their own whistleblower provisions whereby a private party may file a civil lawsuit in state court. From time to time, companies in the healthcare industry, including ours, may be subject to actions under the False Claims Act or similar state laws.

Provisions in the Deficit Reduction Act of 2005 ("DRA") that went into effect on January 1, 2007 give states significant financial incentives to enact false claims laws modeled on the federal False Claims Act. Additionally, the DRA requires every entity that receives annual payments of at least $5 million from a state Medicaid plan to establish written policies for its employees that provide detailed information about federal and state false claims statutes and the whistleblower protections that exist under those laws. Both provisions of the DRA are expected to result in increased false claims litigation against health care providers. We have complied with the written policy requirements.

Corporate Practice of Medicine and Fee Splitting

The states in which we operate have laws that prohibit unlicensed persons or business entities, including corporations, from employing physicians or laws that prohibit certain direct or indirect payments or fee-splitting arrangements between physicians and unlicensed persons or business entities. Possible sanctions for violations of these restrictions include loss of a physician's license, civil and criminal penalties and rescission of business arrangements that may violate these restrictions. These statutes vary from state to state, are often vague and seldom have been interpreted by the courts or regulatory agencies. Although we exercise care to structure our arrangements

with healthcare providers to comply with the relevant state law, and believe these arrangements comply with applicable laws in all material respects, we cannot assure you that governmental officials responsible for enforcing these laws will not assert that we, or transactions in which we are involved, are in violation of such laws, or that such laws ultimately will be interpreted by the courts in a manner consistent with our interpretations.

The Health Insurance Portability and Accountability Act of 1996

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires the use of uniform electronic data transmission standards for healthcare claims and payment transactions submitted or received electronically. These provisions are intended to encourage electronic commerce in the healthcare industry. On August 17, 2000, the Department of Health and Human Services published final regulations establishing electronic data transmission standards that all healthcare providers must use when submitting or receiving certain healthcare transactions electronically. Compliance with these standards became mandatory on October 16, 2003. However, the Department of Health and Human Services agreed to accept noncompliant Medicare claims until October 1, 2005 to assist providers that were not yet able to process compliant transactions. Thus, commencing on October 1, 2005, fee-for-service Medicare claims that did not meet the standards required by HIPAA were returned to the filer for resubmission as compliant claims and non-compliant claims were not processed by Medicare. As of October 1, 2005, all of our facilities were filing compliant Medicare claims and continue doing so as of the date of this report.

HIPAA also requires the Department of Health and Human Services to adopt standards to protect the security and privacy of health-related information. The Department of Health and Human Services released final regulations containing privacy standards in December 2000 and published revisions to the final regulations in August 2002. Compliance with these regulations became mandatory on April 14, 2003. The privacy regulations extensively regulate the use and disclosure of individually identifiable health-related information. The privacy regulations also provide patients with significant new rights related to understanding and controlling how their health information is used or disclosed. The Department of Health and Human Services released final security regulations on February 20, 2003. The security regulations became mandatory on April 20, 2005 and require healthcare providers to implement administrative, physical and technical practices to protect the security of individually identifiable health information that is electronically maintained or transmitted.

Violations of HIPAA could result in civil penalties of up to $25,000 per type of violation in each calendar year and criminal penalties of up to $250,000 per violation. In addition, our facilities will continue to remain subject to any privacy-related federal or state laws that are more restrictive than the privacy regulations issued under HIPAA. These laws vary by jurisdiction and could impose additional penalties.

Compliance with these standards has and will continue to require significant commitment and action by us. We have appointed members of our management team to direct our compliance with these standards. Implementation has and will continue to require us to engage in extensive preparation and make significant expenditures. At this time we have appointed a corporate privacy officer and a privacy officer at each of our facilities, prepared privacy policies, trained our workforce on these policies and entered into business associate agreements with the appropriate vendors. However, failure by us or third parties on which we rely, including payers, to resolve HIPAA-related implementation or operational issues could have a material adverse effect on our results of operations and our ability to provide healthcare services. Consequently, we can give you no assurance that issues related to the full implementation of, or our operations under, HIPAA will not have a material adverse effect on our financial condition or future results of operations.

Conversion Legislation

Many states have enacted laws affecting the conversion or sale of not-for-profit hospitals. These laws generally include provisions relating to attorney general approval, advance notification and community involvement. In addition, attorneys general in states without specific conversion legislation may exercise authority over these transactions based upon existing law. In many states, there has been an increased interest in the oversight of not-for-profit conversions. The adoption of conversion legislation and the increased review of not-for-profit hospital conversions may increase the cost and difficulty or prevent the completion of transactions with or acquisitions of not-for-profit organizations in various states.

The Emergency Medical Treatment and Active Labor Act

The Federal Emergency Medical Treatment and Active Labor Act ("EMTALA") was adopted by Congress in response to reports of a widespread hospital emergency room practice of "patient dumping." At the time of the enactment, patient dumping was considered to have occurred when a hospital capable of providing the needed care sent a patient to another facility or simply turned the patient away based on such patient's inability to pay for his or her care. The law imposes requirements upon physicians, hospitals and other facilities that provide emergency medical services. Such requirements pertain to what care must be provided to anyone who comes to such facilities seeking care before they may be transferred to another facility or otherwise denied care. The government broadly interprets the law to cover situations in which patients do not actually present to a hospital's emergency department, but present to a hospital-based clinic that treats emergency medical conditions on an urgent basis or are transported in a hospital-owned ambulance, subject to certain exceptions. EMTALA does not generally apply to patients admitted for inpatient services. Sanctions for violations of this statute include termination of a hospital's Medicare provider agreement, exclusion of a physician from participation in Medicare and Medicaid programs and civil monetary penalties. In addition, the law creates private civil remedies that enable an individual who suffers personal harm as a direct result of a violation of the law, and a medical facility that suffers a financial loss as a direct result of another participating hospital's violation of the law, to sue the offending hospital for damages and equitable relief. Although we believe that our practices are in substantial compliance with the law, we cannot assure you that governmental officials responsible for enforcing the law will not assert from time to time that our facilities are in violation of this statute.

Antitrust Laws

The federal government and most states have enacted antitrust laws that prohibit certain types of conduct deemed to be anti-competitive. These laws prohibit price fixing, agreements to fix wages, concerted refusal to deal, market monopolization, price discrimination, tying arrangements, acquisitions of competitors and other practices that have, or may have, an adverse effect on competition. Violations of federal or state antitrust laws can result in various sanctions, including criminal and civil penalties. Antitrust enforcement in the healthcare industry is currently a priority of the Federal Trade Commission. We believe we are in compliance with such federal and state laws, but there can be no assurance that a review of our practices by courts or regulatory authorities will not result in a determination that could adversely affect our operations.

Healthcare Reform

The healthcare industry, as one of the largest industries in the United States, continues to attract much legislative interest and public attention. Changes in Medicare, Medicaid and other programs, hospital cost-containment initiatives by public and private payers, proposals to limit payments and healthcare spending and industry-wide competitive factors are highly significant to the healthcare industry. In addition, a framework of extremely complex federal and state laws, rules and regulations governs the healthcare industry and, for many provisions, there is little history of regulatory or judicial interpretation on which to rely.

Both the federal government and many states have enacted or are considering enacting measures designed to reduce their Medicaid expenditures and change private healthcare insurance. Most states, including the states in which we operate, have applied for and been granted federal waivers from current Medicaid regulations to allow them to serve some or all of their Medicaid participants through managed care providers. We are unable to predict the future course of federal, state or local healthcare legislation. Further changes in the law or regulatory framework that reduce our revenues or increase our costs could have a material adverse effect on our business, financial condition or results of operations.

Healthcare Industry Investigations

Significant media and public attention has focused in recent years on the hospital industry. In recent years, increased attention has been paid to hospitals with high Medicare outlier payments and to recruitment arrangements with physicians. Further, there are numerous ongoing federal and state investigations regarding multiple issues. These investigations have targeted hospital companies as well as their executives and managers. Like other hospital companies, we have substantial Medicare, Medicaid and other governmental billings and we engage in various

arrangements with physicians, which could result in scrutiny of our operations. We continue to monitor these and all other aspects of our business and have developed a compliance program to assist us in gaining comfort that our business practices are consistent with both legal principles and current industry standards. However, because the law in this area is complex and constantly evolving, we cannot assure you that government investigations will not result in interpretations that are inconsistent with industry practices, including ours. In public statements surrounding current investigations, governmental authorities have taken positions on a number of issues, including some for which little official interpretation previously has been available, that appear to be inconsistent with practices that have been common within the industry and that previously have not been challenged in this manner. In some instances, government investigations that have in the past been conducted under the civil provisions of federal law may now be conducted as criminal investigations.

Many current healthcare investigations are national initiatives in which federal agencies target an entire segment of the healthcare industry. One example is the federal government's initiative regarding hospital providers' improper requests for separate payments for services rendered to a patient on an outpatient basis within three days prior to the patient's admission to the hospital, where reimbursement for such services is included as part of the reimbursement for services furnished during an inpatient stay. In particular, the government has targeted all hospital providers to ensure conformity with this reimbursement rule. The federal government also has undertaken a national investigative initiative targeting the billing of claims for inpatient services related to bacterial pneumonia, as the government has found that many hospital providers have attempted to bill for pneumonia cases under more complex and higher reimbursed diagnosis related groups codes. Further, the federal government continues to investigate Medicare overpayments to prospective payment hospitals that incorrectly report transfers of patients to other prospective payment system hospitals as discharges. We are aware that prior to our acquisition of them, several of our hospitals were contacted in relation to certain government investigations relating to their operations. Although we take the position that, under the terms of the acquisition agreements, the prior owners of these hospitals retained any liability resulting from these government investigations, we cannot assure you that the prior owners' resolution of these matters or failure to resolve these matters, in the event that any resolution was deemed necessary, will not have a material adverse effect on our operations. Further, under the federal False Claims Act, private parties have the right to bring *"qui tam"* whistleblower lawsuits against companies that submit false claims for payments to the government. Some states have adopted similar state whistleblower and false claims provisions.

In addition to national enforcement initiatives, federal and state investigations commonly relate to a wide variety of routine healthcare operations such as: cost reporting and billing practices; financial arrangements with referral sources; physician recruitment activities; physician joint ventures; and hospital charges and collection practices for self-pay patients. We engage in many of these routine healthcare operations and other activities that could be the subject of governmental investigations or inquiries from time to time. For example, we have significant Medicare and Medicaid billings, we have numerous financial arrangements with physicians who are referral sources to our hospitals and we have joint venture arrangements involving physician investors.

While we are not currently aware of any material investigation of us under federal or state health care laws or regulations, it is possible that governmental entities may conduct investigations at facilities operated by us and that such investigations could result in significant penalties to us, as well as adverse publicity. It is also possible that our executives and managers, many of whom have worked at other healthcare companies that are or may become the subject of federal and state investigations and private litigation, could be included in governmental investigations or named as defendants in private litigation. The positions taken by authorities in any future investigations of us, our executives or managers or other healthcare providers and the liabilities or penalties that may be imposed could have a material adverse effect on our business, financial condition and results of operations.

Health Plan Regulatory Matters

Our health plans are subject to state and federal laws and regulations. CMS has the right to audit our health plans to determine the plans' compliance with such standards. In addition, AHCCCS has the right to audit PHP to determine PHP's compliance with such standards. Also, PHP is required to file periodic reports with AHCCCS, meet certain financial viability standards, provide its enrollees with certain mandated benefits and meet certain quality assurance and improvement requirements. Our health plans also have to comply with the standardized formats for electronic transmissions and privacy and security standards set forth in the Administrative

Simplifications Provisions of HIPAA. Our health plans have implemented the necessary policies and procedures to comply with the final federal regulations on these matters and were in compliance with them by their deadlines.

The Anti-Kickback Statute has been interpreted to prohibit the payment, solicitation, offering or receipt of any form of remuneration in return for the referral of federal health program patients or any item or service that is reimbursed, in whole or in part, by any federal healthcare program. Similar statutes have been adopted in Illinois and Arizona that apply regardless of the source of reimbursement. The Department of Health and Human Services has adopted safe harbor regulations specifying certain relationships and activities that are deemed not to violate the Anti-Kickback Statute which specifically relate to managed care including:

- waivers by health maintenance organizations of Medicare and Medicaid beneficiaries' obligations to pay cost-sharing amounts or to provide other incentives in order to attract Medicare and Medicaid enrollees;
- certain discounts offered to prepaid health plans by contracting providers;
- certain price reductions offered to eligible managed care organizations; and
- certain price reductions offered by contractors with substantial financial risk to managed care organizations.

We believe that the incentives offered by our health plans to their enrollees and the discounts they receive contracting with healthcare providers satisfy the requirements of the safe harbor regulations. However, the failure to satisfy each criterion of the applicable safe harbor does not mean that the arrangement constitutes a violation of the law; rather, the safe harbor regulations provide that an arrangement which does not fit within a safe harbor must be analyzed on the basis of its specific facts and circumstances. We believe that our health plans' arrangements comply in all material respects with the federal Anti-Kickback Statute and similar state statutes.

Environmental Matters

We are subject to various federal, state and local laws and regulations relating to environmental protection. Our hospitals are not highly regulated under environmental laws because we do not engage in any industrial activities at those locations. The principal environmental requirements and concerns applicable to our operations relate to:

- the proper handling and disposal of hazardous and low level medical radioactive waste;
- ownership or historical use of underground and above-ground storage tanks;
- management of impacts from leaks of hydraulic fluid or oil associated with elevators, chiller units or incinerators;
- appropriate management of asbestos-containing materials present or likely to be present at some locations; and
- the potential acquisition of, or maintenance of air emission permits for, boilers or other equipment.

We do not expect our compliance with environmental laws and regulations to have a material effect on us. We may also be subject to requirements related to the remediation of substances that have been released into the environment at properties owned or operated by us or at properties where substances were sent for off-site treatment or disposal. These remediation requirements may be imposed without regard to fault and whether or not we owned or operated the property at the time that the relevant releases or discharges occurred. Liability for environmental remediation can be substantial.

Item 1A. Risk Factors.

If any of the following events discussed in the following risks were to occur, our business, results of operations, financial condition, cash flows or prospects could be materially adversely affected. Additional risks and uncertainties not presently known, or currently deemed immaterial by us, may also constrain our business and operations.

Risks Relating to our Capital Structure

Our high level of debt and significant leverage may adversely affect our operations and our ability to grow and otherwise execute our business strategy.

We have a substantial amount of debt. As of June 30, 2008, we had $1,537.5 million of outstanding debt, excluding letters of credit and guarantees. This represented 73.0% of our total capitalization as of June 30, 2008. The amount of our outstanding indebtedness is large compared to the net book value of our assets, and we have significant repayment obligations under our outstanding indebtedness.

Our substantial indebtedness could:

- limit our ability to obtain additional financing to fund future capital expenditures, working capital, acquisitions or other needs;
- increase our vulnerability to general adverse economic, market and industry conditions and limit our flexibility in planning for, or reacting to, these conditions;
- make us vulnerable to increases in interest rates since $324.1 million of our borrowings under our senior credit facilities as of September 1, 2008 are, and additional borrowings may be, at variable interest rates;
- our flexibility to adjust to changing market conditions and ability to withstand competitive pressures could be limited, and we may be more vulnerable to a downturn in general economic or industry conditions or be unable to carry out capital spending that is necessary or important to our growth strategy and our efforts to improve operating margins;
- limit our ability to use operating cash in other areas of our business because we must use a substantial portion of these funds to make principal and interest payments; and
- limit our ability to compete with others who are not as highly-leveraged.

Our ability to make scheduled payments of principal and interest or to satisfy our other debt obligations, to refinance our indebtedness or to fund capital expenditures will depend on our future operating performance. Prevailing economic conditions (including interest rates) and financial, business and other factors, many of which are beyond our control, will also affect our ability to meet these needs. We may not be able to generate sufficient cash flows from operations or realize anticipated revenue growth or operating improvements, or obtain future borrowings in an amount sufficient to enable us to pay our debt, or to fund our other liquidity needs. We may need to refinance all or a portion of our debt on or before maturity. We may not be able to refinance any of our debt when needed on commercially reasonable terms or at all.

Despite our current significant leverage, we may still be able to incur substantially more debt. This could further exacerbate the risks that we and our subsidiaries face.

We and our subsidiaries may be able to incur substantial additional indebtedness in the future. The terms of the indentures and the senior credit facilities do not fully prohibit us or our subsidiaries from doing so. Our revolving credit facility provides commitments of up to $250.0 million (not giving effect to any outstanding letters of credit, which would reduce the amount available under our revolving credit facility), of which $222.0 million was available for future borrowings as of September 1, 2008. In addition, upon the occurrence of certain events, we may request an incremental term loan facility or facilities be added to our current senior credit facilities in an amount not to exceed $300.0 million in the aggregate, subject to receipt of commitments by existing lenders or other financing institutions and to the satisfaction of certain other conditions. We may in the future borrow all available amounts under the revolving credit facility, under the incremental term loan facility and in addition, we may borrow substantial additional indebtedness in the future under new debt agreements. If new debt is added to our current debt levels, the related risks that we and our subsidiaries now face could intensify.

Operating and financial restrictions in our debt agreements limit our operational and financial flexibility.

The senior credit facilities and the indentures under which $575.0 million aggregate principal amount of our 9.0% senior subordinated notes due 2014 and $216.0 million aggregate principal amount of our 11.25% senior discount notes due 2015 were issued (collectively, the "Public Notes") contain a number of significant covenants that, among other things, restrict our ability to:

- incur additional indebtedness or issue preferred stock;
- pay dividends on or make other distributions or repurchase our capital stock or make other restricted payments;
- make investments;
- enter into certain transactions with affiliates;
- limit dividends or other payments by restricted subsidiaries to our restricted subsidiaries;
- create liens on *pari passu* or subordinated indebtedness without securing the Public Notes;
- designate our subsidiaries as unrestricted subsidiaries; and
- sell certain assets or merge with or into other companies or otherwise dispose of all or substantially all of our assets.

In addition, under the senior credit facilities, we are required to satisfy and maintain specified financial ratios and tests. Events beyond our control may affect our ability to comply with those provisions, and we may not be able to meet those ratios and tests. The breach of any of these covenants would result in a default under the senior credit facilities. In the event of default, the lenders could elect to declare all amounts borrowed under the senior credit facilities, together with accrued interest, to be due and payable and could proceed against the collateral securing that indebtedness. Borrowings under the senior credit facilities are senior in right of payment to the Public Notes. If any of our indebtedness were to be accelerated, our assets may not be sufficient to repay in full that indebtedness and the Public Notes.

Our capital expenditure and acquisition strategies require substantial capital resources. The building of new hospitals and the operations of our existing hospitals and newly acquired hospitals require ongoing capital expenditures for construction, renovation, expansion and the addition of medical equipment and technology. More specifically, we may in the future be contractually obligated to make significant capital expenditures relating to the facilities we acquire. Also, construction costs to build new hospitals are substantial and continue to increase. Our debt agreements may restrict our ability to incur additional indebtedness to fund these expenditures.

A breach of any of the restrictions or covenants in our debt agreements could cause a cross-default under other debt agreements. A significant portion of our indebtedness then may become immediately due and payable. We are not certain whether we would have, or be able to obtain, sufficient funds to make these accelerated payments. If any senior debt is accelerated, our assets may not be sufficient to repay in full such indebtedness and our other indebtedness.

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

Our ability to make scheduled payments or to refinance our debt obligations depends on our financial and operating performance, which is subject to prevailing economic and competitive conditions and to certain financial, business and other factors beyond our control. We may not be able to maintain a level of cash flows from operating activities sufficient to permit us to pay the principal, premium, if any, and interest on our indebtedness. In addition, the indentures governing the Public Notes allow us to make significant dividend payments, investments and other

restricted payments. The making of these payments could decrease available cash and adversely affect our ability to make principal and interest payments on our indebtedness.

If our cash flows and capital resources are insufficient to fund our debt service obligations, we may be forced to reduce or delay capital expenditures, seek additional capital or seek to restructure or refinance our indebtedness. These alternative measures may not be successful and may not permit us to meet our scheduled debt service obligations. In the absence of such operating results and resources, we could face substantial liquidity problems and might be required to sell material assets or operations to attempt to meet our debt service and other obligations. The senior credit facilities and the indentures restrict our ability to use the proceeds from asset sales. We may not be able to consummate those asset sales to raise capital or sell assets at prices that we believe are fair and proceeds that we do receive may not be adequate to meet any debt service obligations then due.

An increase in interest rates would increase the cost of servicing our debt and could reduce our profitability.

A significant portion of the borrowings under our Senior Credit Facilities bear interest at variable rates. As a result, an increase in interest rates, whether because of an increase in market interest rates or an increase in our own cost of borrowing, would increase the cost of servicing our debt and could materially reduce our profitability. The impact of such an increase would be more significant than it would be for some other companies because of our substantial debt. For a discussion of how we manage our exposure to changes in interest rates through the use of interest rate swap agreements on certain portions of our outstanding debt, see "Item 7A. – Quantitave and Qualitative Disclosure About Market Risks."

We are controlled by a small number of stockholders and they may have conflicts of interest with us in the future.

We are controlled by our principal equity sponsors, and they have the ability to control our policies and operations. The interests of our principal equity sponsors may not in all cases be aligned with our interests. For example, our principal equity sponsors could cause us to make acquisitions, divestitures and other transactions that, in their judgment, could enhance their equity investment in us, even though such transactions might reduce cash flows or capital reserves available to fund our debt service obligations. Additionally, our controlling shareholders are in the business of making investments in companies and may from time to time acquire and hold interests in businesses that compete directly or indirectly with us. Accordingly, our principal equity sponsors may also pursue acquisitions that may be complementary to our business, and as a result, those acquisition opportunities may not be available to us. So long as our principal equity sponsors continue to own a significant amount of our equity interests, even if such amount is less than 50%, they will continue to be able to strongly influence or effectively control our decisions.

Risks Related to our Business

If we are unable to enter into favorable contracts with managed care plans, our operating revenues may be reduced.

Our ability to negotiate favorable contracts with health maintenance organizations, insurers offering preferred provider arrangements and other managed care plans significantly affects the revenues and operating results of our hospitals. Revenues derived from health maintenance organizations, insurers offering preferred provider arrangements and other managed care plans, including managed Medicare and managed Medicaid plans, accounted for approximately 57% of our net patient revenues for the year ended June 30, 2008. Managed care organizations offering prepaid and discounted medical services packages represent an increasing portion of our admissions, a general trend in the industry which has limited hospital revenue growth nationwide and a trend that may continue if the Medicare Modernization Act increases enrollment in Medicare managed care plans. In addition, private payers are increasingly attempting to control healthcare costs through direct contracting with hospitals to provide services on a discounted basis, increased utilization review, including the use of hospitalists, and greater enrollment in managed care programs such as health maintenance organizations and preferred provider organizations. Additionally, the trend towards consolidation among private managed care payers tends to increase their bargaining prices over fee structures. In most cases, we negotiate our managed care contracts annually as they

come up for renewal at various times during the year. Our future success will depend, in part, on our ability to renew existing managed care contracts and enter into new managed care contracts on terms favorable to us. Other healthcare companies, including some with greater financial resources, greater geographic coverage or a wider range of services, may compete with us for these opportunities. If we are unable to contain costs through increased operational efficiencies or to obtain higher reimbursements and payments from managed care payers, our results of operations and cash flows will be materially adversely affected.

Our revenues may decline if federal or state programs reduce our Medicare or Medicaid payments or managed care companies reduce our reimbursements.

Approximately 55% of our net patient revenues for the year ended June 30, 2008 came from the Medicare and Medicaid programs, including Medicare and Medicaid managed plans. In recent years, federal and state governments have made significant changes in the Medicare and Medicaid programs. Some of those changes adversely affect the reimbursement we receive for certain services. In addition, due to budget deficits in many states, significant decreases in state funding for Medicaid programs have occurred or are being proposed.

On August 22, 2007, CMS issued a final rule for federal fiscal year 2008 for the hospital inpatient prospective payment system. This rule adopts a two-year implementation of MS-DRGs, a severity-adjusted DRG system. This change represents a refinement to the existing DRG system, and its impact on our revenues has not been significant. Realignments in the DRG system could impact the margins we receive for certain services. This rule provides for a 3.3% market basket update for hospitals that submit certain quality patient care indicators and a 1.3% update for hospitals that do not submit this data. While we will endeavor to comply with all quality data submission requirements, our submissions may not be deemed timely or sufficient to entitle us to the full market basket adjustment for all our hospitals. Medicare payments to hospitals in federal fiscal year 2008 will be reduced by 0.6% to eliminate what CMS estimates will be the effect of coding or classification changes as a result of hospitals implementing the MS-DRG system. This "documentation and coding adjustment" will increase to 0.9% for federal fiscal year 2009. However, Congress has given CMS the ability to retrospectively determine if the documentation and coding adjustment levels for federal fiscal years 2008 and 2009 were adequate to account for changes in payments not related to changes in case mix. If the levels are found to have been inadequate, CMS can impose an adjustment to payments for federal fiscal years 2010, 2011 and 2012. This evaluation of changes in case-mix based on actual claims data may yield a higher documentation and coding adjustment thereby potentially reducing our revenues and impacting our results of operations in ways that cannot be quantified at this time. Additionally, Medicare payments to hospitals are subject to a number of other adjustments, and the actual impact on payments to specific hospitals may vary. In some cases, commercial third-party payers and other payers such as some state Medicaid programs rely on all or portions of the Medicare DRG system to determine payment rates. The change from traditional Medicare DRGs to MS-DRGs could adversely impact those payment rates if any other payers adopt MS-DRGs.

DRG rates are updated and DRG weights are recalibrated each federal fiscal year. The index used to update the market basket gives consideration to the inflation experienced by hospitals and entities outside the healthcare industry in purchasing goods and services. Congressional legislation provides for DRG increases using the full market basket if data for certain patient care quality indicators is submitted quarterly to CMS, and using the market basket minus two percentage points if such data is not submitted. While we will endeavor to comply with all data submission requirements, our submissions may not be deemed timely or sufficient to entitle us to the full market basket adjustment for all of our hospitals.

The federal government and many states have recently adopted or are currently considering reducing the level of Medicaid funding (including upper payment limits) or program eligibility that could adversely affect future levels of Medicaid reimbursement received by our hospitals. Since states must operate with balanced budgets and since the Medicaid program is often a state's largest program, a number of states have adopted, or are considering adopting, legislation designed to reduce their Medicaid expenditures. The Deficit Reduction Act of 2005 includes federal Medicaid cuts of approximately $4.8 billion over five years. Additionally, on May 29, 2007, CMS published a final rule entitled "Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership" which is estimated to reduce federal Medicaid funding from $12 to $20 billion over five years. Congress has enacted two moratoria in respect of this rule. First, Congress delayed its implementation totally until May 2008. Secondly, in June 2008 Congress delayed six of seven

proposed Medicaid regulations in this final CMS rule until April 1, 2009, with only the seventh regulation concerning certain outpatient services and imposing severe restrictions on states covering children with family income levels beyond 250% of the federal poverty level under the Children's Health Insurance Program not being delayed by this second moratorium. As a result of the moratorium on implementing the final rule, the impact on us of the final rule has not been quantified. States have also adopted, or are considering adopting, legislation designed to reduce coverage and program eligibility, enroll Medicaid recipients in managed care programs and/or impose additional taxes on hospitals to help finance or expand the states' Medicaid systems. Future legislation or other changes in the administration or interpretation of government health programs could have a material adverse effect on our financial position and results of operations.

Our ability to negotiate favorable contracts with managed care plans significantly affects the revenues and operating results of most of our hospitals. Approximately, 56% of our net patient revenues for the year ended June 30, 2008 came from managed care plans including managed Medicare and managed Medicaid plans. Managed care payers increasingly are demanding discounted fee structures, and the trend toward consolidation among managed care plans tends to increase their bargaining power over fee structures. Reductions in price increases or the amounts received from managed care plans could have a material adverse effect on our financial position and results of operations.

In recent years, both the Medicare program and several large managed care companies have changed our reimbursement to link some of their payments, especially their annual increases in payments, to performance of quality of care measures. We expect this trend to "pay-for-performance" to increase in the future. If we are unable to meet these performance measures, our results of operations and cash flow will be materially adversely affected.

We conduct business in a heavily regulated industry, and changes in regulations or violations of regulations may result in increased costs or sanctions that could reduce our revenues and profitability.

The healthcare industry is subject to extensive federal, state and local laws and regulations relating to licensing, the conduct of operations, the ownership of facilities, the addition of facilities and services, financial arrangements with physicians and other referral sources, confidentiality, maintenance and security issues associated with medical records, billing for services and prices for services. If a determination were made that we were in material violation of such laws or regulations, our operations and financial results could be materially adversely affected.

In many instances, the industry does not have the benefit of significant regulatory or judicial interpretations of these laws and regulations. This is particularly true in the case of Medicare and Medicaid statute codified under section 1128B(b) of the Social Security Act and known as the "Anti-Kickback Statute." This law prohibits providers and other person or entities from soliciting, receiving, offering or paying, directly or indirectly, any remuneration with the intent to generate referrals of orders for services or items reimbursable under Medicare, Medicaid and other federal healthcare programs. As authorized by Congress, the United States Department of Health and Human Services has issued regulations which describe some of the conduct and business relationships immune from prosecution under the Anti-Kickback Statute. The fact that a given business arrangement does not fall within one of these "safe harbor" provisions does not render the arrangement illegal, but business arrangements of healthcare service providers that fail to satisfy the applicable safe harbor criteria risk increased scrutiny by enforcement authorities.

Some of the financial arrangements that our facilities maintain with physicians do not meet all of the requirements for safe harbor protection. The regulatory authorities that enforce the Anti-Kickback Statute may in the future determine that one or more of these arrangements violate the Anti-Kickback Statute or other federal or state laws. A determination that a facility has violated the Anti-Kickback Statute or other federal laws could subject us to liability under the Social Security Act, including criminal and civil penalties, as well as exclusion of the facility from participation in government programs such as Medicare and Medicaid or other federal healthcare programs.

In addition, the portion of the Social Security Act commonly known as the "Stark Law" prohibits physicians from referring Medicare and (to an extent) Medicaid patients to providers of certain "designated health services" if the physician or a member of his or her immediate family has an ownership or investment interest in, or compensation arrangement with, that provider. In addition, the provider in such arrangements is prohibited from

billing for all of the designated health services referred by the physician. Many of the services furnished by our facilities are "designated health services" for Stark Law purposes. There are multiple exceptions to the Stark Law, among others, for physicians maintaining an ownership interest in an entire hospital or having a compensation relationship with the facility as a result of employment agreements, leases, physician recruitment and certain other arrangements. However, each of these exceptions applies only if detailed conditions are met. An arrangement subject to the Stark Law must qualify for an exception in order for the services to be lawfully referred by the physician and billed by the provider.

CMS has issued three phases of final regulations implementing the Stark Law. Phases I and II became effective in January 2002 and July 2004, respectively, and Phase III became effective in December 2007. While these regulations help clarify the requirements of the exceptions to the Stark Law, it is unclear how the government will interpret many of these exceptions for enforcement purposes. In addition, in July 2007 CMS proposed far-reaching changes to the regulations implementing the Stark Law that would further restrict the types of arrangements that hospitals and physicians may enter, including additional restrictions on certain leases, percentage compensation arrangements, and agreements under which a hospital purchases services under arrangements. On July 31, 2008, CMS issued a final rule which, in part, finalized and responded to public comments regarding some of its July 2007 proposed major changes to the Stark Law regulations to undermine many common hospital/physician joint venture models. The most far-reaching of the changes made in this final July 2008 rule will effectively prohibit, as of a delayed effective date of October 1, 2009, both "under arrangements" ventures between a hospital and any of its physicians and unit-of-service-based "per click" compensation and percentage-based compensation in office space and equipment leases between a hospital and its physicians. Hospitals will need to examine all of their "under arrangements" ventures and their space and equipment leases with physicians to identify those arrangements which violate these new Stark regulations and restructure or terminate those arrangements so identified prior to October 1, 2009. In addition, in this July 2008 final rule CMS indicated that it will continue to enact further regulations tightening aspects of the Stark Law that it perceives allow for Medicare program abuse, especially those regulations that still permit physicians to profit from their referrals of ancillary services. We cannot assure you that the arrangements entered into by our hospitals will be found to be in compliance with the Stark Law, as it ultimately may be implemented or interpreted.

Additionally, if we violate the Anti-kickback Statute or Stark Law, or if we improperly bill for our services, we may be found to violate the False Claims Act, either under a suit brought by the government or by a private person under a *qui tam*, or "whistleblower," suit.

If we fail to comply with the Anti-kickback Statute, the Stark Law, the False Claims Act or other applicable laws and regulations, or if we fail to maintain an effective corporate compliance program, we could be subjected to liabilities, including civil penalties (including the loss of our licenses to operate one or more facilities), exclusion of one or more facilities from participation in the Medicare, Medicaid and other federal and state health care programs and, for violations of certain laws and regulations, criminal penalties. See Item 1, "Business — Governmental Regulation and Other Factors."

All of the states in which we operate have adopted or have considered adopting similar anti-kickback and physician self-referral legislation, some of which extends beyond the scope of the federal law to prohibit the payment or receipt of remuneration for the referral of patients and physician self-referrals, regardless of the source of payment for the care. Little precedent exists for the interpretation or enforcement of these laws. Both federal and state government agencies have announced heightened and coordinated civil and criminal enforcement efforts.

Government officials responsible for enforcing healthcare laws could assert that one or more of our facilities, or any of the transactions in which we are involved, are in violation of the Anti-Kickback Statute or the Stark Law and related state law exceptions. It is also possible that the courts could ultimately interpret these laws in a manner that is different from our interpretations. Moreover, other healthcare companies, alleged to have violated these laws, have paid significant sums to settle such allegations and entered into "corporate integrity agreements" because of concern that the government might exercise its authority to exclude those providers from governmental payment programs (Medicare, Medicaid, TRICARE). A determination that one or more of our facilities has violated these laws, or the public announcement that we are being investigated for possible violations of these laws, could have a material adverse effect on our business, financial condition, results of operations or prospects, and our business reputation could suffer significantly.

Illinois and Massachusetts require governmental determinations of need ("Certificates of Need") prior to the purchase of major medical equipment or the construction, expansion, closure, sale or change of control of healthcare facilities. We believe our facilities have obtained appropriate certificates wherever applicable. However, if a determination were made that we were in material violation of such laws, our operations and financial results could be materially adversely affected. The governmental determinations, embodied in Certificates of Need, can also affect our facilities' ability to add bed capacity or important services. We cannot predict whether we will be able to obtain required Certificates of Need in the future. A failure to obtain any required Certificates of Need may impair our ability to operate the affected facility profitably.

The laws, rules and regulations described above are complex and subject to interpretation. If we are in violation of any of these laws, rules or regulations, or if further changes in the regulatory framework occur, our results of operations could be significantly harmed. For a more detailed discussion of the laws, rules and regulations described above, see Item 1, "Business – Government Regulation and Other Factors."

Some of our hospitals will be required to submit to CMS information on their relationships with physicians and this submission could subject such hospitals and us to liability.

CMS announced in 2007 that it intends to collect information on ownership, investment and compensation arrangements with physicians from 500 (pre-selected) hospitals by requiring these hospitals to submit to CMS Disclosure of Financial Relationship Reports ("DFRR") from each selected hospital. CMS also indicated that at least 10 of our hospitals will be among these 500 hospitals required to submit a DFRR because these 10 hospitals did not respond to CMS' voluntary survey instrument on this topic purportedly submitted to these hospitals via email by CMS in 2006. CMS intends to use this data to determine whether these hospitals were in compliance with the Stark Law and implementing regulations during the reporting period (currently expected to be the cost reporting periods of these hospitals ending in 2006), and CMS has indicated it may share this information with other government agencies and with Congressional committees. Many of these agencies have not previously analyzed this information and have the authority to bring enforcement actions against the hospitals. However, in July 2008 CMS announced that, based on its further review and expected further public comments on this matter, CMS may decide in the future to decrease (but not increase) the number of hospitals to which it will send the DFRR below the 500 hospitals originally designated.

Once a hospital receives this request for a DFRR, the hospital will have 60 days to compile a significant amount of information relating to its financial relationships with physicians. The hospital may be subject to civil monetary penalties of up to $10,000 per day if it is unable to assemble and report this information within the required timeframe or if CMS or any other government agency determines that the submission is inaccurate or incomplete. The hospital may be the subject of investigations or enforcement actions if a government agency determines that any of the information indicates a potential violation of law.

Also, while in 2007 CMS had announced that it was contemplating proposing a regular financial disclosure process that would apply in the future to all Medicare participating hospitals, in July 2008 CMS announced that, based upon public comments previously received, it was not adopting a regular reporting or disclosure process at that time, and, thus, CMS said the DFRR will initially be used as a one-time collection effort. However, CMS also said in July 2008 that, depending on the information received from the initial DFRR process and other factors, it may propose future rulemaking to use the DFRR or some other instrument as a periodic or regular collection instrument. Thus, even if one of our hospitals does not receive the DFRR survey as part of the initial up to 500 selected hospitals, we expect that all of our hospitals will possibly have to report similar information to CMS in the future.

Any governmental investigation or enforcement action which results from the DFRR process could materially adversely affect the results of our operations.

Providers in the healthcare industry have been the subject of federal and state investigations, whistleblower lawsuits and class action litigation, and we may become subject to investigations, whistleblower lawsuits or class action litigation in the future.

Both federal and state government agencies have heightened and coordinated civil and criminal enforcement efforts as part of numerous ongoing investigations of hospital companies, as well as their executives and managers. These investigations relate to a wide variety of topics, including:

- cost reporting and billing practices;
- laboratory and home healthcare services;
- physician ownership of, and joint ventures with, hospitals;
- physician recruitment activities; and
- other financial arrangements with referral sources

In addition, the federal False Claims Act permits private parties to bring *qui tam*, or whistleblower, lawsuits against companies. Whistleblower provisions allow private individuals to bring actions on behalf of the government alleging that the defendant has defrauded the federal government. Because *qui tam* lawsuits are filed under seal, we could be named in one or more such lawsuits of which we are not aware. Defendants determined to be liable under the False Claims Act may be required to pay three times the actual damages sustained by the government, plus mandatory civil penalties of between $5,500 and $11,000 for each separate false claim. Typically, each fraudulent bill submitted by a provider is considered a separate false claim, and thus the penalties under false claims may be substantial. Liability arises when an entity knowingly submits a false claim for reimbursement to the federal government. In some cases, whistleblowers or the federal government have taken the position that providers who allegedly have violated other statutes and have submitted claims to a governmental payer during the time period they allegedly violated these other statutes, have thereby submitted false claims under the False Claims Act. Some states have adopted similar whistleblower and false claims provisions.

The Office of the Inspector General of the Department of Health and Human Services and the Department of Justice have, from time to time, established national enforcement initiatives that focus on specific billing practices or other suspected areas of abuse. Initiatives include a focus on hospital billing for outpatient charges associated with inpatient services, as well as hospital laboratory billing practices. As a result of these regulations and initiatives, some of our activities could become the subject of governmental investigations or inquiries. For example, we have significant Medicare and Medicaid billings, we provide some durable medical equipment and home healthcare services, and we have joint venture arrangements involving physician investors. We also have a variety of other financial arrangements with physicians and other potential referral sources including recruitment arrangements and leases. In addition, our executives and managers, many of whom have worked at other healthcare companies that are or may become the subject of federal and state investigations and private litigation, could be included in governmental investigations or named as defendants in private litigation. We are aware that several of our hospitals or their related healthcare operations were and may still be under investigation in connection with activities conducted prior to our acquisition of them. Under the terms of our various acquisition agreements, the prior owners of our hospitals are responsible for any liabilities arising from pre-closing violations. The prior owners' resolution of these matters or failure to resolve these matters, in the event that any resolution was deemed necessary, may have a material adverse effect on our business, financial condition or results of operations. Any investigations of us, our executives, managers, facilities or operations could result in significant liabilities or penalties to us, as well as adverse publicity.

We maintain a voluntary compliance program to address health regulatory and other compliance requirements. This program includes initial and periodic ethics and compliance training and effectiveness reviews, a toll-free hotline for employees to report, without fear of retaliation, any suspected legal or ethical violations, annual "fraud and abuse" audits to look at all of our financial relationships with physicians and other referral sources and annual "coding audits" to make sure our hospitals bill the proper service codes in respect of obtaining payment from the Medicare and Medicaid programs.

As an element of our corporate compliance program and our internal compliance audits, from time to time we make voluntary disclosures and repayments to the Medicare and Medicaid programs and/or to the federal and/or state regulators for these programs in the ordinary course of business. At the current time, we know of no active investigations by any of these programs or regulators in respect of our disclosures or repayments. All of these voluntary actions on our part could lead to an investigation by the regulators to determine whether any of our facilities have violated the Stark Law, the Anti-Kickback Statute, the False Claims Act or similar state law. Either an investigation or initiation of administrative or judicial actions could result in a public announcement of possible

violations of the Stark Law, the Anti-Kickback Statute or the False Claims Act or similar state law. Such determination or announcements could have a material adverse effect on our business, financial condition, results of operations or prospects, and our business reputation could suffer significantly.

Additionally, several hospital companies have in recent years been named defendants in class action litigation alleging, among other things, that their charge structures are fraudulent and, under state law, unfair or deceptive practices, insofar as those hospitals charge insurers lower rates than those charged to uninsured patients. We cannot assure you that we will not be named as a defendant in litigation of this type. Furthermore, the outcome of these suits may affect the industry standard for charity care policies and any response we take may have a material adverse effect on our financial results.

In June 2006 we and two other hospital systems operating in San Antonio, Texas had a putative class action lawsuit brought against all of us alleging that we and the other defendants has conspired with each other and with other unidentified San Antonio area hospitals to depress the compensation levels of registered nurses employed at the competing hospitals within the San Antonio area by engaging in certain activities that violated the federal antitrust laws. See "Item 3- Legal Proceedings" for further discussion of this litigation. On the same day that this litigation was brought against us and two other hospital systems in San Antonio, substantially similar class action litigation was brought against multiple hospitals in three other cities.

Competition from other hospitals or healthcare providers (especially specialty hospitals) may reduce our patient volumes and profitability.

The healthcare business is highly competitive and competition among hospitals and other healthcare providers for patients has intensified in recent years. Generally, other hospitals in the local communities served by most of our hospitals provide services similar to those offered by our hospitals. In addition, we believe the number of freestanding specialty hospitals and surgery and diagnostic centers in the geographic areas in which we operate has increased significantly in recent years. As a result, most of our hospitals operate in an increasingly competitive environment. Some of the hospitals that compete with our hospitals are owned by governmental agencies or not-for-profit corporations supported by endowments and charitable contributions and can finance capital expenditures and operations on a tax-exempt basis. Increasingly, we are facing competition from physician-owned specialty hospitals and freestanding surgery centers that compete for market share in high margin services and for quality physicians and personnel. Also, we anticipate that the number of physician-owned specialty hospitals may increase as CMS has ended a moratorium on the Medicare enrollment of such hospitals. If ambulatory surgery centers are better able to compete in this environment than our hospitals, our hospitals may experience a decline in patient volume, and we may experience a decrease in margin, even if those patients use our ambulatory surgery centers. Further, if our competitors are better able to attract patients, recruit physicians, expand services or obtain favorable managed care contracts at their facilities than our hospitals and ambulatory surgery centers, we may experience an overall decline in patient volume. See Item 1, "Business - Competition."

In 2005, CMS began making public performance data related to 10 quality measures that hospitals submit in connection with their Medicare reimbursement. In February 2006, federal legislation was enacted to expand and provide for the future expansion of the number of quality measures that must be reported. For federal fiscal year 2008, CMS requires hospitals to report 30 measures of inpatient quality of care to avoid a 2% point reduction in their market basket update. For the federal fiscal year 2009 payment update, CMS will require hospitals to report 42 inpatient quality measures to avoid a 2% point reduction in their market basket update. CMS is also requiring that seven measures of outpatient quality of care be reported during federal fiscal year 2008 to receive the full market basket update for outpatient services in federal fiscal year 2009. If any of our hospitals achieve poor results (or results that are lower than our competitors) on these quality measures, patient volumes could decline. Also, the additional quality measures and future trends toward clinical transparency may have an unanticipated impact on our competitive position and patient volumes.

PHP also faces competition within the Arizona markets that it serves. As in the case of our hospitals, some of our competitors in these markets are owned by governmental agencies or not-for-profit corporations that have greater financial resources than we do. Other competitors have larger membership bases, are more established and have greater geographic coverage areas that give them an advantage in competing for a limited pool of eligible health plan members. The revenues we derive from PHP could significantly decrease if new plans operating under

AHCCCS enter these markets or other existing AHCCCS plans increase their number of enrollees. Moreover, a failure to attract future enrollees may negatively impact our ability to maintain our profitability in these markets.

We may be subject to liabilities from claims brought against our facilities.

We operate in a highly regulated and litigious industry. As a result, various lawsuits, claims and legal and regulatory proceedings have been instituted or asserted against us, including those outside of the ordinary course of business like class actions and those in the ordinary course of business like malpractice lawsuits. Some of these actions may involve large claims as well as significant defense costs. (See "Item 3, "Legal Proceedings.")

We maintain professional and general liability insurance in amounts we believe are sufficient to cover claims arising out of the operations of our facilities. Some of the claims could exceed the scope of the coverage in effect or coverage of particular claims or damages could be denied.

The relatively high cost of professional liability insurance and, in some cases, the lack of availability of such insurance coverage, for physicians with privileges at our hospitals increases our risk of vicarious liability in cases where both our hospital and the uninsured or underinsured physician are named as co-defendants. As a result, we are subject to greater self-insured risk and may be required to fund claims out of our operating cash flows to a greater extent than during fiscal year 2008. We cannot assure you that we will be able to continue to obtain insurance coverage in the future or that such insurance coverage, if it is available, will be available on acceptable terms.

While we cannot predict the likelihood of future claims or inquiries, we expect that new matters may be initiated against us from time to time. Moreover, the results of current claims, lawsuits and investigations cannot be predicted, and it is possible that the ultimate resolution of these matters, individually or in the aggregate, may have a material adverse effect on our business (both in the near and long term), financial position, results of operations or cash flows.

Our hospitals face a growth in uncompensated care as the result of the inability of uninsured patients to pay for healthcare services and difficulties in collecting patient portions of insured accounts.

Like others in the hospital industry, we have experienced an increase in uncompensated care. Our combined provision for doubtful accounts and charity care deductions as a percentage of patient service revenues increased from 11.2% during fiscal 2006 to 12.0% during fiscal 2007 and to 12.5% during fiscal 2008. Our self pay discharges as a percentage of total discharges have not fluctuated significantly during our past three fiscal years. Our hospitals remain at risk for increases in uncompensated care as a result of price increases, the continuing trend of increases in coinsurance and deductible portions of managed care accounts and increases in uninsured patients as a result of potential state Medicaid funding cuts or general economic weakness. Although we continue to seek ways of improving point of service collection efforts and implementing appropriate payment plans with our patients, if we continue to experience growth in self-pay volumes and revenues, our results of operations could be materially adversely affected. Further, our ability to improve collections for self-pay patients may be limited by regulatory and investigatory initiatives, including private lawsuits directed at hospital charges and collection practices for uninsured and underinsured patients.

Our performance depends on our ability to recruit and retain quality physicians.

Physicians generally direct the majority of hospital admissions. Thus, the success of our hospitals depends in part on the following factors:

- the number and quality of the physicians on the medical staffs of our hospitals;
- the admitting practices of those physicians; and
- the maintenance of good relations with those physicians.

Most physicians at our hospitals also have admitting privileges at other hospitals. Our efforts to attract and retain physicians are affected by our managed care contracting relationships, national shortages in some specialties, such as anesthesiology and radiology, the adequacy of our support personnel, the condition of our facilities and

medical equipment, the availability of suitable medical office space and federal and state laws and regulations prohibiting financial relationships that may have the effect of inducing patient referrals. If facilities are not staffed with adequate support personnel or technologically advanced equipment that meets the needs of patients, physicians may be discouraged from referring patients to our facilities, which could adversely affect our profitability.

In an effort to meet community needs in the markets in which we operate, we have implemented a strategy to employ physicians both in primary care and in certain specialties. As of June 30, 2008, we employed 196 practicing physicians. The deployment of a physician employment strategy includes increased salary costs, physician integration risks and difficulties associated with physician practice management. While we believe this strategy is consistent with industry trends, we cannot be assured of the long-term success of such a strategy.

We may be unable to achieve our acquisition and growth strategies and we may have difficulty acquiring not-for-profit hospitals due to regulatory scrutiny.

An important element of our business strategy is expansion by acquiring hospitals in our existing and in new urban and suburban markets and by entering into partnerships or affiliations with other healthcare service providers. The competition to acquire hospitals is significant, including competition from healthcare companies with greater financial resources than ours, and we may not be able to make suitable acquisitions on favorable terms. We may have difficulty obtaining financing, if necessary, for such acquisitions on satisfactory terms. We sometimes agree not to sell an acquired hospital for some period of time (currently no longer than 10 years) after closing and/or grant the seller a right of first refusal to purchase the hospital if we agree to sell it to a third party. In addition, we may not be able to effectively integrate any acquired facilities with our operations. Even if we continue to acquire additional facilities and/or enter into partnerships or affiliations with other healthcare service providers, federal and state regulatory agencies may constrain our ability to grow.

Additionally, many states, including some where we have hospitals and others where we may in the future attempt to acquire hospitals, have adopted legislation regarding the sale or other disposition of hospitals operated by not-for-profit entities. In other states that do not have specific legislation, the attorneys general have demonstrated an interest in these transactions under their general obligations to protect charitable assets from waste. These legislative and administrative efforts focus primarily on the appropriate valuation of the assets divested and the use of the sale proceeds by the not-for-profit seller. These review and approval processes can add time to the consummation of an acquisition of a not-for profit hospital, and future actions on the state level could seriously delay or even prevent future acquisitions of not-for-profit hospitals. Furthermore, as a condition to approving an acquisition, the attorney general of the state in which the hospital is located may require us to maintain specific services, such as emergency departments, or to continue to provide specific levels of charity care, which may affect our decision to acquire or the terms upon which we acquire one of these hospitals.

Difficulties with integrating our acquisitions may disrupt our ongoing operations.

We may not be able to profitably or effectively integrate the operations of, or otherwise achieve the intended benefits from, any acquisitions we make or partnerships or affiliations we may form. The process of integrating acquired hospitals may require a disproportionate amount of management's time and attention, potentially distracting management from its day-to-day responsibilities. This process may be even more difficult in the case of hospitals we may acquire out of bankruptcy or otherwise in financial distress. In addition, poor integration of acquired facilities could cause interruptions to our business activities, including those of the acquired facilities. As a result, we may incur significant costs related to acquiring or integrating these facilities and may not realize the anticipated benefits.

Moreover, acquired businesses may have unknown or contingent liabilities, including liabilities for failure to comply with healthcare laws and regulations. We could in the future become liable for past activities of acquired businesses and these liabilities could be material.

Our hospitals face competition for staffing, which may increase our labor costs and reduce profitability.

We compete with other healthcare providers in recruiting and retaining qualified management and staff personnel responsible for the day-to-day operations of each of our hospitals, including nurses and other non-

physician healthcare professionals. In the healthcare industry generally, including in our markets, the scarcity of nurses and other medical support personnel has become a significant operating issue. This shortage may require us to increase wages and benefits to recruit and retain nurses and other medical support personnel or to hire more expensive temporary personnel. We have raised on several occasions in the past, and expect to raise in the future, wages for our nurses and other medical support personnel. We also depend on the available labor pool of semi-skilled and unskilled employees in each of the markets in which we operate. In addition, to the extent that a significant additional portion of our employee base unionizes, or attempts to unionize, our labor costs could increase materially. If our labor costs increase, we may not be able to raise rates to offset these increased costs. Because approximately 90% of our net patient revenues for the year ended June 30, 2008, consisted of payments based on fixed or negotiated rates, our ability to pass along increased labor costs is constrained. Our failure to recruit and retain qualified management, nurses and other medical support personnel, or to control our labor costs, could have a material adverse effect on our profitability.

The cost of our malpractice insurance and the malpractice insurance of physicians who practice at our facilities remains volatile. Successful malpractice or tort claims asserted against us, our physicians or our employees could materially adversely affect our financial condition and profitability.

Physicians, hospitals and other healthcare providers are subject to legal actions alleging malpractice, product liability or related legal theories. Many of these actions involve large monetary claims and significant defense costs. Hospitals and physicians have typically maintained a special type of insurance (commonly called malpractice or professional liability insurance) to protect against the costs of these types of legal actions. We created a captive insurance subsidiary on June 1, 2002, to assume a substantial portion of the professional and general liability risks of our facilities. For claims incurred during the period June 1, 2002 to May 31, 2006, we maintained all of our professional and general liability insurance through this captive insurance subsidiary in respect of losses up to $10.0 million per occurrence. For claims incurred subsequent to May 31, 2006, we self-insure the first $9.0 million per occurrence, and our captive subsidiary insures the next $1.0 million per occurrence. We have also purchased an umbrella excess policy for professional and general liability insurance for the period June 1, 2008 to May 31, 2009 with unrelated commercial carriers. This policy covers losses in excess of $10.0 million per occurrence up to $75.0 million, but is limited to total annual payments of $65.0 million in the aggregate. While our premium prices have declined during the past few years, the total cost of professional and general liability insurance remains sensitive to the volume and severity of cases reported. There is no guarantee that excess insurance coverage will continue to be available in the future at a cost allowing us to maintain adequate levels of such insurance. Moreover, due to the increased retention limits insured by us and our captive subsidiary, if actual payments of claims materially exceed our projected estimates of malpractice claims, our financial condition could be materially adversely affected.

Physicians' professional liability insurance costs in certain markets have dramatically increased to the point where some physicians are either choosing to retire early or leave those markets. If physician professional liability insurance costs continue to escalate in markets in which we operate, some physicians may choose not to practice at our facilities, which could reduce our patient volumes and revenues. Our hospitals may also incur a greater percentage of the amounts paid to claimants if physicians are unable to obtain adequate malpractice coverage.

We anticipate employing over 90 additional physicians during our fiscal year 2009. Such a significant increase in employed physicians could significantly increase our professional and general liability risks and related costs in future periods.

We are subject to uncertainties regarding healthcare reform that could materially and adversely affect our business.

In recent years, an increasing number of legislative initiatives have been introduced or proposed in Congress and in state legislatures that would result in major changes in the healthcare system, either nationally or at the state level. Among the proposals that have been introduced are price controls on hospitals, insurance market reforms to increase the availability of group health insurance to small businesses, requirements that all businesses offer health insurance coverage to their employees and the creation of a government health insurance plan or plans that would cover all citizens and increase payments by beneficiaries. Increased regulations, mandated benefits and more oversight, audits and investigations and changes in laws allowing access to federal and state courts to

challenge healthcare decisions may increase our administrative, litigation and healthcare costs. We cannot predict whether any of the above proposals or any other proposals will be adopted, and if adopted, we cannot assure you that the implementation of these reforms will not have a material adverse effect on our business, financial position or results of operations.

Our facilities are concentrated in a small number of regions. If any one of the regions in which we operate experiences a regulatory change, economic downturn or other material change, our overall business results may suffer.

Among our operations as of June 30, 2008, five hospitals and various related healthcare businesses were located in San Antonio, Texas; five hospitals and related healthcare businesses were located in metropolitan Phoenix, Arizona; two hospitals and related healthcare businesses were located in metropolitan Chicago, Illinois; and three hospitals and related healthcare businesses were located in Massachusetts. For the year ended June 30, 2008, our total revenues were generated as follows:

	Year Ended June 30, 2008
San Antonio	32.1 %
Massachusetts	19.7
Metropolitan Phoenix, excluding Phoenix Health Plan and Abrazo Advantage Health Plan	18.8
Phoenix Health Plan and Abrazo Advantage Health Plan	14.1
Metropolitan Chicago (1)	14.9
Other	0.4
	100.0 %

(1) Includes MacNeal Health Providers.

Any material change in the current demographic, economic, competitive or regulatory conditions in any of these regions could adversely affect our overall business results because of the significance of our operations in each of these regions to our overall operating performance. Moreover, due to the concentration of our revenues in only four regions, our business is less diversified and, accordingly, is subject to greater regional risk than that of some of our larger competitors.

If we are unable to control our healthcare costs at Phoenix Health Plan and Abrazo Advantage Health Plan, if the health plans should lose their governmental contracts or if budgetary cuts reduce the scope of Medicaid or dual-eligibility coverage, our profitability may be adversely affected.

For the year ended June 30, 2008, PHP generated approximately 12.7% of our total revenues. PHP derives substantially all of its revenues through a contract with AHCCCS. AHCCCS pays capitated rates to PHP, and PHP subcontracts with physicians, hospitals and other healthcare providers to provide services to its enrollees. If we fail to effectively manage our healthcare costs, these costs may exceed the payments we receive. Many factors can cause actual healthcare costs to exceed the capitated rates paid by AHCCCS, including:

- our ability to contract with cost-effective healthcare providers;
- the increased cost of individual healthcare services;
- the type and number of individual healthcare services delivered; and
- the occurrence of catastrophes, epidemics or other unforeseen occurrences

Our new contract with AHCCCS begins October 1, 2008 and expires September 30, 2011 and could result in significant membership growth in geographic areas in which we did not provide services under our previous AHCCCS contract that could increase our risk. The new contract is terminable without cause on 90 days' written notice from AHCCCS or for cause upon written notice from AHCCCS if we fail to comply with any term or condition of the contract or fail to take corrective action as required to comply with the terms of the contract. AHCCCS may also terminate the contract with PHP in the event of unavailability of state or federal funding. If our AHCCCS contract is terminated, our profitability would be adversely affected by the loss of these revenues and cash

flows. Also, should the scope of the Medicaid program be reduced as a result of state budgetary cuts or other political factors, our results of operations could be adversely affected.

For the year ended June 30, 2008, AAHP generated 1.4% of our total revenues. AAHP began providing healthcare coverage to Medicare and Medicaid dual-eligible enrollees on January 1, 2006. Most of AAHP's members were formerly enrolled in PHP. AAHP's contract with CMS went into effect on January 1, 2006, for a term of one year, with a provision for successive one year renewals, and has currently been renewed through December 31, 2008. If we fail to effectively manage AAHP's healthcare costs, these costs may exceed the payments we receive.

We are dependent on our senior management team and local management personnel, and the loss of the services of one or more of our senior management team or key local management personnel could have a material adverse effect on our business.

The success of our business is largely dependent upon the services and management experience of our senior management team, which includes Charles N. Martin, Jr., our Chairman and Chief Executive Officer; Kent H. Wallace, our President and Chief Operating Officer; Keith B. Pitts, our Vice Chairman, Phillip W. Roe, our Executive Vice President, Chief Financial Officer and Treasurer; and Joseph D. Moore, Executive Vice President. In addition, we depend on our ability to attract and retain local managers at our hospitals and related facilities, on the ability of our senior officers and key employees to manage growth successfully and on our ability to attract and retain skilled employees. We do not maintain key man life insurance policies on any of our officers. If we were to lose any of our senior management team or members of our local management teams, or if we are unable to attract other necessary personnel in the future, it could have a material adverse effect on our business, financial condition and results of operations. If we were to lose the services of one or more members of our senior management team or a significant portion of our hospital management staff at one or more of our hospitals, we would likely experience a significant disruption in our operations and failure of the affected hospitals to adhere to their respective business plans.

Changes in legislation may significantly reduce government healthcare spending and our revenues.

Governmental healthcare programs, principally Medicare and Medicaid, accounted for 55% of our net patient revenues (including managed Medicare and managed Medicaid programs) for both the years ended June 30, 2007 and 2008. In recent years, legislative changes have resulted in limitations on and, in some cases, reductions in levels of, payments to healthcare providers for certain services under many of these government programs. Further, legislative changes have altered the method of payment for various services under the Medicare and Medicaid programs. We believe that hospital operating margins across the country, including ours, have been and may continue to be under pressure because of limited pricing flexibility and growth in operating expenses in excess of the increase in prospective payments under the Medicare program. DRA 2005 passed in February 2006 reduces federal funding for Medicare and Medicaid by approximately $11 billion over the next five years. In addition, a number of states are experiencing budget problems and have adopted or are considering legislation designed to reduce their Medicaid expenditures and to provide universal coverage and additional care, including enrolling Medicaid recipients in managed care programs and imposing additional taxes on hospitals to help finance or expand states' Medicaid systems.

Controls designed to reduce inpatient services may reduce our revenues.

Controls imposed by Medicare and commercial third-party payers designed to reduce admissions and lengths of stay, commonly referred to as "utilization review," have affected and are expected to continue to affect our facilities. Utilization review entails the review of the admission and course of treatment of a patient by managed care plans. Inpatient utilization, average lengths of stay and occupancy rates continue to be negatively affected by payer-required preadmission authorization and utilization review and by payer pressures to maximize outpatient and alternative healthcare delivery services for less acutely ill patients. Efforts to impose more stringent cost controls are expected to continue. Although we are unable to predict the effect these changes will have on our operations, significant limits on the scope of services reimbursed and on reimbursement rates and fees could have a material, adverse effect on our business, financial position and results of operations.

If we fail to continually enhance our hospitals with the most recent technological advances in diagnostic and surgical equipment, our ability to maintain and expand our markets will be adversely affected.

Technological advances with respect to computed axial tomography (CT), magnetic resonance imaging (MRI) and positron emission tomography (PET) equipment, as well as other equipment used in our facilities, are continually evolving. In an effort to compete with other healthcare providers, we must constantly evaluate our equipment needs and upgrade equipment as a result of technological improvements. Such equipment costs typically range from $1.0 million to $3.0 million, exclusive of construction or build-out costs.

Our hospitals face competition for staffing especially as a result of the national shortage of nurses and the increased imposition on us of nurse-staffing ratios, which has in the past and may in the future increase our labor costs and materially reduce our profitability.

We compete with other healthcare providers in recruiting and retaining qualified management and staff personnel responsible for the day-to-day operations of each of our hospitals, including most significantly nurses and other non-physician healthcare professionals. In the healthcare industry generally, including in our markets, the national shortage of nurses and other medical support personnel has become a significant operating issue. This shortage has caused us in the past and may require us in the future to increase wages and benefits to recruit and retain nurses and other medical support personnel or to hire more expensive temporary personnel. We have voluntarily raised on several occasions in the past, and expect to raise in the future, wages for our nurses and other medical support personnel. In addition, union-mandated or state-mandated nurse-staffing ratios significantly affect not only labor costs, but may also cause us to limit patient admissions with a corresponding adverse effect on revenues if we are unable to hire the appropriate number of nurses to meet the required ratios. While we do not currently operate in any states with mandated nurse-staffing ratios, the states in which we operate could adopt mandatory nurse-staffing ratios at any time. In those instances where our nurses are unionized, it is our experience that new union contracts often impose significant new additional staffing ratios by contract on our hospitals. This was the case with the increased staffing ratios imposed on us in our union contract with our nurses at Saint Vincent Hospital in Worcester, Massachusetts negotiated in 2007. In addition, to the extent that a significant additional portion of our employee base unionizes, or attempts to unionize, our labor costs could increase materially, especially if the newly unionized employees are nurses. If our labor costs continue to increase, we may not be able to raise our payer reimbursement levels to offset these increased costs, including the significantly increased costs that we will incur for wage increases and nurse-staffing ratios under our new union contract with our nurses at Saint Vincent Hospital. Because substantially all of our net patient revenues consist of payments based on fixed or negotiated rates, our ability to pass along increased labor costs is materially constrained. Our failure to recruit and retain qualified management, nurses and other medical support personnel, or to control our labor costs, could have a material adverse effect on our profitability.

Compliance with section 404 of the Sarbanes-Oxley Act may negatively impact our results of operations and failure to comply may subject us to regulatory scrutiny and a loss of investors' confidence in our internal control over financial reporting.

Section 404 of the Sarbanes-Oxley Act of 2002 (the "404 Act") requires us to perform an evaluation of our internal control over financial reporting and file management's attestation with our annual report beginning with our fiscal year ended June 30, 2008. The 404 Act also requires our independent auditors to opine on our internal control over financial reporting beginning with our fiscal year ending June 30, 2010. We have evaluated, tested and implemented internal controls over financial reporting to enable management to report on such internal controls under the 404 Act as of June 30, 2008. However, we can not assure you that the conclusions reached by management in its June 30, 2010 report will be the same as those reached by our independent auditors in its report. Failure on our part to comply with the 404 Act may subject us to regulatory scrutiny and a loss of public confidence in our internal control over financial reporting.

A failure of our information systems would adversely affect our ability to properly manage our operations.

We rely on our advanced information systems and our ability to successfully use these systems in our operations. These systems are essential to the following areas of our business operations, among others:

- patient accounting, including billing and collection of patient service revenues;
- financial, accounting, reporting and payroll;
- coding and compliance;
- laboratory, radiology and pharmacy systems;
- remote physician access to patient data;
- negotiating, pricing and administering managed care contracts; and
- monitoring quality of care.

If we are unable to use these systems effectively, we may experience delays in collection of patient service revenues and may not be able to properly manage our operations or oversee the compliance with laws or regulations.

Difficulties with current construction projects or new construction projects such as additional hospitals or major expansion projects may involve significant capital expenditures that could have an adverse impact on our liquidity.

We may decide to construct an additional hospital or hospitals in the future or construct additional major expansion projects to existing hospitals in order to achieve our growth objectives. Our ability to complete construction of new hospitals or new expansion projects on budget and on schedule would depend on a number of factors, including, but not limited to:

- our ability to control construction costs;
- the failure of general contractors or subcontractors to perform under their contracts;
- adverse weather conditions;
- shortages of labor or materials;
- our ability to obtain necessary licensing and other required governmental authorizations; and
- other unforeseen problems and delays.

As a result of these and other factors, we cannot assure you that we will not experience increased construction costs on our construction projects or that we will be able to construct our current or any future construction projects as originally planned. In addition, our current and any future major construction projects has and would involve a significant commitment of capital with no revenues associated with the projects during construction, which also could have in the future an adverse impact on our liquidity.

If the costs for construction materials and labor continue to rise, such increased costs could have an adverse impact on the return on investment relating to our expansion projects.

The cost of construction materials and labor has significantly increased over the past year as a result of global and domestic events. We have experienced significant increases in the cost of steel due to the demand in China for such materials and an increase in the cost of lumber due to multiple factors. Increases in oil and gas prices have increased costs for oil-based products and for transporting materials to job sites. As we continue to invest in modern technologies, emergency rooms and operating room expansions, we expend large sums of cash generated from operating activities. We evaluate the financial viability of such projects based on whether the projected cash flow return on investment exceeds our cost of capital. Such returns may not be achieved if the cost of construction continues to rise significantly or anticipated volumes do not materialize.

State efforts to regulate the construction or expansion of hospitals could impair our ability to operate and expand our operations.

Some states require healthcare providers to obtain prior approval, known as certificates of need, for:

- the purchase, construction or expansion of healthcare facilities;
- capital expenditures exceeding a prescribed amount; or
- changes in services or bed capacity.

In giving approval, these states consider the need for additional or expanded healthcare facilities or services. Illinois and Massachusetts are the only states in which we currently own hospitals that have certificate of need laws. The failure to obtain any required certificate of need could impair our ability to operate or expand operations in these states.

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

Blackstone acquired our predecessor company during fiscal 2005. We recorded a significant portion of the purchase price as goodwill. At June 30, 2008, we had approximately $689.2 million of goodwill recorded on our financial statements. We expect to recover the carrying value of this goodwill through our future cash flows. On an ongoing basis, we evaluate, based on the fair value of our reporting units, whether the carrying value of our goodwill is impaired. During fiscal 2007, we recorded a $123.8 million ($110.5 million, net of tax benefit) impairment charge to goodwill to reduce the carrying values of our Chicago hospitals to their fair values. If the carrying value of our goodwill is further impaired, we may incur an additional material non-cash charge to earnings.

Additional Risk Factors

See the additional risks related to our business in "Item 7 – Management's Discussion and Analysis of Financial Conditions and Results of Operations – General Trends" which are incorporated by reference in this Item 1A as if fully set forth herein.

Available Information

We currently voluntarily file certain reports with the Securities and Exchange Commission ("SEC"), including annual reports on Form 10-K and quarterly reports on Form 10-Q. The public may read and copy any materials we file with the SEC at the SEC's Public Reference Room at 100 F Street, N.E., Washington, DC 20549. The public may obtain information on the operation of the Public Reference Room by calling the SEC at 1-800-SEC-0330. We are an electronic filer and the SEC maintains an Internet site at http://www.sec.gov that contains the reports and other information we file electronically. Our Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q, Current Reports on Form 8-K and amendments to those reports are also available free of charge on our internet website at www.vanguardhealth.com under "Investor Relations-SEC Filings-SEC Filings on the Edgar Database" as soon as reasonably practicable after such reports are electronically filed with or furnished to the SEC. Please note that our website address is provided as an inactive textual reference only. Also, the information provided on our website is not part of this report, and is therefore not incorporated by reference unless such information is specifically referenced elsewhere in this report.

Item 1B. Unresolved Staff Comments.

Not applicable.

Item 2. Properties.

A listing of our owned acute hospitals is included in Item 1 of this report under the caption "Business-Our Facilities". We also own or lease space for outpatient service facilities complementary to our hospitals and own and operate a limited number of medical office buildings (some of which are joint ventures) associated with our hospitals that are occupied primarily by physicians who practice at our hospitals. The most significant of these complementary outpatient healthcare facilities are two surgery centers in Orange County, California, five diagnostic imaging centers in metropolitan Phoenix, Arizona and a 50% interest in seven diagnostic imaging centers in San Antonio, Texas. Most of these outpatient facilities are in leased facilities, and the diagnostic imaging centers in San Antonio are owned and operated in joint ventures where we have minority partners.

As of June 30, 2008, we leased approximately 53,200 square feet of office space at 20 Burton Hills Boulevard, Nashville, Tennessee, for our corporate headquarters.

Our headquarters, hospitals and other facilities are suitable for their respective uses and are, in general, adequate for our present needs. Our obligations under our senior credit facilities are secured by a pledge of substantially all of our assets, including first priority mortgages on each of our hospitals. Also, our properties are subject to various federal, state and local statutes and ordinances regulating their operation. Management does not believe that compliance with such statutes and ordinances will materially affect our financial position or results from operations.

Item 3. Legal Proceedings.

We operate in a highly regulated and litigious industry. As a result, various lawsuits, claims and legal and regulatory proceedings have been instituted or asserted against us. While we cannot predict the likelihood of future claims or inquiries, we expect that new matters may be initiated against us from time to time. The results of claims, lawsuits and investigations cannot be predicted, and it is possible that the ultimate resolution of these matters, individually or in the aggregate, may have a material adverse effect on our business (both in the near and long term), financial position, results of operations or cash flows. We recognize that, where appropriate, our interests may be best served by resolving certain matters without litigation. If non-litigated resolution is not possible or appropriate with respect to a particular matter, we will continue to defend ourselves vigorously.

Currently pending and recently settled legal proceedings and investigations that are not in the ordinary course of business are set forth below. Where specific amounts are sought in any pending legal proceeding, those amounts are disclosed. For all other matters, where the possible loss or range of loss is reasonably estimable, an estimate is provided. Where no estimate is provided, the possible amount of loss is not reasonably estimable at this time. We record reserves for claims and lawsuits when they are probable and reasonably estimable. For matters where the likelihood or extent of a loss is not probable or cannot be reasonably estimated, we have not recognized in our consolidated financial statements all potential liabilities that may result. We undertake no obligation to update the following disclosures for any new developments.

Sherman Act Antitrust Class Action Litigation – Maderazo, et al v. VHS San Antonio Partners, L.P. d/b/a Baptist Health Systems, et al, Case No. 5:06cv00535 (United States District Court, Western District of Texas, San Antonio Division, filed June 20, 2006 and amended August 29, 2006)

On June 20, 2006, a federal antitrust class action suit was filed in San Antonio, Texas against our Baptist Health System subsidiary in San Antonio, Texas and two other large hospital systems in San Antonio. In the complaint, plaintiffs allege that the three hospital system defendants conspired with each other and with other unidentified San Antonio area hospitals to depress the compensation levels of registered nurses employed at the conspiring hospitals within the San Antonio area by engaging in certain activities that violated the federal antitrust laws. The complaint alleges two separate claims. The first count asserts that the defendant hospitals violated Section 1 of the federal Sherman Act, which prohibits agreements that unreasonably restrain competition, by conspiring to depress nurses' compensation. The second count alleges that the defendant hospital systems also violated Section 1 of the Sherman Act by participating in wage, salary and benefits surveys for the purpose, and having the effect, of depressing registered nurses' compensation or limiting competition for nurses based on their compensation. The class on whose behalf the plaintiffs filed the complaint is alleged to comprise all registered nurses employed by the defendant hospitals since June 20, 2002. The suit seeks unspecified damages, trebling of this damage amount pursuant to federal law, interest, costs and attorneys fees. Currently, the parties are producing documents relating to our efforts to defeat class certification in this suit. We believe that the allegations contained within this putative class action suit are without merit, and we intend to vigorously defend against the litigation.

On the same date that this suit was filed against us in federal district court in San Antonio, the same attorneys filed three other substantially similar putative class action lawsuits in federal district courts in Chicago, Illinois, Albany, New York and Memphis, Tennessee against some of the hospitals in those cities (none of such hospitals being owned by us). The attorneys representing the plaintiffs in all four of these cases said in June 2006 that they may file similar complaints in other jurisdictions and in December 2006 they brought a substantially similar class action lawsuit against various hospitals in the Detroit, Michigan metropolitan area. Since representatives of the Service Employees International Union joined plaintiffs' attorneys in announcing the filing of all four complaints on June 20, 2006, and as has been reported in the media, we believe that SEIU's involvement in

these actions appears to be part of a corporate campaign to attempt to organize nurses in these cities, including San Antonio. The nurses in our hospitals in San Antonio are currently not members of any union.

Medicare Secondary Payor Act Litigation - Brockovich, on behalf of the United States of America v. Vanguard Health Systems, Inc., et al. Case No. SACV06-547 JVS(MLGx) (United States District Court, Central District of California, Southern Division, filed June 9, 2006)

In June 2006, Plaintiff Erin Brockovich, purportedly on behalf of the United States of America, filed a civil complaint in United States District Court in California claiming our violation of the Medicare Secondary Payer Act. In the complaint plaintiff alleged that we have inappropriately received and retained reimbursement from Medicare for treatment given to certain unidentified patients of our facilities whose injuries were caused by us as a result of unidentified and unadjudicated incidents of medical malpractice. Also, in June 2006 this same plaintiff filed identical lawsuits against more than 20 other companies that own hospitals and convalescent homes in California. In the case against us, plaintiff is seeking damages of twice the amount that defendants were allegedly obligated to pay or reimburse Medicare in connection with the treatment in question under the Medicare Secondary Payor Act, plus interest, together with plaintiff's costs and fees, including attorneys' fees. On July 25, 2006, we filed with the court a motion to dismiss this litigation (1) for failure to state a claim in so far as plaintiff has no standing to bring this action since she alleges no injury to herself as a result of our alleged acts and (2) for failure to state a cause of action since no court has ever held that claims may be brought under the Medicare Secondary Payer Act based upon unadjudicated and unidentified tort claims. On October 24, 2006, the United States District Court granted our July 25, 2006 motion to dismiss this litigation on the grounds that plaintiff Erin Brockovich lacked constitutional standing to bring this action. The District Court dismissed the litigation with prejudice because the deficiencies could not be cured by amendment of plaintiff's compliant. On November 17, 2006, plaintiff appealed the District Court's order dismissing this litigation to the United States Court of Appeals for the Ninth Circuit. On June 10, 2008, the Ninth Circuit granted plaintiff's motion for voluntary dismissal of this appeal which has terminated this litigation.

Claims in the ordinary course of business.

We are also subject to claims and lawsuits arising in the ordinary course of business, including potential claims related to care and treatment provided at our hospitals and outpatient services facilities. Although the results of these claims and lawsuits cannot be predicted with certainty, we believe that the ultimate resolution of these ordinary course claims and lawsuits will not have a material adverse effect on our business, financial condition or results of operations.

Item 4. Submission of Matters to a Vote of Security Holders.

No matters were submitted to a vote of stockholders during the fourth quarter ended June 30, 2008, except that the holders of 100% of our outstanding common stock approved Amendments 4 and 5 to our 2004 Stock Incentive Plan pursuant to a written consent dated May 6, 2008. These Amendments increased the total number of our shares which may be issued under the Plan from 98,120 to 101,117 and expanded participants in the Plan from solely our employees to also our non-employed directors and those natural persons who perform services for us like consultants.

PART II

Item 5. Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities.

There is no established public trading market for our common stock. At September 1, 2008, there were five holders of record of our common stock. These holders are VHS Holdings LLC and four investment funds affiliated with Blackstone.

We have not declared or paid any dividends on its common stock in its two most recent fiscal years. We intend to retain all current and foreseeable future earnings to support operations and finance expansion. Our senior secured credit facility and the indentures governing our long-term indebtedness restrict our ability to pay cash dividends on our common stock.

There have been no unregistered sales of our equity securities during the quarter ended June 30, 2008.

Information regarding our equity compensation plans is set forth in this report under "Item 12 – Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters – Equity Compensation Plan Information", which information is incorporated herein by reference.

Item 6. Selected Financial Data.

The following table sets forth our selected historical financial and operating data for, or as of the end of, each of the five years ended June 30, 2008 (including the predecessor and successor periods). The selected historical financial data as of and for the predecessor year ended June 30, 2004, the combined predecessor and successor year ended June 30, 2005 and the years ended June 30, 2006, 2007 and 2008 were derived from our audited consolidated financial statements that have been audited by Ernst & Young LLP, an independent registered public accounting firm. Comparability of the selected historical financial and operating data has been impacted by the timing of acquisitions completed during fiscal 2005. Dispositions completed during fiscal 2006 and 2007 have been excluded from all periods presented. See "Executive Overview" included in "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations." This table should be read in conjunction with the consolidated financial statements and notes thereto.

	Predecessor Year Ended June 30, 2004	Combined Basis Year Ended June 30, 2005	Year Ended June 30, 2006	Year ended June 30, 2007	Year ended June 30, 2008	Predecessor July 1, 2004 through September 22, 2004	Successor September 23, 2004 through June 30, 2005
			(Dollars in millions, except Operating Data)				
Statement of Operations Data:							
Total revenues	$ 1,583.1	$ 2,037.3	$ 2,418.6	$ 2,580.7	$ 2,790.7	$ 397.9	$ 1,639.4
Costs and expenses:							
Salaries and benefits (includes stock compensation of $0.1, $97.4, $1.7, $1.2, $2.5, $96.7 and $0.7, respectively)	633.5	909.2	991.4	1,067.9	1,152.7	248.2	661.0
Supplies	253.2	336.8	394.1	421.8	434.5	63.7	273.1
Medical claims expense	211.8	237.2	270.3	297.0	328.2	55.0	182.2
Provision for doubtful accounts	104.7	133.0	156.8	175.2	205.6	27.8	105.2
Other operating expenses	222.0	288.8	353.0	375.0	405.8	57.3	231.5
Depreciation and amortization	58.8	75.7	100.3	118.6	131.0	16.0	59.7
Interest, net	41.4	82.3	103.8	123.8	122.1	9.0	73.3
Debt extinguishment costs	4.9	62.2	0.1	—	—	62.2	—
Minority interests	(2.5)	(0.3)	2.6	2.6	3.0	(0.5)	0.2
Merger expenses	—	23.3	—	—	—	23.1	0.2
Impairment loss	—	—	—	123.8	—	—	—
Other expenses	(2.3)	3.6	6.5	0.2	6.5	0.4	3.2
Subtotal	1,525.5	2,151.8	2,378.9	2,705.9	2,789.4	562.2	1,589.6
Income (loss) from continuing operations before income taxes	57.6	(114.5)	39.7	(125.2)	1.3	(164.3)	49.8
Income tax expense (benefit)	21.9	(34.7)	17.8	(11.6)	1.7	(52.2)	17.5
Income (loss) from continuing operations	35.7	(79.8)	21.9	(113.6)	(0.4)	(112.1)	32.3
Income (loss) from discontinued operations, net of taxes	4.4	1.7	(9.0)	(19.1)	(0.3)	1.4	0.3
Net income (loss)	40.1	(78.1)	12.9	(132.7)	(0.7)	(110.7)	32.6
Preferred dividends	(4.0)	(1.0)	—	—	—	(1.0)	—
Net income (loss) attributable to common stockholders	$ 36.1	$ (79.1)	$ 12.9	$ (132.7)	$ (0.7)	$ (111.7)	$ 32.6
Balance Sheet Data:							
Assets	$ 1,427.8	$ 2,471.7	$ 2,650.5	$ 2,538.1	$ 2,582.3		$ 2,471.7
Long-term debt, including current portion	623.5	1,357.1	1,519.2	1,528.7	1,537.5		1,357.1
Payable-in-Kind Preferred Stock	61.0	—	—	—	—		—
Working capital	162.7	77.7	193.0	156.4	217.8		77.7
Other Financial Data:							
Capital expenditures	$ 136.1	$ 224.2	$ 275.5	$ 164.3	$ 121.6	$ 27.1	$ 197.1
Cash provided by operating activities	109.0	201.8	149.3	123.3	173.1	78.8	123.0
Cash used in investing activities	(225.1)	(324.3)	(245.4)	(118.5)	(143.8)	(50.0)	(274.3)
Cash provided by (used in) financing activities	139.0	151.6	140.5	(8.3)	(7.8)	(20.0)	171.6
Operating Data-continuing operations: (unaudited)							
Number of hospitals at end of period	12	15	15	15	15		
Number of licensed beds at end of period (a)	3,133	3,907	3,937	4,143	4,181		
Discharges (b)	126,356	147,798	162,446	166,873	169,668		
Adjusted discharges - hospitals (c)	186,464	231,322	261,056	264,698	270,076		
Net revenue per adjusted discharge – hospitals (d)	$ 6,455	$ 6,859	$ 7,319	$ 7,766	$ 8,110		
Patient days (e)	519,589	623,333	701,307	721,832	734,838		
Adjusted patient days – hospitals (f)	766,760	975,593	1,127,024	1,144,989	1,169,710		
Average length of stay (days) (g)	4.1	4.2	4.3	4.3	4.3		
Inpatient surgeries (h)	29,816	33,424	36,606	37,227	37,538		
Outpatient surgeries (i)	54,180	67,944	76,437	76,606	73,339		
Emergency room visits (j)	430,794	504,172	554,250	572,946	588,491		
Occupancy rate (k)	45.5%	48.5%	49.2%	48.2%	48.5%		
Average daily census (l)	1,420	1,708	1,921	1,978	2,008		
Member lives (m)	142,200	146,700	146,200	145,600	149,600		
Medical claims expense percentage (n)	72.1%	71.1%	72.1%	74.0%	72.9%		

(a) Licensed beds are those beds for which a facility has been granted approval to operate from the applicable state licensing agency.

(b) Discharges represent the total number of patients discharged (in the facility for a period in excess of 23 hours) from our hospitals and is used by management and certain investors as a general measure of inpatient volumes.

(c) Adjusted discharges-hospitals is used by management and certain investors as a general measure of combined inpatient and outpatient volumes. Adjusted discharges-hospitals is computed by multiplying discharges by the sum of gross hospital inpatient and outpatient revenues and then dividing the result by gross hospital inpatient revenues. This computation enables management to assess hospital volumes by a combined measure of inpatient and outpatient utilization.

(d) Net revenue per adjusted discharge-hospitals is calculated by dividing hospital net patient revenues by adjusted discharges-hospitals and measures the average net payment expected to be received for a patient's stay in the hospital.

(e) Patient days represent the number of days (calculated as overnight stays) our beds were occupied by patients during the periods.

(f) Adjusted patient days-hospitals is calculated by multiplying patient days by the sum of gross hospital inpatient and outpatient revenues and then dividing the result by gross hospital inpatient revenues. This computation is an indicator of combined inpatient and outpatient volumes.

(g) Average length of stay represents the average number of days an admitted patient stays in our hospitals.

(h) Inpatient surgeries represent the number of surgeries performed in our hospitals where overnight stays are necessary.

(i) Outpatient surgeries represent the number of surgeries performed at hospitals or ambulatory surgery centers on an outpatient basis (patient overnight stay not necessary).

(j) Emergency room visits represent the number of patient visits to a hospital or freestanding emergency room where treatment is received, regardless of whether an overnight stay is subsequently required.

(k) Occupancy rate represents the percentage of hospital licensed beds occupied by patients. Occupancy rate provides a measure of the utilization of inpatient rooms.

(l) Average daily census represents the average number of patients in our hospitals each day during our ownership.

(m) Member lives represent the total number of enrollees in PHP, AAHP and MHP as of the end of the respective period.

(n) Medical claims expense percentage is calculated by dividing medical claims expense by premium revenues.

Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations.

You should read the following discussion together with our historical financial statements and related notes included elsewhere herein and the information set forth under "Item 6. Selected Financial Data." The discussion contains forward-looking statements that involve risks and uncertainties. For additional information regarding some of the risks and uncertainties that affect our business and the industry in which we operate, please read "Item 1A. - Risk Factors" included elsewhere herein. Our actual results may differ materially from those estimated or projected in any of these forward-looking statements.

Executive Overview

As of June 30, 2008, we owned and operated 15 hospitals with a total of 4,181 licensed beds, and related outpatient service facilities complementary to the hospitals in San Antonio, Texas, metropolitan Phoenix, Arizona, metropolitan Chicago, Illinois, and Massachusetts, and two surgery centers in Orange County, California. On October 1, 2006, we sold our three California hospitals with combined 491 licensed beds to subsidiaries of Prime Healthcare, Inc. for a base purchase price of $44.0 million, prior to adjustments for working capital items included in the sale and transaction expenses. The operating results of the California hospitals are classified as discontinued operations in our consolidated statements of operations for all periods presented. In June 2007, we ceased providing acute care services at Phoenix Memorial Hospital ("PMH") and began leasing certain floors of the building to various third party healthcare providers. As a result, the acute care operating results of PMH are also classified as discontinued operations in our consolidated statements of operations for all periods presented.

As of June 30, 2008, we also owned three health plans as set forth in the following table.

Health Plan	Location	June 30, 2008 Membership
Phoenix Health Plan ("PHP") – managed Medicaid	Arizona	103,400
Abrazo Advantage Health Plan ("AAHP") – managed Medicare and Dual Eligible	Arizona	3,200
MacNeal Health Providers ("MHP") – capitated outpatient and physician services	Illinois	43,000
		149,600

Our objective is to provide high-quality, cost-effective healthcare services through an integrated delivery platform serving the needs of the communities in which we operate. We focus our business development efforts and operations on hospitals and other related healthcare facilities where we see an opportunity to improve operating performance and profitability and increase market share.

Operating Environment

We believe that the operating environment for hospital operators is currently undergoing a significant change that presents both challenges and opportunities for us. In order to remain competitive in the markets we serve, we must adapt our operating strategies to not only accommodate changing environmental factors but to make them operating advantages for us relative to our peers. These factors will require continued focus on quality of care initiatives. As consumers become more involved in their healthcare decisions, we believe perceived quality of care will become an even greater factor in determining where physicians choose to practice and where patients choose to receive care. In the following paragraphs we discuss some of the challenges that we currently face and that we expect to become more prominent during the foreseeable future.

Pay for Performance Reimbursement

Many payers, including Medicare and several large managed care organizations, currently require providers to report certain quality measures in order to receive the full amount of payment increases that were awarded automatically in the past. For federal fiscal year 2009, Medicare expanded the number of quality measures to be reported to 42 compared to 30 during federal fiscal year 2008, 21 during federal fiscal year 2007 and 10 during

federal fiscal year 2006. These measures include risk-adjusted outcomes measures such as 30-day mortality measures for patients who suffered a heart attack, heart failure or pneumonia; additional measures related to patients who undergo surgical procedures such as hospital-acquired infections data; and several patient satisfaction indicators. Many large managed care organizations have developed quality measurement criteria that are similar to or even more stringent than these Medicare requirements. We have implemented clinical systems upgrades to enable us to report these measures and will continue to invest in further upgrades as necessary to comply with reporting requirements.

While current payer guidelines are based upon the reporting of quality measures, we believe it is only a matter of time until the quality measures themselves determine reimbursement rates for hospital services. For example, on April 13, 2007, CMS proposed reforms in the hospital inpatient prospective payment system that would implement a provision of the Deficit Reduction Act of 2005 ("DRA") that takes the first steps toward preventing Medicare from giving hospitals higher payment for the additional costs of treating a patient that acquires a medical condition (including an infection) during a hospital stay. The DRA required CMS to select at least two conditions that are (1) high cost, high volume or both; (2) assigned to a higher rate of reimbursement when present as a secondary diagnosis; and (3) are reasonably preventable through application of evidence-based guidelines. These rules were adopted in August 2007. Under the rules, beginning in federal fiscal year 2009 (which commences October 1, 2008) cases with these conditions would not be paid at a higher reimbursement rate unless they were present on admission. The initial rules identified eight conditions, including three serious preventable events (sometimes called "never events"), that meet the statutory criteria. In April 2008, CMS proposed expanding the current list of eight hospital-acquired conditions to seventeen for federal fiscal year 2009. Thus, our ability to demonstrate quality of care in our hospitals could significantly impact our future operating results.

Physician Integration

Our ability to attract skilled physicians to our hospitals is critical to our success. We have adopted several significant physician recruitment goals with primary emphasis on recruiting physicians specializing in family practice, internal medicine, obstetrics and gynecology, cardiology, neurology, orthopedics and inpatient hospital care (hospitalists). To achieve our recruitment goals, we expect to recruit over 140 new physicians to the communities served by our hospitals during our fiscal year June 30, 2009 through employment agreements, relocation agreements or physician practice acquisitions. We have invested heavily in the infrastructure necessary to coordinate our physician recruitment strategies and manage our physician operations. The costs associated with recruiting, integrating and managing such a large number of new physicians will have a negative impact on our operating results and cash flows during our fiscal year ended June 30, 2009. However, we expect to realize improved clinical quality and service expansion capabilities from this initiative that will positively impact our operating results over the long-term. The perceived quality of care at our hospitals will be a key determining factor in whether these physicians agree to partner with us. Similar to hospital reimbursement, payers are developing plans to transform physician reimbursement to a pay for performance basis. In a hospital setting, many of the quality measures that apply to nursing care also apply to physician care. This interdependence aligns the quality of care focus of physicians and hospitals in order that both can receive equitable compensation for services provided.

We also face the risk of heightened physician reimbursement pressures that could cause physicians to seek to increase revenues by competing with hospitals for inpatient business. Additional competition from physician-owned specialty hospitals could adversely impact our future operating results. Again, we expect to mitigate this risk by achieving a competitive advantage with our quality of care initiatives that new specialty hospitals might not be equipped to implement. These pressures may also result in our employing more physicians or pursuing additional opportunities to partner with physicians to provide healthcare services to the communities we serve.

Nursing Salary Pressures

In order to demonstrate high quality services, we must hire and retain nurses who share our ideals and beliefs and who have access to the training necessary to implement our clinical quality initiatives. Given the nationwide nursing shortage and the particular limited nursing availability in the Phoenix area, we expect continued pressures on nursing salaries and benefits. These pressures include higher than normal base wage increases, flexible working hours and other benefits and higher nurse to patient ratios necessary to improve quality of care. Our clinical quality initiatives also require additional nurse training programs that increase salaries and benefits costs. We have

incurred and will continue to incur significant training costs as nurses learn to utilize our new information technology tools that allow us to monitor and report quality performance indicators. Becoming the employer of choice for nurses requires upfront human resource investments that could negatively affect operating results in the short-term. We may also be limited in our ability to adjust staffing levels in periods of lower than expected volumes. However, we expect that reducing turnover and improving the skill sets of our nurses will reduce our reliance on contract labor and result in improved quality of care and increased revenues in the long-term.

We expect to increase our current level of trained nursing professionals by expanding our comprehensive nurse recruiting and retention program. This program includes the following key components, among others:

- Nursing school in San Antonio
- Foreign nurse recruiting initiatives
- Tuition reimbursement and internal training to promote career advancement opportunities, including specialization qualification
- Extern programs and campus events to network with students
- Preceptor and other mentoring programs
- Expansion of orientation programs and employee involvement initiatives
- Performance leadership training for managers and directors
- Flexible work hours for nurses
- Employee safety initiatives
- Competitive pay and benefits and nursing recognition programs

We operate the Baptist Health System School of Health Professions ("SHP") in San Antonio, which offers seven different healthcare educational programs with its greatest enrollment in its professional nursing program. The SHP trains approximately 450 students each year in San Antonio. The majority of these students have historically chosen permanent employment with our hospitals. SHP expects its enrollment to increase by approximately 10% for fall 2008 compared to fall 2007. We have begun the application process to transition SHP's current diploma program to a degree granting program that we expect will be more attractive to potential students. Some of the students are provided with Vanguard-funded scholarships that cover tuition, books and fees in return for a commitment to work at one of our hospitals for a defined period of time. Should we be unsuccessful in our attempts to maintain adequate nursing staff for our present and future needs, our future operating results could be materially adversely impacted.

Competition for Outpatient Services

With advances in medical technologies and pharmaceuticals, many services once provided in an inpatient setting are now available in an outpatient setting. The redirection of services to outpatient settings is also influenced by pressures from payers to reduce costs and by patients who seek convenience. Our hospitals and many other acute hospitals have struggled to retain or increase outpatient business resulting from this inpatient to outpatient shift. Competition for outpatient services has increased significantly with the proliferation of surgery centers, outpatient imaging centers and outpatient laboratories that are often viewed as more convenient to physicians and patients. While we remain at risk for further migration of our hospital-based outpatient services to other facilities we do not own, we expect to mitigate these risks with our quality of care initiatives, physician integration strategies and capital projects to improve the design of and access to outpatient service areas in our hospitals.

Implementation of our Clinical Quality Initiatives

In the previous paragraphs we discuss the industry trends that are integral to our future success and how quality of care is the most important component in achieving success in those areas. While we are in the middle stages of implementing our expanded clinical quality initiatives, we believe that the following programs currently in place represent key building blocks to the implementation of a successful strategy.

- Monthly review of the 30 quality indicators prescribed by CMS for federal fiscal year 2008 with further expansion for new quality indicators set forth by CMS for upcoming federal fiscal year 2009
- Rapid response teams in place at all of our hospitals to provide more timely and efficient care
- Hourly nursing rounds in place at most of our hospitals

- Engagement of an external group to conduct unannounced mock Joint Commission surveys
- Alignment of hospital management incentive compensation with quality performance indicators
- Additional staffing to collect and report quality information and to facilitate action plans to address areas for improvement
- Common information system in place at all hospitals to report quality indicators
- Common information system at departmental level to achieve efficiencies in delivering care and to feed data to the common reporting system (ancillary department and physician portal components implemented, with remaining patient care and advanced physician components to be implemented in stages during the next three years)
- Formation of Physician Advisory Councils at each of our hospitals to align the quality goals of our hospitals with the physicians who practice in our hospitals

Revenue/Volume Trends

Our revenues depend upon inpatient occupancy levels, outpatient procedures performed at our facilities, the ancillary services and therapy programs ordered by physicians and provided to patients and our ability to successfully negotiate appropriate payment rates for these services with third party payers.

Sources of Revenues

The primary sources of our revenues include various managed care payers including managed Medicare and Medicaid programs, the traditional Medicare program, various state Medicaid programs, commercial health plans and the patients themselves. We are typically paid much less than our gross charges regardless of the payer source. Revenues from governmental programs are based upon complex reimbursement methodologies that require us to extensively monitor compliance with regulations including billing, coding and cost reimbursement items. These regulations change frequently and require us to adjust our processes, procedures and information systems in order to ensure that we bill these programs correctly and record related revenues appropriately. Revenues from managed care programs are typically based on contractually-stated rates or discounts we have negotiated with the various managed care plans. The contracts often contain exclusions, carve-outs, performance criteria and other guidelines that also require our constant focus and attention. Private patients who are members of managed care plans are not required to pay us for their healthcare services other than the coinsurance and deductible portions of their plan coverage calculated after managed care discounts have been applied. A more detailed description of these revenue sources is set forth in Part I, Item 1, "Business", "Reimbursement for Services Provided" in this document.

The following table sets forth the percentages of net patient revenues by payer for the years ended June 30, 2006, 2007 and 2008.

	Year ended June 30,		
	2006	2007	2008
Medicare	28.2%	26.4%	26.2%
Medicaid	7.1%	8.6%	7.6%
Managed Medicare (1)	n/a	12.8%	14.0%
Managed Medicaid (1)	n/a	7.5%	7.5%
Managed care	51.2%	32.0%	35.0%
Self pay	9.2%	9.7%	8.6%
Other	4.3%	3.0%	1.1%
Total	100%	100.0%	100.0%

(1) Managed Medicare and Managed Medicaid net patient revenues were not separately identifiable and are included in managed care net patient revenues for the year ended June 30, 2006.

Volumes by Payer

During the years ended June 30, 2007 and 2008, we experienced a 2.7% and 1.7% increase in discharges from continuing operations and a 1.4% and 2.0% increase in hospital adjusted discharges from continuing operations, respectively. The following table provides details of discharges from continuing operations by payer for the years ended June 30, 2006, 2007 and 2008.

	Year ended June 30,					
	2006		2007		2008	
Medicare	47,352	29.2%	46,452	27.8%	47,040	27.7%
Medicaid	20,514	12.6%	22,518	13.5%	20,195	11.9%
Managed Medicare (1)	n/a	n/a	23,339	14.0%	26,040	15.3%
Managed Medicaid (1)	n/a	n/a	18,579	11.1%	19,893	11.7%
Managed care	87,910	54.1%	48,481	29.1%	50,040	29.5%
Self pay	5,169	3.2%	6,181	3.7%	5,854	3.5%
Other	1,501	0.9%	1,323	0.8%	606	0.4%
Total	162,446	100.0%	166,873	100.0%	169,668	100.0%

(1) Managed Medicare and Managed Medicaid discharges were not separately identifiable and are included in managed care discharges for the year ended June 30, 2006.

We continue to experience limited volume growth due to stagnant demand for inpatient healthcare services and increased competition for available patients. Additionally, decreases in certain subacute services as a result of regulatory changes and reduced demand for elective procedures as a result of changes in patient insurance coverage continue to weaken our inpatient and outpatient volumes. We expect our volumes to improve more significantly over the long-term as a result of our quality of care and service expansion initiatives and other market-specific strategies.

Traditional Medicare volumes have shifted to managed Medicare volumes during the current year period. These shifts have resulted in increased bad debts and increased exposure to collection risks for patient co-insurance and deductible amounts, which are subject to cost reimbursement under the traditional Medicare program but not under many managed Medicare plans. Our operating results were positively impacted by the lower combined Medicaid and managed Medicaid volumes and higher managed care volumes during the current year compared to the prior year.

Payer Reimbursement Trends

In addition to the volume factors described above, patient mix, acuity factors and pricing trends affect our patient service revenues. Net patient revenue per adjusted hospital discharge from continuing operations was $7,319, $7,766 and $8,110 for the years ended June 30, 2006, 2007 and 2008, respectively. Net patient revenue per adjusted hospital discharge would have been $7,718 for the year ended June 30, 2007 absent the Texas upper payment limit ("UPL") revenues recorded during fiscal 2007 that were not recorded during fiscal 2008. The Texas UPL program is discussed further below. These increases reflect improved reimbursement for services provided under negotiated managed care contracts and improved Medicare reimbursements. However, due to consolidation of managed care plans and federal and state efforts to decrease Medicare and Medicaid spending, our ability to recognize improved reimbursement above or equal to rates recognized in previous periods is becoming more difficult. We cannot assure you that future reimbursement rates, even if improved, will sufficiently cover potential increases in the cost of providing healthcare services to our patients.

During fiscal 2007 we were approved to receive payments under the Bexar County, Texas UPL Medicaid program. UPL programs allow private hospitals to enter into indigent care affiliation agreements with governmental

entities. Within the parameters of these programs, private hospitals expand charity care services to indigent patients and alleviate expenses for the governmental entity. The governmental entity is then able to utilize its tax revenue to fund the Medicaid program for private hospitals. During fiscal 2007 we recorded UPL-related revenues and income from continuing operations before income taxes of $11.6 million and $6.0 million, respectively, that related to services provided during fiscal 2006 and prior. We received a total cash payment of $18.7 million in April 2007, representing amounts earned under the UPL program for all periods through March 31, 2007. Since the beginning of our participation with this Texas UPL program, we have recognized $25.6 million of revenues and $11.6 million of income from continuing operations before income taxes directly related to the program. CMS began reviewing the operations of this private hospital UPL program after the state of Texas made the first payments in April 2007. It is customary for CMS to review Medicaid UPL payment programs. In October 2007, the state of Texas halted all funding of its private hospital UPL programs due to the deferral by CMS of certain federal Medicaid payments to the State of Texas. In August 2008, the state lifted its moratorium on payments under this UPL program, and we received a payment of approximately $12.1 million. While the possible termination of future benefits under this UPL program is not material to our financial statements, should the federal, state or county governments require recoupment of the previous matching funds paid to us, our results of operations and cash flows could be materially adversely impacted.

Premium Revenues

We recognize premium revenues from our three health plans, PHP, AAHP and MHP. AAHP commenced operations on January 1, 2006 primarily to provide healthcare services (including Medicare Part D) to those individuals eligible for both Medicare and Medicaid benefits based on age and income levels. As of June 30, 2008, approximately 3,200 members were enrolled in this program, most of whom were previously enrolled in PHP. PHP's membership increased to approximately 103,400 at June 30, 2008 compared to approximately 98,300 at June 30, 2007 and 96,700 at June 30, 2006. Premium revenues from these three plans increased by $48.8 million or 12.2% during fiscal 2008 compared to fiscal 2007 after an increase of $26.4 million or 7.0% from fiscal 2006 to 2007. These increases resulted primarily from the increased number of enrollees period over period. PHP also experienced period over period increases in per member per month reimbursement as a result of annual rate increases that went into effect on October 1, 2007 and 2006. In September 2007, the Arizona Health Care Cost Containment System ("AHCCCS") exercised its final one-year renewal option under its contract with PHP that commenced on October 1, 2003, which extended the current contract through September 30, 2008. In May 2008, PHP was awarded a new contract with AHCCCS effective for the three-year period beginning October 1, 2008 and ending September 30, 2011. AHCCCS has the option to renew the new contract, in whole or in part, for two additional one-year periods commencing on October 1, 2011 and on October 1, 2012. The new contract will cover the existing three counties under the current contract plus an additional six Arizona counties: Apache, Coconino, Mohave, Navajo, Pima and Yavapai. We expect a significant increase in PHP membership and premium revenues under the new contract but are unable to determine the impact of the new contract on our future operating results and cash flows at this time. The Centers for Medicare and Medicaid Services ("CMS") renewed its contract with AAHP for a one-year period effective January 1, 2008. If AHCCCS terminates PHP's contract due to lack of funding or for other reasons, our future liquidity, operating results and cash flows would be materially reduced.

General Trends

The following paragraphs discuss recent trends that we believe are significant factors in our current and/or future operating results and cash flows. While these trends may involve certain factors that are outside of our control, the extent to which these trends affect us and our ability to manage the impact of these trends play vital roles in our current and future success. In many cases, we are unable to predict what impact these trends, if any, will have on us.

Accounts Receivable Collection Risks Leading to Increased Bad Debts

Similar to other companies in the hospital industry, we face continued pressures in collecting outstanding accounts receivable primarily due to volatility in the uninsured and underinsured populations in the markets we serve. The following table provides a summary of our accounts receivable payer class mix as of each respective period presented.

June 30, 2006	0-90 days	91-180 days	Over 180 days	Total
Medicare	17.0%	1.0%	0.6%	18.6%
Medicaid	7.4%	2.1%	1.3%	10.8%
Managed Medicare	7.5%	1.0%	0.4%	8.9%
Managed Medicaid	5.9%	1.0%	0.6%	7.5%
Managed Care	24.3%	2.4%	1.2%	27.9%
Self Pay[1]	10.7%	9.4%	2.2%	22.3%
Other	2.7%	0.9%	0.4%	4.0%
Total	75.5%	17.8%	6.7%	100.0%

June 30, 2007	0-90 days	91-180 days	Over 180 days	Total
Medicare	15.0%	0.6%	0.6%	16.2%
Medicaid	7.5%	2.0%	1.0%	10.5%
Managed Medicare	7.6%	0.7%	0.6%	8.9%
Managed Medicaid	5.3%	0.6%	0.7%	6.6%
Managed Care	25.1%	2.7%	1.6%	29.4%
Self-Pay[2]	10.2%	8.0%	1.7%	19.9%
Self-Pay after primary[3]	1.8%	2.8%	1.1%	5.7%
Other	1.8%	0.6%	0.4%	2.8%
Total	74.3%	18.0%	7.7%	100.0%

June 30, 2008	0-90 days	91-180 days	Over 180 days	Total
Medicare	15.3%	0.6%	0.4%	16.3%
Medicaid	8.0%	2.2%	1.3%	11.5%
Managed Medicare	8.5%	0.6%	0.5%	9.6%
Managed Medicaid	5.6%	0.4%	0.3%	6.3%
Managed Care	25.8%	2.6%	1.9%	30.3%
Self-Pay[2]	9.3%	7.6%	1.1%	18.0%
Self-Pay after primary[3]	1.9%	2.6%	1.0%	5.5%
Other	1.6%	0.5%	0.4%	2.5%
Total	76.0%	17.1%	6.9%	100.0%

(1) Includes uninsured patients and those patient co-insurance and deductible amounts for which payment has been received from the primary payer. If primary payment has not been received for an account, the patient co-insurance and deductible amounts remain classified in the primary payer category. The breakout between uninsured accounts and patient co-insurance and deductible amounts is not available for this period.
(2) Includes uninsured patient accounts only.
(3) Includes patient co-insurance and deductible amounts after payment has been received from the primary payer.

Our combined allowance for doubtful accounts and allowance for charity care on a consolidated basis covered 91.4% and 96.3% of self-pay accounts receivable as of June 30, 2007 and 2008, respectively. Our combined allowance for doubtful accounts and allowance for charity care from continuing operations covered 87.5% and 95.2% of self-pay accounts receivable from continuing operations as of June 30, 2007 and June 30, 2008, respectively.

While self-pay accounts receivable as a percentage of total accounts receivable at June 30, 2008 decreased relative to the prior year period, self-pay accounts receivable dollars have remained flat compared to the prior year period and have become more difficult to collect. The volume of self-pay accounts receivable remains sensitive to a combination of factors including price increases, acuity of services, higher levels of patient deductibles and co-insurance under managed care plans, economic factors and the increased difficulties of uninsured patients who do not qualify for charity care programs to pay for escalating healthcare costs. We have implemented policies and procedures designed to expedite upfront cash collections and promote repayment plans from our patients. Our upfront cash collections from continuing operations increased 4.8% during fiscal 2008 compared to fiscal 2007. However, we believe bad debts will remain a significant risk for us and the rest of the hospital industry during the foreseeable future.

Charity Care and Self-Pay Discount Programs

We do not pursue collection of amounts due from uninsured patients that qualify for charity care under our guidelines (currently those uninsured patients whose incomes are equal to or less than 200% of the current federal poverty guidelines set forth by the Department of Health and Human Services). We exclude charity care accounts from revenues when we determine that the account meets our charity care guidelines. We deducted $71.1 million, $86.1 million and $86.1 million of charity care from total revenues during the years ended June 30, 2006, 2007 and 2008, respectively. Healthcare services provided to undocumented aliens that qualify for border funding reimbursement, net of payments received, represented $10.5 million, $19.4 million and $29.6 million of the charity care deductions during the years ended June 30, 2006, 2007 and 2008, respectively. Payments received for border funding claims were $0.9 million, $2.0 million and $3.8 million during the years ended June 30, 2006, 2007 and 2008, respectively. We expect that border funding qualification will end after December 31, 2008 and there is no assurance that additional funding will be available for these services.

Medicaid Funding Cuts

Many states, including certain states in which we operate, have periodically reported budget deficits as a result of increased costs and lower than expected tax collections. Health and human service programs, including Medicaid and similar programs, represent a significant component of state spending. To address these budgetary concerns, certain states have decreased funding for these programs and other states may make similar funding cuts. These cuts may include tightened participant eligibility standards, reduction of benefits, enrollment caps or payment reductions. Additionally, pressure exists at the federal level to reduce Medicaid matching funds provided to states. CMS issued a final rule in May 2007 that was expected to reduce Medicaid funding by approximately $12 to $20 billion over five years. Congress has twice enacted bills that placed moratoriums on this rule until April 2009. However, if the second moratorium expires as scheduled in April 2009, this final rule would go into effect and could significantly negatively impact state Medicaid funding. We are unable to assess the financial impact on our business of state and federal funding cuts at this time.

Volatility of Professional Liability Costs

We maintained professional and general liability insurance coverage through a wholly-owned captive insurance subsidiary for individual claims incurred through May 31, 2006 up to $10.0 million. For claims incurred subsequent to May 31, 2006, we self-insure the first $9.0 million per occurrence, and the captive subsidiary insures the next $1.0 million per occurrence. We maintain excess insurance coverage with independent third party carriers on a claims-made basis for individual claims exceeding $10.0 million up to $75.0 million, but limited to total annual payments of $65.0 million in the aggregate. The total cost of our professional and general liability insurance is sensitive to the volume and severity of cases reported. Malpractice premiums have adversely affected the ability of physicians to obtain malpractice insurance at reasonable rates in certain of our markets, particularly in metropolitan Chicago, resulting in physicians relocating to different geographic areas. In the event physicians practicing in our

hospitals are unable to obtain adequate malpractice insurance coverage, our hospitals are likely to incur a greater percentage of the amounts paid to claimants. Our professional liability exposures also increase when we employ physicians. As a result of our current plans to employ more than 90 new physicians during our fiscal year ended June 30, 2009, our exposure to professional and general liability risks could increase significantly in future years. On the other hand, some states in which we operate, including Texas and Illinois, have passed in recent years tort reform legislation to place limits on non-economic damages. However, in November 2007 a judge in the Illinois Cook County Circuit Court declared that these Illinois malpractice limits were unconstitutional under state law. While such ruling is being considered in an appeal to the Illinois Supreme Court, we understand that the trial courts are not enforcing the non-economic damages limits under that Illinois tort reform statute. Additionally, in Texas an action has been brought to declare its tort reform legislation unconstitutional under federal law. Thus, while we have taken multiple steps at our facilities to reduce our professional liability exposures, without significant legislation (not later declared unconstitutional) to curb the size of malpractice judgments in the states in which we operate, our insurance costs may increase in the future.

Increased Cost of Compliance in a Heavily Regulated Industry

We conduct business in a heavily regulated industry. Accordingly, we maintain a comprehensive, company-wide compliance program to address healthcare regulatory and other compliance requirements. This compliance program includes, among other things, initial and periodic ethics and compliance training, a toll-free reporting hotline for employees, annual fraud and abuse audits and annual coding audits. The organizational structure of our compliance program includes oversight by our board of directors and a high-level corporate management compliance committee. Our Senior Vice President of Compliance and Ethics reports jointly to our Chairman and Chief Executive Officer and to our board of directors, serves as our Chief Compliance Officer and is charged with direct responsibility for the day-to-day management of our compliance program. We also have regional compliance officers in our markets that are 100% dedicated to compliance duties. The financial resources necessary for program oversight, internal enforcement and periodic improvements to our program continue to grow, especially when we add new features to our program or engage external resources to assist with these highly complex matters.

Critical Accounting Policies

Our consolidated financial statements have been prepared in accordance with accounting principles generally accepted in the United States. In preparing these financial statements, we make estimates and assumptions that affect the reported amounts of assets, liabilities, revenues and expenses included in the financial statements. Management bases its estimates on historical experience and other available information, the results of which form the basis of the estimates and assumptions. We consider the following accounting policies to be critical because they involve highly subjective and complex assumptions and assessments, are subject to a great degree of fluctuation period over period and are the most critical to our operating performance.

Revenues and Revenue Deductions

We recognize patient service revenues during the period the healthcare services are provided based upon estimated amounts due from payers. We record contractual adjustments to our gross charges to reflect expected reimbursement negotiated with or prescribed by third party payers. We estimate contractual adjustments and allowances based upon payment terms set forth in managed care health plan contracts and by federal and state regulations. For the majority of our patient service revenues, we apply contractual adjustments to patient accounts at the time of billing using specific payer contract terms entered into the accounts receivable systems, but in some cases we record an estimated allowance until payment is received. We derive most of our patient service revenues from healthcare services provided to patients with Medicare (including managed Medicare plans) or managed care insurance coverage.

Services provided to Medicare patients are generally reimbursed at prospectively determined rates per diagnosis ("PPS"), while services provided to managed care patients are generally reimbursed based upon predetermined rates per diagnosis, per diem rates or discounted fee-for-service rates. Medicaid reimbursements vary by state. Other than Medicare and related Medicare managed plans, no individual payer represents more than 10% of our patient service revenues.

Medicare regulations and many of our managed care contracts are often complex and may include multiple reimbursement mechanisms for different types of services provided in our healthcare facilities. To obtain reimbursement for certain services under the Medicare program, we must submit annual cost reports and record estimates of amounts owed to or receivable from Medicare. These cost reports include complex calculations and estimates related to indirect medical education, reimbursable Medicare bad debts, disproportionate share and other items that are often subject to interpretation that could result in payments that differ from recorded estimates. We estimate amounts owed to or receivable from the Medicare program using the best information available and our interpretation of the applicable Medicare regulations. We include differences between original estimates and subsequent revisions to those estimates (including final cost report settlements) in our consolidated statements of operations in the period in which the revisions are made. Net adjustments for final third party settlements increased patient service revenues and income from continuing operations before income taxes by $8.6 million, $6.3 million and $7.9 million during the years ended June 30, 2006, 2007 and 2008, respectively. Additionally, updated regulations and contract negotiations with payers occur frequently, which necessitates continual review of revenue estimation processes by management. Management believes that future adjustments to its current third party settlement estimates will not materially impact our results of operations, cash flows or financial position.

We do not pursue collection of amounts due from uninsured patients that qualify for charity care under our guidelines (currently those uninsured patients whose incomes are equal to or less than 200% of the current federal poverty guidelines set forth by the Department of Health and Human Services). We deduct charity care accounts from revenues when we determine that the account meets our charity care guidelines. We also provide discounts from billed charges and alternative payment structures for uninsured patients who do not qualify for charity care but meet certain other minimum income guidelines, primarily those uninsured patients with incomes between 200% and 500% of the federal poverty guidelines. During the years ended June 30, 2006, 2007 and 2008, we deducted $71.1 million, $86.1 million and $86.1 million of charity care from revenues, respectively.

During our fiscal year ended June 30, 2007, we were approved to receive payments under the Bexar County, Texas upper payment limit ("UPL") Medicaid payment program. UPL programs allow private hospitals to enter into indigent care affiliation agreements with governmental entities. Within the parameters of these programs, private hospitals expand charity care services to indigent patients and alleviate expenses for the governmental entity. The governmental entity is then able to utilize its tax revenue to fund the Medicaid program for private hospitals. We recognize revenues from the UPL program when we become entitled to the reimbursements, including a federal match portion, and such reimbursements are assured.

We earned premium revenues of $375.0 million, $401.4 million and $450.2 million during the years ended June 30, 2006, 2007 and 2008, respectively, from our health plans. Our health plans, PHP, AAHP and MHP, have agreements with AHCCCS, CMS and various health maintenance organizations ("HMOs"), respectively, to contract to provide medical services to subscribing participants. Under these agreements, our health plans receive monthly payments based on the number of HMO participants in MHP or the number and coverage type of enrollees in PHP and AAHP. Our health plans recognize the payments as revenues in the month in which members are entitled to healthcare services with the exception of AAHP Medicare Part D reinsurance premiums and low income subsidy cost sharing premiums that are recorded as a liability to fund future healthcare costs or else repaid to the government.

Allowance for Doubtful Accounts and Provision for Doubtful Accounts

Our ability to collect the self-pay portions of our receivables is critical to our operating performance and cash flows. Our allowance for doubtful accounts was approximately 28.3% and 28.1% of accounts receivable, net of contractual discounts, as of June 30, 2007 and 2008, respectively. The primary collection risk relates to uninsured patient accounts and patient accounts for which primary insurance has paid but patient deductibles or co-insurance portions remain outstanding.

Effective July 1, 2007, we began estimating the allowance for doubtful accounts using a standard policy that reserves 100% of all accounts aged greater than 365 days subsequent to discharge date plus 85% of uninsured accounts less than 365 days old plus 40% of self pay after insurance/Medicare less than 365 days old. Our previous policy reserved all accounts greater than 180 days plus a market-specific percentage of uninsured and self pay after insurance/Medicare balances. Effective June 30, 2008, we adjusted our policy to reserve for all accounts aged

greater than 365 days subsequent to discharge date plus 92% of uninsured accounts less than 365 days old plus 45% of self-pay after insurance/Medicare less than 365 days old. These changes in our policy negatively impacted our provision for doubtful accounts during the year ended June 30, 2008. However, management believes the revised policy will adjust more quickly to payer mix shifts over time. We test our allowance for doubtful accounts policy quarterly using a hindsight calculation that utilizes write-off data for all payer classes during the previous twelve-month period to estimate the allowance for doubtful accounts at a point in time. We also supplement our analysis by comparing cash collections to net patient revenues and monitoring self-pay utilization. If our uninsured accounts receivable as of June 30, 2008 were 1% higher, our provision for doubtful accounts would have increased by $1.0 million. Significant changes in payer mix, business office operations, general economic conditions and healthcare coverage provided by federal or state governments or private insurers may have a significant impact on our estimates and significantly affect our liquidity, results of operations and cash flows.

We classify accounts pending Medicaid approval as Medicaid accounts in our accounts receivable aging report and record a manual contractual allowance for these accounts equal to the average Medicaid reimbursement rate for that specific state until qualification is confirmed at which time the account is netted. We have historically been successful in qualifying approximately 40%-45% of submitted accounts for Medicaid coverage. As of June 30, 2008, we had approximately $13.0 million of Medicaid pending accounts receivable from continuing operations ($4.1 million of which was stated at gross charges with a manual contractual allowance and $8.9 million of which was stated net of contractual discounts). In the event an account is not successfully qualified for Medicaid coverage and does not meet our charity guidelines, the previously recorded Medicaid contractual adjustment remains a revenue deduction (similar to a self-pay discount), and the remaining net account balance is reclassified to uninsured status and subjected to our allowance for doubtful accounts policy. During the years ended June 30, 2007 and 2008, approximately $13.2 million and $25.1 million, respectively, of net accounts receivable from continuing operations was reclassified from Medicaid pending status to uninsured status. If accounts do not qualify for Medicaid coverage but do qualify as charity care, the contractual adjustments are reversed and the gross account balances are recorded as charity deductions. During the years ended June 30, 2007 and 2008, we recorded $6.4 million and $7.1 million, respectively, of charity deductions from continuing operations for the net balances of accounts previously classified as Medicaid pending that did not meet Medicaid eligibility requirements.

Because we require patient verification of coverage at the time of admission, reclassifications of Medicare or managed care accounts to self-pay, other than patient coinsurance or deductible amounts, occur infrequently and are not material to our financial statements. Additionally, the impact of these classification changes is further limited by our ability to identify any necessary classification changes prior to patient discharge or soon thereafter. Due to information system limitations, we are unable to quantify patient deductible and co-insurance receivables that are included in the primary payer classification in the accounts receivable aging report at any given point in time. When classification changes occur, the account balance remains aged from the patient discharge date.

Insurance Reserves

Due to the nature of our operating environment, we are subject to professional and general liability and workers compensation claims and related lawsuits in the ordinary course of business. For professional and general liability claims incurred from June 1, 2002 to May 31, 2006, our wholly owned captive subsidiary insured our professional and general liability risks at a $10.0 million retention level. For professional and general liability claims incurred subsequent to May 31, 2006, we self-insure the first $9.0 million per claim, and the captive subsidiary insures the next $1.0 million per claim. We maintain excess coverage from independent third party insurers on a claims-made basis for individual claims exceeding $10.0 million up to $75.0 million, but limited to total annual payments of $65.0 million in the aggregate.

We insured our excess coverage under a retrospectively rated policy, and premiums under this policy are recorded based on our historical claims experience. We self-insure our workers compensation claims up to $1.0 million per claim and purchase excess insurance coverage for claims exceeding $1.0 million.

The following tables summarize our professional and general liability and workers compensation reserve balances as of June 30, 2007 and 2008 and our total provision for professional and general liability and workers compensation losses and related claims payments during the years ended June 30, 2006, 2007 and 2008.

	Professional and General Liability	Workers Compensation
	(In millions)	
Reserve balance:		
June 30, 2007	$ 64.6	$ 18.5
June 30, 2008	$ 74.3	$ 18.8
Provision for claims losses:		
Fiscal Year 2006	$ 21.0	$ 8.9
Fiscal Year 2007	$ 20.2	$ 9.4
Fiscal Year 2008	$ 21.8	$ 5.3
Claims paid:		
Fiscal Year 2006	$ 12.7	$ 6.4
Fiscal Year 2007	$ 14.4	$ 6.2
Fiscal Year 2008	$ 12.1	$ 5.0

In developing our estimates of our reserves for professional and general liability and workers compensation claims, we utilize actuarial information. Each reserve is comprised of estimated indemnity and expense payments related to: 1) reported events ("case reserves") and 2) incurred but not reported ("IBNR") events as of the end of the period. Management uses information from its risk managers and its best judgment to estimate case reserves. Actuarial IBNR estimates are dependent on multiple variables including our risk exposures, our self-insurance limits, geographic locations in which we operate, the severity of our historical losses compared to industry averages and the reporting pattern of our historical losses compared to industry averages, among others. Most of these variables require judgment, and changes in these variables could result in significant period over period fluctuations in our estimates. We discount our workers compensation reserve using actuarial estimates of projected cash payments in future periods. We adjust these reserves from time to time as we receive updated information. During our fiscal years ended June 30, 2006, 2007 and 2008, due to changes in historical loss trends, we decreased our professional and general liability reserve related to prior fiscal years by $6.9 million, $4.5 million and $0.6 million, respectively. Similarly, we decreased our workers compensation reserve related to prior fiscal years by $2.3 million during our fiscal year ended June 30, 2008. Adjustments to the workers compensation reserve related to prior years during fiscal years ended June 30, 2006 and 2007 were not significant. Additional adjustments to prior year estimates may be necessary in future periods as our reporting history and loss portfolio matures.

Our best estimate of IBNR utilizes statistical confidence levels that are below 75%. Using a higher statistical confidence level, while not permitted under United States generally accepted accounting principles, would increase the estimated reserve. The following table illustrates the sensitivity of the reserve estimates at 75% and 90% confidence levels.

	Professional and General Liability	Workers Compensation
	(In millions)	
June 30, 2007 reserve:		
As reported	$ 64.6	$ 18.5
With 75% Confidence Level	$ 76.9	$ 20.8
With 90% Confidence Level	$ 88.9	$ 22.6
June 30, 2008 reserve:		
As reported	$ 74.3	$ 18.8
With 75% Confidence Level	$ 85.7	$ 21.5
With 90% Confidence Level	$ 97.2	$ 23.8

Medical Claims Reserves

During the years ended June 30, 2006, 2007 and 2008, medical claims expense was $270.3 million, $297.0 million and $328.2 million, respectively, primarily representing medical claims of PHP. Vanguard estimates PHP's reserve for medical claims using historical claims experience (including cost per member and payment lag time) and other actuarial data including number of enrollees and certain enrollee demographic information. The reserve for medical claims and related payer settlements, including incurred but not reported claims, for all of our health plans combined was approximately $61.4 million and $51.1 million as of June 30, 2007 and 2008, respectively. The year over year decrease was primarily due to the payment of settlement amounts due to AHCCCS and CMS. While management believes that its estimation methodology effectively captures trends in medical claims costs, actual payments could differ significantly from its estimates given changes in the healthcare cost structure or adverse experience. During the years ended June 30, 2006, 2007 and 2008, approximately $40.0 million, $34.2 million and $31.2 million, respectively, of accrued and paid claims for services provided to our health plan enrollees by our hospitals and our other healthcare facilities were eliminated in consolidation. Our operating results and cash flows could be materially affected by increased or decreased utilization of our healthcare facilities by enrollees in our health plans.

Income Taxes

We believe that our income tax provisions are accurate and supportable, but certain tax matters require interpretations of tax law that may be subject to future challenge and may not be upheld under tax audit. To reflect the possibility that all of our tax positions may not be sustained, we maintain tax reserves that are subject to adjustment as updated information becomes available or as circumstances change. We record the impact of tax reserve changes to our income tax provision in the period in which the additional information, including the progress of tax audits, is obtained.

We assess the realization of our deferred tax assets to determine whether an income tax valuation allowance is required. Based on all available evidence, both positive and negative, and the weight of that evidence to the extent such evidence can be objectively verified, we determine whether it is more likely than not that all or a portion of the deferred tax assets will be realized. The factors used in this determination include the following:

- Cumulative losses in recent years
- Income/losses expected in future years
- Unsettled circumstances that, if favorably resolved, would adversely affect future operations
- Availability, or lack thereof, of taxable income in prior carryback periods that would limit realization of tax benefits
- Carryforward period associated with the deferred tax assets and liabilities
- Prudent and feasible tax planning strategies

In addition, financial forecasts used in determining the need for or amount of federal and state valuation allowances are subject to changes in underlying assumptions and fluctuations in market conditions that could significantly alter our recoverability analysis and thus have a material adverse effect on our consolidated financial condition, results of operations or cash flows.

Effective July 1, 2007, we adopted the provisions of FASB Interpretation No. 48, *Accounting for Uncertainty in Income Taxes – An Interpretation of FASB Statement No. 109* ("FIN 48"). In connection with the adoption of FIN 48, we recorded a $0.4 million net liability for unrecognized tax benefits, accrued interest and penalties, which was comprised of the following (in millions).

Reclassification from income taxes payable	$	0.3
Increase to non-current deferred tax assets		2.7
Cumulative impact of change recorded to retained earnings		(2.6)
	$	0.4

The provisions of FIN 48 allow for the classification election of interest on an underpayment of income taxes, when the tax law requires interest to be paid, and penalties, when a tax position does not meet the minimum statutory threshold to avoid payment of penalties, in income taxes, interest expense or another appropriate expense classification based on the accounting policy election of the entity. We elected to continue our historical practice of classifying interest and penalties as a component of income tax expense. Approximately $0.3 million of the $0.4 million of unrecognized tax benefits, if recognized, would impact the effective tax rate, while the remaining $0.1 million of unrecognized tax benefits, if recognized, would increase goodwill.

Long-Lived Assets and Goodwill

Long-lived assets, including property, plant and equipment and amortizable intangible assets, comprise a significant portion of our total assets. We evaluate the carrying value of long-lived assets when impairment indicators are present or when circumstances indicate that impairment may exist under the provisions of SFAS 144, *Accounting for the Impairment or Disposal of Long-Lived Assets*. When management believes impairment indicators may exist, projections of the undiscounted future cash flows associated with the use of and eventual disposition of long-lived assets held for use are prepared. If the projections indicate that the carrying values of the long-lived assets are not expected to be recoverable, we reduce the carrying values to fair value. For long-lived assets held for sale, we compare the carrying values to an estimate of fair value less selling costs to determine potential impairment. We test for impairment of long-lived assets at the lowest level for which cash flows are measurable. These impairment tests are heavily influenced by assumptions and estimates that are subject to change as additional information becomes available. Given the relatively few number of hospitals we own and the significant amounts of long-lived assets attributable to those hospitals, an impairment of the long-lived assets for even a single hospital could materially adversely impact our operating results or financial position.

Goodwill also represents a significant portion of our total assets. We review goodwill for impairment annually during our fourth fiscal quarter or more frequently if certain impairment indicators arise under the provisions of SFAS 142, *Goodwill and Other Intangible Assets*. We review goodwill at the reporting level unit, which is one level below an operating segment. We review the carrying value of the net assets of each reporting unit to the net present value of estimated discounted future cash flows of the reporting unit. If the carrying value exceeds the net present value of estimated discounted future cash flows, an impairment indicator exists and an estimate of the impairment loss is calculated. The fair value calculation includes multiple assumptions and estimates, including the projected cash flows and discount rates applied. Changes in these assumptions and estimates could result in goodwill impairment that could materially adversely impact our financial position or results of operations. In December 2006, we recorded a goodwill impairment charge in the amount of $123.8 million ($110.5 million, net of tax benefit) related to our Chicago hospitals.

We completed our annual goodwill impairment test during the fourth quarter of fiscal 2008 noting no impairment. However, we will continue to closely monitor the operations of our Chicago hospitals, with goodwill of approximately $40.6 million, due to the sensitivity of the projected operating results of this reporting unit to the goodwill impairment analysis. If projected future cash flows become less favorable than those projected by management, an additional impairment charge relating to our Chicago hospitals may become necessary that could have a material adverse impact on our financial position and results of operations.

Selected Operating Statistics

The following table sets forth certain operating statistics for the periods indicated below.

	Year Ended June 30,		
	2006	2007	2008
Number of hospitals at end of period	15	15	15
Number of licensed beds at end of period	3,937	4,143	4,181
Discharges (a)	162,446	166,873	169,668
Adjusted discharges - hospitals (b)	261,056	264,698	270,076
Net revenue per adjusted discharge-hospitals (c)	$ 7,319	$ 7,766	$ 8,110
Patient days (d)	701,307	721,832	734,838
Adjusted patient days-hospitals (e)	1,127,024	1,144,989	1,169,710
Average length of stay (days) (f)	4.3	4.3	4.3
Inpatient surgeries (g)	36,606	37,227	37,538
Outpatient surgeries (h)	76,437	76,606	73,339
Emergency room visits (i)	554,250	572,946	588,491
Occupancy rate (j)	49.2%	48.2%	48.5%
Average daily census (k)	1,921	1,978	2,008
Member lives (l)	146,200	145,600	149,600
Medical claims expense percentage (m)	72.1%	74.0%	72.9%

(a) Discharges represent the total number of patients discharged (in the facility for a period in excess of 23 hours) from our hospitals and is used by management and certain investors as a general measure of inpatient volumes.

(b) Adjusted discharges-hospitals is used by management and certain investors as a general measure of combined hospital inpatient and outpatient volumes. Adjusted discharges-hospitals is computed by multiplying discharges by the sum of gross hospital inpatient and outpatient revenues and then dividing the result by gross hospital inpatient revenues.

(c) Net revenue per adjusted discharge-hospitals is calculated by dividing net hospital patient revenues by adjusted discharge-hospitals and measures the average net payment expected to be received for a patient's stay in the hospital.

(d) Patient days represent the number of days (calculated as overnight stays) our beds were occupied by patients during the periods.

(e) Adjusted patient days-hospitals is calculated by multiplying patient days by the sum of gross hospital inpatient and outpatient revenues and then dividing the result by gross hospital inpatient revenues. This computation is an indicator of combined inpatient and outpatient volumes.

(f) Average length of stay represents the average number of days an admitted patient stays in our hospitals.

(g) Inpatient surgeries represent the number of surgeries performed in our hospitals where overnight stays are necessary.

(h) Outpatient surgeries represent the number of surgeries performed at hospitals or ambulatory surgery centers on an outpatient basis (patient overnight stay not necessary).

(i) Emergency room visits represent the number of patient visits to a hospital emergency room where treatment is received, regardless of whether an overnight stay is subsequently required.

(j) Occupancy rate represents the percentage of hospital licensed beds occupied by patients. Occupancy rate provides a measure of the utilization of inpatient beds.

(k) Average daily census represents the average number of patients in our hospitals each day during our ownership.

(l) Member lives represent the total number of enrollees in PHP, AAHP and MHP as of the end of the respective period.

(m) Medical claims expense percentage is calculated by dividing medical claims expense by premium revenues.

Results of Operations

The following tables present a summary of our operating results for the respective periods shown.

	Year Ended June 30,					
	2006		2007		2008	
	Amount	%	Amount	%	Amount	%
	(Dollars in millions)					
Patient service revenues	$ 2,043.6	84.5%	$ 2,179.3	84.4%	$ 2,340.5	83.9%
Premium revenues	375.0	15.5	401.4	15.6	450.2	16.1
Total revenues	2,418.6	100.0	2,580.7	100.0	2,790.7	100.0
Salaries and benefits (includes stock compensation of $1.7, $1.2 and $2.5 respectively)	991.4	41.0	1,067.9	41.4	1,152.7	41.3
Supplies	394.1	16.3	421.8	16.3	434.5	15.5
Medical claims expense	270.3	11.2	297.0	11.5	328.2	11.8
Provision for doubtful accounts	156.8	6.5	175.2	6.8	205.6	7.4
Other operating expenses	353.0	14.6	375.0	14.5	405.8	14.5
Depreciation and amortization	100.3	4.1	118.6	4.6	131.0	4.7
Interest, net	103.8	4.3	123.8	4.8	122.1	4.4
Debt extinguishment costs	0.1	0.0	–	0.0	–	0.0
Impairment loss	–	0.0	123.8	4.8	–	0.0
Other expenses	9.1	0.4	2.8	0.1	9.5	0.3
Income (loss) from continuing operations before income taxes	39.7	1.6	(125.2)	(4.8)	1.3	0.1
Provision for income taxes	17.8	0.7	(11.6)	(0.4)	1.7	(0.1)
Income (loss) from continuing operations	21.9	0.9	(113.6)	(4.4)	(0.4)	(0.0)
Loss from discounted operations, net of taxes	(9.0)	(0.4)	(19.1)	(0.7)	(0.3)	(0.0)
Net income (loss)	$ 12.9	0.5%	$ (132.7)	(5.1)%	$ (0.7)	(0.0)%

Year Ended June 30, 2008 Compared to the Year Ended June 30, 2007

Revenues. Patient service revenues increased 7.4% year over year primarily as a result of a 4.4% increase in patient revenues per adjusted hospital discharge and a 2.0% increase in adjusted hospital discharges. Total outpatient volumes increased year over year, including a 2.7% increase in emergency room visits, although outpatient surgeries decreased year over year. We experienced positive year over year payer mix shifts highlighted by an increase in combined Medicare and managed Medicare volumes compared to a decrease in combined Medicaid and managed Medicaid volumes. The acuity level of our patients also increased year over year. However, we continued to generate most of our inpatient stays from emergency room visits and struggled to improve our elective admissions. Patients often elect to defer elective procedures when general economic conditions are weak. We also face continued intense competition from other hospitals to recruit and retain the best physicians to practice in our facilities. In order to improve our operating results, we must increase our elective inpatient and outpatient business to maintain a favorable payer mix. We believe our quality initiatives will be the catalyst for long-term revenue growth especially given the forecasted population growth for most of the markets in which we operate. However, environmental factors outside our control, including patient demand, deterioration of general economic conditions, payer pressures and increased competition could limit our future revenue growth.

Premium revenues increased 12.2% during fiscal 2008 primarily as a result of a 5.7% in year over year annual membership at PHP and a capitation rate increase that went into effect for PHP as of October 1, 2007. PHP's membership increased as a result of a greater number of AHCCCS-eligible residents as a result of weakened general economic conditions and a greater allocation of the AHCCCS enrollees to PHP. PHP was awarded a new AHCCCS contract that commences on October 1, 2008 that adds six additional counties to the three counties already served by PHP. We expect PHP to experience a significant increase in membership during fiscal 2009, which would increase our premium revenues, but we are unable to estimate the impact to our future financial position, results of operations or cash flows at this time.

Costs and Expenses. Total costs and expenses, exclusive of income taxes and discontinued operations, were $2,789.4 million or 99.9% of total revenues during fiscal 2008 compared to 104.9% during fiscal 2007. Fiscal 2007 costs and expenses were negatively impacted by the $123.8 million impairment loss related to our Chicago hospitals. Salaries and benefits, supplies, medical claims and provision for doubtful accounts represent our most significant individual costs and expenses or those subject to the greatest level of fluctuation period over period.

- **Salaries and benefits.** Salaries and benefits as a percentage of total revenues were relatively flat period over period. Excluding the growth in our health plan operations, salaries and benefits would have increased to 42.0% during fiscal 2008 compared to the 41.4% during the prior year. The national nursing shortage, which is particularly prevalent in Phoenix, continues to hinder our ability to fully manage salaries and benefits costs. Even with the nursing shortage in Phoenix, we made progress in stabilizing our nurse workforce in Phoenix to reduce contract labor utilization. We incurred a significant increase in period over period salaries and benefits costs in our Massachusetts hospitals primarily resulting from requirements set forth in our most recent collective bargaining agreement ratified with the nurses union at St. Vincent Hospital. We expect to face continued competition from other healthcare providers to obtain qualified nurses, which will increase our salaries and benefits costs, but we expect to mitigate a portion of this increase through implementation of expanded recruiting and retention initiatives, care management efficiency initiatives and our clinical quality programs.

- **Supplies.** Supplies as a percentage of total revenues decreased from 16.3% during fiscal 2007 to 15.5% during fiscal 2008. Supplies as a percentage of patient service revenues decreased to 18.6% during fiscal 2008 compared to 19.4% during fiscal 2007. Fiscal 2008 was the first full year that certain of our supply chain corporate initiatives were fully implemented. These initiatives included formulary refinements, standardization of commodities and supplies reprocessing and improved compliance with our group purchasing contract. Effective May 2008, we renewed our group purchasing contract with HealthTrust Purchasing Group for an additional five years. We expect to recognize only slight improvement in this ratio during fiscal 2009 as additional supply chain initiatives are implemented. However, because most of our growth strategies include expansion of high acuity services, we will continue to be exposed to increased pricing pressures for pharmaceuticals and expensive medical devices including those used in cardiac and orthopedic surgeries that could negate our cost containment initiatives.

- **Medical claims expense.** Medical claims expense as a percentage of premium revenues decreased from 74.0% during fiscal 2007 to 72.9% during fiscal 2008. Capitation revenues for our health plans increased at a greater rate year over year than did the utilization of medical services by our health plans' enrollees. Medical claims expense represents the amounts paid by health plans for healthcare services provided to their members, including an estimate of incurred but not reported claims that is determined based upon lag data and other actuarial assumptions. Revenues and expenses between the health plans and our hospitals and related outpatient service providers of approximately $31.2 million, or 8.7% of gross health plan medical claims expense, were eliminated in consolidation during fiscal 2008 compared to $34.2 million or 10.3% of gross health plan medical claims expense during fiscal 2007.

- **Provision for doubtful accounts.** During fiscal 2008, the provision for doubtful accounts as a percentage of patient service revenues increased to 8.8% from 8.0% during fiscal 2007. During fiscal 2008, our self-pay discharges as a percentage of total discharges decreased to 3.5% from 3.7% during fiscal 2007. However, price increases at our hospitals and increased levels of patient co-insurance and deductibles under managed care plans increased our exposure to uncollectible revenues. The previously discussed change in our allowance for doubtful accounts policy during fiscal 2008 resulted in a higher provision for doubtful accounts as a percentage of patient service revenues during fiscal 2008 compared to fiscal 2007. Our provision for doubtful accounts as a percentage of patient service revenues is reduced by our policy of deducting charity accounts from revenues at the time in which those accounts meet our charity care guidelines. On a combined basis, the provision for doubtful accounts and charity care deductions as a percentage of patient service revenues increased to 12.5% during fiscal 2008 compared to 12.0% during fiscal 2007. We do not expect these ratios to improve significantly in the near future given current trends in patient insurance coverage. However, we believe our upfront collection efforts and revenues growth initiatives will help mitigate future increases to these ratios.

Other operating expenses. Other operating expenses include, among others, purchased services, insurance, property taxes, rents and leases, repairs and maintenance and utilities. Other operating expenses as a percentage of total revenues were flat year over year. We continue to incur increasing physician recruiting costs, higher repairs and maintenance costs related to the implementation of our clinical information systems in our hospitals and higher utilities costs.

Other. Depreciation and amortization as a percentage of total revenues increased to 4.7% during fiscal 2008 compared to 4.6% during fiscal 2007 as a result of our capital improvement and expansion initiatives. Portions of our clinical quality systems were placed into service during fiscal 2008, and fiscal 2008 was the first full year in which all of our previous significant expansion projects in Phoenix and San Antonio had been fully in service. The decrease in net interest as a percentage of total revenues to 4.4% during fiscal 2008 compared to 4.8% during fiscal 2007 resulted primarily from the increase in total revenues during fiscal 2008 compared to fiscal 2007 without additional debt borrowings.

Income taxes. Income taxes were not significant during fiscal 2008. The effective tax rate for fiscal 2007 was 9.3% due to the majority of the impairment loss being nondeductible for tax purposes.

Discontinued operations. Our loss from discontinued operations was not significant during the fiscal year ended June 30, 2008 due to the winding down of operations at PMH compared to fiscal 2007 when PMH operated as an acute care hospital for the majority of the fiscal year.

Net loss. The $132.0 million year over year decrease in net loss resulted primarily from the improved operating results during fiscal 2008 and the after tax impact of the impairment loss recorded during fiscal 2007.

Year Ended June 30, 2007 Compared to the Year Ended June 30, 2006

Revenues. Patient service revenues increased by 6.6% year over year primarily as a result of a 6.1% increase in patient revenues per adjusted hospital discharge and a 1.4% increase in adjusted hospital discharges. Outpatient volumes increased year over year with outpatient surgeries increasing 0.2% and emergency room visits increasing 3.4%. However, much of the year over year revenues improvement related to low acuity services provided to uninsured and Medicaid patients. Self-pay and Medicaid discharges increased 19.6% and 9.8%, respectively, year over year, while combined Medicare, managed care and commercial discharges were relatively flat year over year. We also continued to generate a lot of our inpatient stays from emergency room activity. We attribute this payer mix shift to the continued rising cost of healthcare insurance that has forced many people to go uninsured or else participate in a plan with higher deductibles and coinsurance.

Premium revenues increased by 7.0% during fiscal 2007 primarily as a result of having AAHP operations for the full fiscal year. Per member per month reimbursement rates are significantly higher under AAHP than under the traditional AHCCCS Medicaid program. Per member per month reimbursement for PHP also increased effective October 1, 2006, and PHP supplemental revenues increased year over year. Total average membership in PHP and AAHP decreased slightly from approximately 100,300 during fiscal 2006 to approximately 99,500 during fiscal 2007.

Costs and Expenses. Total costs and expenses, exclusive of income taxes and discontinued operations, were $2,705.9 million or 104.8% of total revenues during fiscal 2007 compared to 98.4% during fiscal 2006. Fiscal 2007 costs and expenses were negatively impacted by the impairment loss related to our Chicago hospitals and significant increases in net interest and depreciation and amortization. Salaries and benefits, supplies, medical claims and provision for doubtful accounts represent our most significant individual costs and expenses or those subject to the greatest level of fluctuation period over period.

- **Salaries and benefits.** Salaries and benefits as a percentage of total revenues increased to 41.4% during fiscal 2007 from 41.0% during fiscal 2006 primarily as a result of salaries and benefits pressures in our Phoenix market. The national nursing shortage has been particularly challenging in Phoenix during the past few years. Our salaries and benefits at our Phoenix hospitals increased by 2.5% of patient service revenues year over year primarily due to a 6.5% year over year increase in total hospital employed and contract labor full-time equivalents and the limited revenue growth previously discussed. We were

successful in building our employed nurse workforce in Phoenix and decreasing our dependence on contract labor in light of the nursing shortage. We also successfully negotiated a new three-year union contract with a significant portion of our nurse workforce in Massachusetts during fiscal 2007.

- **Supplies**. Supplies as a percentage of total revenues remained flat at 16.3% year over year. Supplies as a percentage of patient service revenues increased slightly to 19.4% during fiscal 2007 compared to 19.3% during fiscal 2006. Advances in medical technologies and new medications continue to pressure our supplies costs. We added additional corporate resources and increased our focus on supply chain management and group purchasing organization compliance during fiscal 2007 to manage supplies utilization.

- **Medical claims expense**. Medical claims expense as a percentage of premium revenues increased from 72.1% during fiscal 2006 to 74.0% during fiscal 2007 primarily as a result of increased healthcare utilization by PHP enrollees during fiscal 2007. Inpatient days for PHP enrollees increased by 3.5% year over year. Medical claims expense represents the amounts paid by the health plans for healthcare services provided to their members, including an estimate of incurred but not reported claims that is determined based upon lag data and other actuarial assumptions. Revenues and expenses between the health plans and our hospitals and related outpatient service providers of approximately $34.2 million, or 10.3% of gross health plan medical claims expense, were eliminated in consolidation during fiscal 2007.

- **Provision for doubtful accounts**. During fiscal 2007, the provision for doubtful accounts as a percentage of patient service revenues increased to 8.0% from 7.7% during fiscal 2006. During fiscal 2007, self-pay revenues as a percentage of net patient revenues increased from 9.2% to 9.7%. Self-pay discharges as a percentage of total discharges increased from 3.2% during fiscal 2006 to 3.7% during fiscal 2007. Our provision for doubtful accounts as a percentage of patient service revenues is reduced by our policy of deducting charity accounts from revenues at the time in which those accounts meet our charity care guidelines. On a combined basis, the provision for doubtful accounts and charity care deductions as a percentage of patient service revenues increased to 12.0% during fiscal 2007 compared to 11.2% during fiscal 2006.

Other operating expenses. Other operating expenses include, among others, purchased services, insurance, property taxes, rents and leases, repairs and maintenance and utilities. Other operating expenses as a percentage of total revenues were relatively flat year over year. We continue to incur increasing physician costs for coverage in our emergency rooms and other specialty programs. Our repairs and maintenance costs also increased year over year as we began to roll out portions of our quality information systems in our hospitals.

Other. Depreciation and amortization as a percentage of total revenues increased to 4.6% during fiscal 2007 compared to 4.1% during fiscal 2006 as a result of our capital improvement and expansion initiatives. Four of our six significant expansion projects were placed into service during fiscal 2007 and portions of the other two were completed during fiscal 2007. The increase in net interest as a percentage of total revenues to 4.8% during fiscal 2007 compared to 4.3% during fiscal 2006 resulted primarily from our incurring interest on the September 2005 $175.0 million delayed draw term loan borrowing for all 12 months of fiscal 2007 and increased LIBOR rates on our term loan borrowings. As previously discussed, we incurred a $123.8 million ($110.5 million, net of tax benefit) impairment loss during fiscal 2007 related to our Chicago hospitals.

Income taxes. The effective tax rate decreased from 44.8% in fiscal 2006 to 9.3% in fiscal 2007. The significant decrease is due to the majority of the Chicago impairment loss during fiscal 2007 being nondeductible for tax purposes.

Discontinued operations. The significant year over year increase in loss from discontinued operations, net of taxes, primarily relates to the deterioration in the operating results of PMH during fiscal 2007 that led to our decision to eliminate acute care services at PMH.

Net income. The $145.6 million year over year decrease in net income resulted primarily from the after tax impact of the impairment loss recorded during fiscal 2007 and the significant increases in depreciation and amortization and net interest discussed above.

Liquidity and Capital Resources

Operating Activities

At June 30, 2008, we had working capital of $217.8 million, including cash and cash equivalents of $141.6 million. Working capital at June 30, 2007 was $156.4 million. Cash provided by operating activities increased from $123.3 million during fiscal 2007 to $173.1 million during fiscal 2008. The significant increase was primarily due to improved operating results, improved collections of outstanding receivables and more efficient cash management processes.

Investing Activities

Cash used in investing activities increased from $118.5 million during fiscal 2007 to $143.8 million during fiscal 2008. We received $37.0 million of cash proceeds from the sale of the California hospitals during fiscal 2007. During fiscal 2008, capital expenditures were $121.6 million and decreased by $42.7 million from fiscal 2007 primarily due to the completion of our spending related to the significant expansion projects in Phoenix and San Antonio during fiscal 2007. During fiscal 2008, cash used in investing activities was negatively impacted by our inability to liquidate $26.3 million of investments in student loan-backed auction rate securities due to the global credit crisis that resulted in failed auctions of these securities.

We anticipate spending a total of $170.0 million to $190.0 million in capital expenditures during fiscal 2009. This estimate includes the remaining expenditures for our clinical information systems upgrades necessary to support our quality initiatives and all other renovation projects and technology upgrades at our facilities. These capital expenditures will be funded by cash flows from operations and availability under our revolving credit facility. We believe our capital expenditure program is sufficient to service, expand and improve our existing facilities to meet our quality objectives and growth strategies.

Financing Activities

Cash used in financing activities decreased from $8.3 million during fiscal 2007 to $7.8 million during fiscal 2008.

As of June 30, 2008, we had outstanding $1,537.5 million in aggregate indebtedness and $222.0 million of available borrowing capacity under our revolving credit facility ($250.0 million net of outstanding letters of credit of $28.0 million). Our liquidity requirements are significant, primarily due to debt service requirements. Our estimated remaining principal and interest due on our outstanding debt borrowings exceeds $2.0 billion through our fiscal year ending June 30, 2016. The 9.0% Notes require semi-annual interest payments. However, prior to October 1, 2009, the interest expense on the 11.25% Notes consists solely of non-cash accretions of principal.

On September 26, 2005, we refinanced and repriced all $795.7 million of the then outstanding term loans under the initial term loan facility by borrowing $795.7 million of replacement term loans (the "2005 term loan facility").

The 2005 term loan facility borrowings bear interest at a rate equal to, at our option, a base rate plus 1.25% per annum or LIBOR plus 2.25% per annum. These rates reflect a savings of 1.0% per annum over the interest rate options for our previous initial term loan facility. The borrowings under the revolving credit facility currently bear interest at a rate equal to, at our option, a base rate plus 1.25% per annum or LIBOR plus 2.25% per annum. These rates are subject to increase by up to 0.25% per annum should our leverage ratio exceed certain designated levels.

In April 2008, we entered into an interest rate swap agreement with Bank of America, N.A. that went into effect on June 30, 2008. We will continue to make our usual quarterly term debt interest payments at a rate equal to the 90-day LIBOR rate plus 2.25%. In addition, we will begin making quarterly fixed interest payments on

September 30, 2008 at a rate equal to 2.785% on a notional $450.0 million of our term debt in exchange for payments to us from Bank of America, N.A. based upon the applicable variable 90-day LIBOR rate on the same notional amount. We account for this swap as a highly effective cash flow hedge with critical terms that substantially match the underlying term debt and will measure any ineffectiveness using the hypothetical derivative method. We will make quarterly adjustments to other comprehensive income equal to the change in the fair value of the swap from quarter to quarter until the maturity of the swap on March 31, 2010. As of June 30, 2008, the estimated fair value of the interest rate swap was an asset for Vanguard of approximately $2.8 million (net of taxes).

We are required to pay a commitment fee to the lenders under the revolving credit facility in respect of the unutilized commitments thereunder at a rate equal to 0.50% per annum. We also pay customary letter of credit fees.

The 2005 term loan facility and the revolving credit facility contain a number of covenants that, among other things, restrict, subject to certain exceptions, our ability, and the ability of our subsidiaries, to sell assets, incur additional indebtedness or issue preferred stock, repay other indebtedness (including the 9.0% Notes and 11.25% Notes), pay dividends and distributions or repurchase our capital stock, create liens on assets, make investments, loans or advances, make certain acquisitions, engage in mergers or consolidations, enter into sale and leaseback transactions, engage in certain transactions with affiliates, amend certain material agreements governing our indebtedness, including the 9.0% Notes and 11.25% Notes, change the business conducted by our subsidiaries and enter into certain hedging agreements. In addition, the senior credit facilities require us to maintain the following financial covenants: a maximum total leverage ratio, a maximum senior leverage ratio, a minimum interest coverage ratio and a maximum capital expenditures limitation.

As of June 30, 2008, our capital expenditures, as defined in the senior credit agreement, were in compliance with our capital expenditures covenant, and we were also in compliance with the other debt covenant ratios as defined in our senior secured credit agreement, as follows.

	Debt Covenant Ratio	Actual Ratio
Interest coverage ratio requirement	2.00x	2.85x
Total leverage ratio limit	5.75x	4.26x
Senior leverage ratio limit	3.50x	2.15x

The table below summarizes our credit ratings as of the date of the filing of this report.

	Standard & Poor's	Moody's
Corporate credit rating	B	B2
9% Senior Subordinated Notes	CCC+	Caa1
11¼% Senior Discount Notes	CCC+	Caa1
Senior credit facilities	B+	Ba3

We expect that cash generated from our operations and cash available under our revolving credit facility will be sufficient to meet our working capital needs, debt service requirements and planned capital expenditure programs that we consider necessary to continue our growth during the next twelve months and into the foreseeable future. However, we cannot assure you that our operations will generate sufficient cash or that future borrowings under our refinanced senior credit facilities will be available to enable us to meet these requirements and needs.

We continually assess our capital structure to ensure the optimal mix of debt and equity. As market conditions warrant, we and our primary equity sponsors, including The Blackstone Group L.P. and its affiliates, may from time to time, at our or their sole discretion, purchase, repay, redeem or retire any of our outstanding 9.0% Notes, 11.25% Notes, term or revolving loan borrowings or equity securities (including any publicly issued securities) in privately negotiated or open market transactions, by tender offer or otherwise.

We also intend to continue to pursue acquisitions or partnering arrangements, either in existing markets or new markets, which fit our growth strategies. To finance such transactions, we may draw upon amounts available under our revolving credit facility or seek additional funding sources. However, if our operating results and borrowing capacities do not sufficiently support these capital projects or acquisition opportunities, our growth strategies may not be fully realized. Our future operating performance, ability to service or refinance our debt and ability to utilize other sources of capital will be subject to future economic conditions and other business factors, many of which are beyond our control.

Guarantees and Off Balance Sheet Arrangements

We are a party to certain rent shortfall agreements with certain unconsolidated entities, physician income guarantees and service agreement guarantees and other guarantee arrangements, including parent-subsidiary guarantees, in the ordinary course of business. We have not engaged in any transaction or arrangement with an unconsolidated entity that is reasonably likely to materially affect liquidity.

Obligations and Commitments

The following table reflects a summary of obligations and commitments outstanding, including both the principal and interest portions of long-term debt and capital leases, with payment dates as of June 30, 2008.

	Payments due by period				
	Within 1 year	During Years 2-3	During Years 4-5	After 5 years	Total
Contractual Cash Obligations:			*(In millions)*		
Long-term debt (1)	$ 98.5	$ 220.2	$ 911.8	$ 941.5	$ 2,172.0
Operating leases (2)	33.6	53.6	37.0	55.8	180.0
Purchase obligations (2)	18.9	–	–	–	18.9
Health claims payable (3)	51.1	–	–	–	51.1
Estimated self-insurance liabilities (4)	20.5	44.4	22.2	7.4	94.5
Subtotal	$ 222.6	$ 318.2	$ 971.0	$ 1,004.7	$ 2,516.5

	Within 1 year	During Years 2-3	During Years 4-5	After 5 years	Total
Other Commitments:			*(In millions)*		
Construction and capital improvements (5)	$ 24.1	$ 5.4	$ –	$ –	$ 29.5
Guarantees of surety bonds (6)	22.0	–	–	–	22.0
Letters of credit (7)	–	28.0	–	–	28.0
Physician commitments (8)	5.3	–	–	–	5.3
FIN 48 net liability (9)	0.6	–	–	–	0.6
Subtotal	$ 52.0	$ 33.4	$ –	$ –	$ 85.4
Total obligations and commitments	$ 274.6	$ 351.6	$ 971.0	$ 1,004.7	$ 2,601.9

(1) Includes both principal and interest portions of outstanding debt. The interest portion of our debt assumes an approximate 5.0% rate over the remaining term of the debt.

(2) These obligations are not reflected in our consolidated balance sheets.

(3) Represents estimated payments to be made in future periods for healthcare costs incurred by enrollees in PHP, AAHP and MHP and is separately stated on our consolidated balance sheets.

(4) Includes the current and long-term portions of our professional and general liability, workers' compensation and employee health reserves.

(5) Represents our estimate of amounts we are committed to fund in future periods through executed agreements to complete projects included as construction in progress on our consolidated balance sheets.

(6) Represents performance bonds we have purchased related to medical claims liabilities of PHP.

(7) Amounts relate primarily to instances in which we have letters of credit outstanding with the third party administrator of our self-insured workers' compensation program.

(8) Includes physician guarantee liabilities recognized in our consolidated balance sheets under the provisions of FSP 45-3, *Application of FASB Interpretation No. 45 to Minimum Revenue Guarantees Granted to a Business or Its Owners*, and liabilities for other fixed expenses under physician relocation agreements not yet paid.

(9) Represents expected future tax liabilities determined under the provisions of FIN 48.

Healthcare Reform

In recent years, an increasing number of legislative proposals have been introduced or proposed to Congress and in some state legislatures that would significantly affect the services provided by and reimbursement to healthcare providers in our markets. The cost of certain proposals would be funded in significant part by reduction in payments by government programs, including Medicare and Medicaid, to healthcare providers or by taxes levied on hospitals or other providers. While we are unable to predict which, if any, proposals for healthcare reform will be adopted, we cannot assure you that proposals adverse to our business will not be adopted.

Federal and State Regulation and Investigations

The healthcare industry is subject to extensive federal, state and local laws and regulations relating to licensing, conduct of operations, ownership of facilities, addition of facilities and services, confidentiality and security issues associated with medical records, financial arrangements with physicians and other referral sources, and billing for services and prices for services. These laws and regulations are extremely complex and the penalties for violations are severe. In many instances, the industry does not have the benefit of significant regulatory or judicial interpretation of these laws and regulations. As a result of these laws and regulations, some of our activities could become the subject of governmental investigations or inquiries. Both federal and state government agencies have heightened and coordinated civil and criminal enforcement efforts as part of numerous ongoing investigations of hospital companies. Several hospital companies have settled allegations raised during such investigations for substantial sums out of concern for the possible exclusion from the Medicare and Medicaid programs. In the event of a determination that we are in violation of any of these laws, rules or regulations, or if further changes in the regulatory framework occur, our results of operations could be adversely affected.

Effects of Inflation and Changing Prices

Various federal, state and local laws have been enacted that, in certain cases, limit our ability to increase prices. Revenues for acute hospital services rendered to Medicare patients are established under the federal government's prospective payment system. We believe that hospital industry operating margins have been, and may continue to be, under significant pressure because of changes in payer mix and growth in operating expenses in excess of the increase in prospective payments under the Medicare program. In addition, as a result of increasing regulatory and competitive pressures, our ability to maintain operating margins through price increases to non-Medicare patients is limited.

Item 7A. Quantitative and Qualitative Disclosures About Market Risk.

We are subject to market risk from exposure to changes in interest rates based on our financing, investing, and cash management activities. As of June 30, 2008, we had in place $1,024.1 million of senior credit facilities bearing interest at variable rates at specified margins above either the agent bank's alternate base rate or its LIBOR rate. The senior credit facilities consist of $774.1 million in term loans maturing in September 2011 and a $250.0 million revolving credit facility maturing in September 2010 (of which $28.0 million of capacity was utilized by outstanding letters of credit as of June 30, 2008). Although changes in the alternate base rate or the LIBOR rate would affect the cost of funds borrowed in the future, we believe the effect, if any, of reasonably possible near-term changes in interest rates would not be material to our results of operations or cash flows. The variable interest rate risk is partially mitigated by the interest rate swap that became effective on June 30, 2008, as discussed below.

Our $250.0 million revolving credit facility bears interest at the alternate base rate plus a margin ranging from 1.00%-1.50% per annum or the LIBOR rate plus a margin ranging from 2.00%-2.50% per annum, in each case dependent upon our leverage ratio. Our revolving credit facility matures in September 2010. Our $774.1 million in outstanding term loans bear interest at the alternate base rate plus a margin of 1.25% per annum or the LIBOR rate plus a margin of 2.25% per annum and mature in September 2011. The interest rate related to the unhedged term loans was approximately 5.1% as of June 30, 2008.

In April 2008, we entered into an interest rate swap agreement with Bank of America, N.A. that became effective on June 30, 2008. We continue to make our usual quarterly term debt interest payments at a rate equal to the 90-day LIBOR rate plus 2.25%. In addition, we will begin making quarterly fixed interest payments on

September 30, 2008 at a rate equal to 2.785% on a notional $450.0 million of our term debt in exchange for payments to us from Bank of America, N.A. based upon the applicable variable 90-day LIBOR rate on the same notional amount. We account for this swap as a highly effective cash flow hedge with critical terms that substantially match the underlying term debt and will measure any ineffectiveness using the hypothetical derivative method. We will make quarterly adjustments to other comprehensive income equal to the change in the fair value of the swap from quarter to quarter until the maturity of the swap on March 31, 2010. As of June 30, 2008, the estimated fair value of the interest rate swap was an asset for Vanguard of approximately $2.8 million (net of taxes).

We use derivatives such as interest rate swaps from time to time to manage our market risk associated with variable rate debt or similar derivatives for fixed rate debt. We do not hold or issue derivative instruments for trading purposes and are not a party to any instruments with leverage features.

At June 30, 2008, we held $26.3 million par value investments in auction rate securities ("ARS") backed by student loans. Our ARS have maturity dates ranging from 2039 to 2043. Despite the underlying long-term maturity of ARS, these securities have been priced and traded as short-term investments as a result of a Dutch auction process that resets the ARS interest rates at predetermined periods ranging from 7 to 35 days. Historically, the Dutch auction process has enabled us to liquidate our ARS prior to each fiscal quarter-end. However, due to liquidity issues affecting the global credit and capital markets, the auctions for our remaining ARS since February 2008 have "failed", and we were unable to liquidate these ARS as of June 30, 2008. A failed auction does not result in default of the debt instrument. The ARS continue to accrue interest until a successful auction occurs, the issuer calls the securities or the securities mature. We accepted a par value tender of approximately $3.7 million of our previously outstanding ARS during May 2008. The ARS continue to accrue interest until a successful auction occurs, the issuer calls the securities or the securities mature.

Our ARS were rated "AAA" by one or more major credit rating agencies at June 30, 2008 based on their most recent ratings update. The ratings take into account insurance policies guaranteeing both the principal and accrued interest of the investments. The U.S. government guarantees approximately 96%-98% of the principal and accrued interest on each investment in student loans under the Federal Family Education Loan Program or similar programs.

Based upon the tender completed in May 2008 for a portion of our ARS and additional available market information, we believe that the remaining $26.3 million par value of our ARS will become liquid during the next 12 months. Thus, we classified the ARS as current marketable securities on our consolidated balance sheet as of June 30, 2008. We determined that the fair value of the ARS approximated par value due to their expected short-term liquidation with no expectation of liquidation discounts. We will continue to monitor market conditions for this type of ARS to ensure that our classification and fair value estimate remain appropriate. Should market conditions in future periods warrant a reclassification or other than temporary impairment of our ARS, we do not believe our financial position, results of operations, cash flows or compliance with debt covenants would be materially impacted. We believe that we currently have adequate working capital to fund operations during the near future based on access to cash and cash equivalents, expected operating cash flows and availability under our revolving credit facility. We do not expect that our holding of the ARS until market conditions improve will significantly adversely impact our operating cash flows.

Item 8. Financial Statements and Supplementary Data.

INDEX TO AUDITED CONSOLIDATED FINANCIAL STATEMENTS

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

Board of Directors
Vanguard Health Systems, Inc.

We have audited the accompanying consolidated balance sheets of Vanguard Health Systems, Inc. as of June 30, 2008 and 2007 and the related consolidated statements of operations, stockholders' equity and cash flows for each of the three years in the period ended June 30, 2008. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. We were not engaged to perform an audit of the Company's internal control over financial reporting. Our audits included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Vanguard Health Systems, Inc. at June 30, 2008 and 2007 and the consolidated results of its operations and its cash flows for each of the three years in the period ended June 30, 2008, in conformity with U.S. generally accepted accounting principles.

As discussed in Note 9 to the consolidated financial statements, the Company adopted FASB Interpretation No. 48, *Accounting for Uncertainty in Income Taxes – An Interpretation of FASB Statement No. 109*, effective July 1, 2007.

/s/ Ernst & Young LLP

Nashville, Tennessee
September 15, 2008

VANGUARD HEALTH SYSTEMS, INC.
CONSOLIDATED BALANCE SHEETS

	June 30, 2007	June 30, 2008
	(In millions except share and per share amounts)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 120.1	$ 141.6
Restricted cash	6.2	2.1
Marketable securities	–	26.3
Accounts receivable, net of allowance for doubtful accounts of approximately $113.2 and $117.7 at June 30, 2007 and 2008, respectively	287.3	300.4
Inventories	46.8	49.2
Prepaid expenses and other current assets	64.4	80.3
Total current assets	524.8	599.9
Property, plant and equipment, net of accumulated depreciation	1,186.6	1,174.0
Goodwill	689.2	689.2
Intangible assets, net of accumulated amortization	68.0	61.4
Investments in and advances to affiliates	7.3	6.0
Other assets	62.2	51.8
Total assets	$ 2,538.1	$ 2,582.3
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Accounts payable	$ 144.1	$ 162.8
Accrued salaries and benefits	75.0	97.4
Accrued health claims	61.4	51.1
Accrued interest	13.4	13.2
Other accrued expenses and current liabilities	66.5	49.6
Current maturities of long-term debt	8.0	8.0
Total current liabilities	368.4	382.1
Minority interests in equity of consolidated entities	9.3	9.1
Other liabilities	82.3	97.0
Long-term debt, less current maturities	1,520.7	1,529.5
Commitments and contingencies		
Stockholders' equity:		
Common Stock; $.01 par value, 1,000,000 shares authorized, 749,550 shares issued and outstanding at June 30, 2007 and 2008, respectively	–	–
Additional paid-in capital	644.6	647.1
Accumulated other comprehensive income	–	2.8
Retained deficit	(87.2)	(85.3)
Total stockholders' equity	557.4	564.6
Total liabilities and stockholders' equity	$ 2,538.1	$ 2,582.3

See accompanying notes.

VANGUARD HEALTH SYSTEMS, INC.
CONSOLIDATED STATEMENTS OF OPERATIONS

	For the Year Ended June 30,		
	2006	2007	2008
		(In millions)	
Patient service revenues	$ 2,043.6	$ 2,179.3	$ 2,340.5
Premium revenues	375.0	401.4	450.2
Total revenues	2,418.6	2,580.7	2,790.7
Costs and expenses:			
Salaries and benefits (includes stock compensation of $1.7, $1.2 and $2.5, respectively)	991.4	1,067.9	1,152.7
Supplies	394.1	421.8	434.5
Medical claims expense	270.3	297.0	328.2
Purchased services	128.1	141.2	149.5
Provision for doubtful accounts	156.8	175.2	205.6
Other operating expenses	191.0	196.4	214.5
Rents and leases	33.9	37.4	41.8
Depreciation and amortization	100.3	118.6	131.0
Interest, net	103.8	123.8	122.1
Debt extinguishment costs	0.1	–	–
Impairment loss	–	123.8	–
Other expenses	9.1	2.8	9.5
Income (loss) from continuing operations before income taxes	39.7	(125.2)	1.3
Income tax expense (benefit)	17.8	(11.6)	1.7
Income (loss) from continuing operations	21.9	(113.6)	(0.4)
Loss from discontinued operations, net of taxes	(9.0)	(19.1)	(0.3)
Net income (loss)	$ 12.9	$ (132.7)	$ (0.7)

See accompanying notes.

VANGUARD HEALTH SYSTEMS, INC.
CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

	Common Stock		Additional Paid-In Capital	Accumulated Other Comprehensive Income	Retained Earnings (Deficit)	Total Stockholders' Equity
	Shares	Amount				
			(In millions, except share amounts)			
Balance at June 30, 2005	749,550	$ –	$ 643.2	$ –	$ 32.6	$ 675.8
Stock compensation (non-cash)	–	–	1.7	–	–	1.7
Repurchase of equity incentive units	–	–	(1.5)	–	–	(1.5)
Issuance of common stock	141	–	0.1	–	–	0.1
Repurchase of common stock	(141)	–	(0.1)	–	–	(0.1)
Adjustment to income tax effect of options payouts in connection with merger	–	–	0.3	–	–	0.3
Net income	–	–	–	–	12.9	12.9
Balance at June 30, 2006	749,550	–	643.7	–	45.5	689.2
Stock compensation (non-cash)	–	–	1.2	–	–	1.2
Repurchase of equity incentive units	–	–	(0.2)	–	–	(0.2)
Issuance of common stock	195	–	0.2	–	–	0.2
Repurchase of common stock	(195)	–	(0.3)	–	–	(0.3)
Net loss	–	–	–	–	(132.7)	(132.7)
Balance at June 30, 2007	749,550	–	644.6	–	(87.2)	557.4
Stock compensation (non-cash)	–	–	2.5	–	–	2.5
Issuance of common stock	168	–	0.2	–	–	0.2
Repurchase of common stock	(168)	–	(0.2)	–	–	(0.2)
Cumulative effect of adoption of FIN 48	–	–	–	–	2.6	2.6
Comprehensive income:						
Fair value of interest rate swap (net of tax effect)	–	–	–	2.8	–	2.8
Net loss	–	–	–	–	(0.7)	(0.7)
Total comprehensive income	–	–	–	2.8	(0.7)	2.1
Balance at June 30, 2008	749,550	$ –	$ 647.1	$ 2.8	$ (85.3)	$ 564.6

See accompanying notes.

VANGUARD HEALTH SYSTEMS, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS

	For the Year Ended June 30,		
	2006	2007	2008
		(In millions)	
Operating activities:			
Net income (loss)	$ 12.9	$ (132.7)	$ (0.7)
Adjustments to reconcile net income (loss) to net cash provided by operating activities			
Loss from discontinued operations	9.0	19.1	0.3
Depreciation and amortization	100.3	118.6	131.0
Provision for doubtful accounts	156.8	175.2	205.6
Amortization of loan costs	4.0	4.5	4.9
Accretion of principal on senior discount notes	15.7	17.5	19.5
Debt extinguishment costs	0.1	–	–
Loss (gain) on disposal of assets	1.5	(4.1)	0.9
Stock compensation	1.7	1.2	2.5
Deferred income taxes	10.1	(12.7)	(2.2)
Impairment loss	–	123.8	–
Changes in operating assets and liabilities, net of effects of acquisitions and dispositions			
Accounts receivable	(162.4)	(204.0)	(223.6)
Inventories	(5.2)	(1.9)	(4.1)
Prepaid expenses and other current assets	3.6	(30.0)	(19.7)
Accounts payable	2.4	7.4	19.9
Accrued expenses and other liabilities	(11.9)	37.8	37.3
Net cash provided by operating activities – continuing operations	138.6	119.7	171.6
Net cash provided by operating activities – discontinued operations	10.7	3.6	1.5
Net cash provided by operating activities	149.3	123.3	173.1
Investing activities:			
Acquisitions	(1.2)	(0.2)	(0.2)
Capital expenditures	(275.5)	(164.3)	(121.6)
Proceeds from asset dispositions	11.1	9.5	0.4
Purchases of marketable securities	(128.4)	(120.0)	(90.0)
Sales of marketable securities	128.4	120.0	63.7
Other	0.6	2.0	1.1
Net cash used in investing activities – continuing operations	(265.0)	(153.0)	(146.6)
Net cash provided by investing activities – discontinued operations	19.6	34.5	2.8
Net cash used in investing activities	(245.4)	(118.5)	(143.8)
Financing activities:			
Proceeds from long-term debt	175.0	–	–
Payments of long-term debt and capital leases	(31.4)	(8.0)	(7.8)
Payments of loan costs and debt termination fees	(0.7)	–	–
Payments to retire stock, equity incentive units and stock options	(2.5)	(0.5)	(0.2)
Proceeds from the exercise of stock options	0.1	0.2	0.2
Net cash provided by (used in) financing activities	140.5	(8.3)	(7.8)
Increase (decrease) in cash and cash equivalents	44.4	(3.5)	21.5
Cash and cash equivalents at beginning of year	79.2	123.6	120.1
Cash and cash equivalents at end of year	$ 123.6	$ 120.1	$ 141.6

VANGUARD HEALTH SYSTEMS, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS
(continued)

	For the Year Ended June 30,		
	2006	2007	2008
		(In millions)	
Supplemental cash flow information:			
Net interest paid	$ 101.3	$ 107.8	$ 99.1
Net income taxes paid	$ 2.1	$ 0.9	$ 1.3
Supplemental noncash activities:			
Capitalized interest	$ 8.3	$ 3.0	$ 1.4
Fair value of interest rate swap, net of taxes	$ 2.8	$ –	$ –
Acquisitions:			
Cash paid, net of cash received	$ 1.2	$ 0.2	$ 0.2
Fair value of assets acquired	(3.3)	–	0.2
Liabilities assumed	0.7	–	–
Additional paid-in capital	(0.3)	–	–
Net assets acquired	(4.3)	–	0.2
Goodwill and intangible assets acquired	$ 5.5	$ 0.2	$ –
Dispositions:			
Cash received	$ 28.7	$ 37.0	$ 3.0
Carrying value of assets sold	(14.8)	(42.1)	–
Gain on sale	11.1	–	–
Escrow receivable	–	3.0	(3.0)
Liabilities assumed by buyer	–	5.5	–
Goodwill and intangible assets disposed	$ 2.8	$ 3.4	$ –

See accompanying notes.

1. Business and Basis of Presentation

Business

Vanguard Health Systems, Inc. ("Vanguard") is an investor-owned healthcare company whose affiliates own and operate hospitals and related healthcare businesses in urban and suburban areas. As of June 30, 2008, Vanguard's affiliates owned and managed 15 acute care hospitals with 4,181 licensed beds and related outpatient service locations complementary to the hospitals providing healthcare services in San Antonio, Texas; metropolitan Phoenix, Arizona; metropolitan Chicago, Illinois; and Massachusetts. Vanguard also owns managed health plans in Chicago and Phoenix and two surgery centers in Orange County, California.

Basis of Presentation

The accompanying consolidated financial statements include the accounts of subsidiaries and affiliates controlled by Vanguard. Vanguard generally defines control as the ownership of the majority of an entity's voting interests. Vanguard also consolidates any entities for which it receives the majority of the entity's expected returns or is at risk for the majority of the entity's expected losses based upon its investment or financial interest in the entity. All material intercompany accounts and transactions have been eliminated. Since none of Vanguard's common shares are publicly held, no earnings per share information is presented in the accompanying consolidated financial statements. Certain prior year amounts from the accompanying consolidated balance sheet have been reclassified to conform to current year presentation. The majority of Vanguard's expenses are "cost of revenue" items. Costs that could be classified as general and administrative include certain Vanguard corporate office costs, which approximated $30.6 million, $30.2 million and $44.3 million for the years ended June 30, 2006, 2007 and 2008, respectively.

Use of Estimates

In preparing Vanguard's consolidated financial statements in conformity with accounting principles generally accepted in the United States, management makes estimates and assumptions that affect the amounts recorded or classification of items in the consolidated financial statements and accompanying notes. Actual results could differ from those estimates.

2. Summary of Significant Accounting Policies

Revenues and Revenue Deductions

Vanguard recognizes patient service revenues during the period the healthcare services are provided based upon estimated amounts due from payers. Vanguard estimates contractual adjustments and allowances based upon payment terms set forth in managed care health plan contracts and by federal and state regulations. For the majority of its patient service revenues, Vanguard applies contractual adjustments to patient accounts at the time of billing using specific payer contract terms entered into the accounts receivable systems, but in some cases Vanguard records an estimated allowance until payment is received. Vanguard derives most of its patient service revenues from healthcare services provided to patients with Medicare and related managed Medicare plans or managed care insurance coverage. Medicare was the only individual payer for which Vanguard derived more than 10% of net patient revenues during its fiscal years ended June 30, 2006, 2007 and 2008.

Services provided to Medicare and related managed Medicare patients are generally reimbursed at prospectively determined rates per diagnosis ("PPS"), while services provided to managed care patients are generally reimbursed based upon predetermined rates per diagnosis, per diem rates or discounted fee-for-service rates. Medicaid reimbursements vary by state.

Medicare regulations and Vanguard's principal managed care contracts are often complex and may include multiple reimbursement mechanisms for different types of services provided in its healthcare facilities. To obtain reimbursement for certain services under the Medicare program, Vanguard must submit annual cost reports and record estimates of amounts owed to or receivable from Medicare. These cost reports include complex calculations and estimates related to indirect medical education, reimbursable Medicare bad debts and other items that are often subject to interpretation that could result in payments that differ from recorded estimates. Vanguard estimates amounts owed to or receivable from the Medicare program using the best information available and its interpretation of the applicable Medicare regulations. Vanguard includes differences between original estimates and subsequent revisions to those estimates (including final cost report settlements) in the consolidated statements of operations in the period in which the revisions are made. Net adjustments for final third party settlements increased patient service revenues and income from continuing operations before income taxes by $8.6 million, $6.3 million and $7.9 million during the years ended June 30, 2006, 2007 and 2008, respectively. Additionally, updated regulations and contract negotiations occur frequently, which necessitates continual review of estimation processes by management. Management believes that future adjustments to its current third party settlement estimates will not significantly impact Vanguard's results of operations or financial position.

Vanguard does not pursue collection of amounts due from uninsured patients that qualify for charity care under its guidelines (currently those uninsured patients whose incomes are equal to or less than 200% of the current federal poverty guidelines set forth by the Department of Health and Human Services). Vanguard deducts charity care accounts from revenues when it determines that the account meets its charity care guidelines. Vanguard also provides discounts from billed charges and alternative payment structures for uninsured patients who do not qualify for charity care but meet certain other minimum income guidelines, primarily those uninsured patients with incomes between 200% and 500% of the federal poverty guidelines. During the years ended June 30, 2006, 2007 and 2008, Vanguard deducted $71.1 million, $86.1 million and $86.1 million of charity care from revenues, respectively.

During the third quarter of its fiscal year ended June 30, 2007, Vanguard was approved to receive payments under the Bexar County, Texas upper payment limit ("UPL") Medicaid payment program. UPL programs allow private hospitals to enter into indigent care affiliation agreements with governmental entities. Within the parameters of these programs, private hospitals expand charity care services to indigent patients and alleviate expenses for the governmental entity. The governmental entity is then able to utilize its tax revenue to fund the Medicaid program for private hospitals. Vanguard recognizes revenues from the UPL program when Vanguard becomes entitled to the expected reimbursements, including a federal match portion, and such reimbursements are assured.

Vanguard had premium revenues from its health plans of $375.0 million, $401.4 million and $450.2 million during the years ended June 30, 2006, 2007 and 2008, respectively. Vanguard's health plans, Phoenix Health Plan ("PHP"), Abrazo Advantage Health Plan ("AAHP") and MacNeal Health Providers ("MHP"), have agreements with the Arizona Health Care Cost Containment System ("AHCCCS"), Centers for Medicare and Medicaid Services ("CMS") and various health maintenance organizations ("HMOs"), respectively, to contract to provide medical services to subscribing participants. Under these agreements, Vanguard's health plans receive monthly payments based on the number of HMO participants in MHP or the number and coverage type of enrollees in PHP and AAHP. Vanguard's health plans recognize the payments as revenues in the month in which members are entitled to healthcare services with the exception of AAHP Medicare Part D reinsurance premiums and low income subsidy cost sharing premiums that are recorded as a liability to fund future healthcare costs or else repaid to the government.

Cash and Cash Equivalents

Vanguard considers all highly liquid investments with maturity of 90 days or less when purchased to be cash equivalents. Vanguard manages its credit exposure by placing its investments in high quality securities and by periodically evaluating the relative credit standing of the financial institutions holding its cash and investments.

Restricted Cash

As of June 30, 2008 and 2007, Vanguard had restricted cash balances of $2.1 million and $6.2 million, respectively. These balances primarily represent restricted cash accounts related to liquidity requirements of AAHP and certain other arrangements.

Marketable Securities

At June 30, 2008, Vanguard held $26.3 million par value investments in auction rate securities ("ARS") backed by student loans. The ARS have maturity dates ranging from 2039 to 2043. Despite the underlying long-term maturity of the ARS, these securities have been priced and traded as short-term investments as a result of a Dutch auction process that resets the ARS interest rates at predetermined periods ranging from 7 to 35 days. Historically, the Dutch auction process has enabled Vanguard to liquidate its ARS prior to each fiscal quarter-end. However, due to liquidity issues affecting the global credit and capital markets, the auctions for these ARS since February 2008 have "failed", and Vanguard was unable to liquidate these ARS as of June 30, 2008. A failed auction does not result in default of the debt instrument. The ARS continue to accrue interest until a successful auction occurs, the issuer calls the securities or the securities mature. During May 2008, Vanguard liquidated approximately $3.7 million of the $30.0 million ARS it held as of March 31, 2008 at par value plus accrued interest through a tender from the holder leaving $26.3 million of ARS outstanding as of June 30, 2008.

Vanguard's ARS were rated "AAA" by one or more major credit rating agencies at June 30, 2008. The ratings take into account insurance policies guaranteeing both the principal and accrued interest of the investments. The U.S. government guarantees approximately 96%-98% of the principal and accrued interest on each investment in student loans under the Federal Family Education Loan Program or other similar programs.

Based upon the ARS successfully liquidated in May 2008 and additional available market information, Vanguard believes that the remaining $26.3 million par value of its ARS will become liquid during fiscal 2009. Thus, Vanguard has classified the ARS as current available-for-sale marketable securities under SFAS 115, *Accounting for Certain Investments in Debt and Equity* Securities ("SFAS 115"), on its consolidated balance sheet as of June 30, 2008. Vanguard determined that the fair value of the ARS, as required by SFAS 115, approximated par value due to the expected short-term liquidation of these marketable securities with no expectation of significant liquidation discounts supported by the governmental guarantee of the ARS. Vanguard intends and has the ability to hold the ARS until liquidation. Vanguard will continue to monitor market conditions for this type of ARS to ensure that its classification and fair value estimate for the ARS remain appropriate in future periods.

If Vanguard sells any of the ARS, prior to maturity, at an amount below carrying value, or if it becomes probable that Vanguard will not receive full par value and accrued interest as to any of the ARS, Vanguard will be required to recognize an other-than-temporary impairment.

Accounts Receivable

Vanguard's primary concentration of credit risk is patient accounts receivable, which consists of amounts owed by various governmental agencies, insurance companies and private patients. Vanguard manages the receivables by regularly reviewing its accounts and contracts and by providing appropriate allowances for contractual discounts and uncollectible amounts. Vanguard typically writes off uncollected accounts receivable 180 days subsequent to discharge date. Medicare program net receivables, including managed Medicare receivables, comprised approximately 29% and 31% of net patient receivables as of June 30, 2007 and 2008, respectively. Medicare revenues are included in the acute care services operating segment. Receivables from various state Medicaid programs and managed Medicaid programs comprised approximately 24% and 23% of net patient receivables as of June 30, 2007 and 2008, respectively. Remaining receivables relate primarily to various HMO and Preferred Provider Organization ("PPO") payers, commercial insurers and private patients. Concentration of credit risk for these payers is limited by the number of patients and payers.

Effective July 1, 2007, Vanguard began estimating the allowance for doubtful accounts using a standard policy that reserves 100% of all accounts aged greater than 365 days subsequent to discharge date plus 85% of uninsured accounts less than 365 days old plus 40% of self-pay after insurance/Medicare less than 365 days old.

Vanguard's previous policy reserved all accounts greater than 180 days plus a market-specific percentage of uninsured and self-pay after insurance/Medicare balances. Effective June 30, 2008, Vanguard adjusted its policy to reserve for all accounts aged greater than 365 days subsequent to discharge date plus 92% of uninsured accounts less than 365 days old plus 45% of self-pay after insurance/Medicare less than 365 days old. These changes in policy negatively impacted Vanguard's provision for doubtful accounts during the year ended June 30, 2008. However, management believes the revised policy will adjust more quickly to payer mix shifts over time. Vanguard tests its allowance for doubtful accounts policy quarterly using a hindsight calculation that utilizes write-off data for all payer classes during the previous twelve-month period to estimate the allowance for doubtful accounts at a point in time. Vanguard also supplements its analysis by comparing cash collections to net patient revenues and monitoring self-pay utilization. Significant changes in payer mix, business office operations, general economic conditions and healthcare coverage provided by federal or state governments or private insurers may have a significant impact on Vanguard's estimates and significantly affect its results of operations and cash flows.

Vanguard classifies accounts pending Medicaid approval as Medicaid accounts in its accounts receivable aging report and records a manual contractual allowance for these accounts equal to the average Medicaid reimbursement rate for that specific state. Vanguard has historically been successful in qualifying approximately 40%-45% of submitted accounts for Medicaid coverage. As of June 30, 2008, Vanguard had approximately $13.0 million of Medicaid pending accounts receivable from continuing operations ($4.1 million of which was stated at gross charges with a manual contractual allowance and $8.9 million of which was stated net of contractual discounts). In the event an account is not successfully qualified for Medicaid coverage and does not meet Vanguard's charity guidelines, the previously recorded Medicaid contractual adjustment remains a revenue deduction (similar to a self-pay discount), and the remaining net account balance is reclassified to uninsured status and subjected to Vanguard's allowance for doubtful accounts policy. During the years ended June 30, 2007 and 2008, approximately $13.2 million and $25.1 million, respectively, of net accounts receivable from continuing operations was reclassified from Medicaid pending status to uninsured status. If accounts do not qualify for Medicaid coverage but do qualify as charity care, the contractual adjustments are reversed and the gross account balances are recorded as charity deductions. During the years ended June 30, 2007 and 2008, Vanguard recorded $6.4 million and $7.1 million, respectively, of charity deductions from continuing operations for the net balances of accounts previously classified as Medicaid pending that did not meet Medicaid eligibility requirements.

Because Vanguard requires patient verification of coverage at the time of admission, reclassifications of Medicare or managed care accounts to self-pay, other than patient coinsurance or deductible amounts, occur infrequently and are not material to its financial statements. Additionally, the impact of these classification changes is further limited by Vanguard's ability to identify any necessary classification changes prior to patient discharge or soon thereafter. Due to information system limitations, Vanguard is unable to quantify patient deductible and coinsurance receivables that are included in the primary payer classification in the accounts receivable aging report at any given point in time. When classification changes occur, the account balance remains aged from the patient discharge date.

A summary of Vanguard's allowance for doubtful accounts activity, including those for discontinued operations, during the three most recent fiscal years follows (in millions).

	Balance at Beginning of Period	Additions Charged to Costs and Expenses	Accounts Written Off, Net of Recoveries	Balance at End of Period
Allowance for doubtful accounts:				
Year ended June 30, 2006	$ 90.1	$ 178.1	$ 164.7	$ 103.5
Year ended June 30, 2007	$ 103.5	$ 191.3	$ 181.6	$ 113.2
Year ended June 30, 2008	$ 113.2	$ 201.0	$ 196.5	$ 117.7

Inventories

Inventories, consisting of medical supplies and pharmaceuticals, are stated at the lower of cost (first-in, first-out) or market.

Property, Plant and Equipment

Purchases of property, plant and equipment are stated at cost. Routine maintenance and repairs are charged to expense as incurred. Expenditures that increase values, change capacities or extend useful lives are capitalized. Depreciation is computed using the straight-line method over the estimated useful lives of the assets, which approximate 18 months to 44 years. Depreciation expense was approximately $97.1 million, $115.4 million and $127.8 million for the years ended June 30, 2006, 2007 and 2008, respectively. Vanguard tests its property, plant and equipment and other long-lived assets for impairment as management becomes aware of impairment indicators.

During fiscal 2006, 2007 and 2008, Vanguard capitalized $8.3 million, $3.0 million and $1.4 million of interest, respectively, associated with certain of its hospital construction and expansion projects. Vanguard estimates that it is contractually obligated to expend approximately $29.5 million related to projects classified as construction in progress as of June 30, 2008. Vanguard also capitalizes costs associated with developing computer software for internal use under the provisions of AICPA Statement of Position 98-1 ("SOP 98-1"). Under SOP 98-1, Vanguard capitalizes both internal and external direct costs, excluding training, during the application development stage primarily for the purpose of customizing vendor software to integrate with our hospitals' information systems. The following table provides the gross asset balances for each major class of asset and total accumulated depreciation as of June 30, 2007 and 2008 (in millions).

	June 30, 2007	June 30, 2008
Class of asset:		
Land and improvements	$ 131.8	$ 143.5
Buildings and improvements	794.2	826.2
Equipment	485.0	558.9
Construction in progress	46.3	40.4
	1,457.3	1,569.0
Less: accumulated depreciation	(270.7)	(395.0)
Net property, plant and equipment	$ 1,186.6	$ 1,174.0

Long-Lived Assets and Goodwill

Long-lived assets, including property, plant and equipment and amortizable intangible assets, comprise a significant portion of Vanguard's total assets. Vanguard evaluates the carrying value of long-lived assets when impairment indicators are present or when circumstances indicate that impairment may exist under the provisions of SFAS 144, *Accounting for the Impairment or Disposal of Long-Lived Assets*. When management believes impairment indicators may exist, projections of the undiscounted future cash flows associated with the use of and eventual disposition of long-lived assets held for use are prepared. If the projections indicate that the carrying values of the long-lived assets are not expected to be recoverable, Vanguard reduces the carrying values to fair value. For long-lived assets held for sale, Vanguard compares the carrying values to an estimate of fair value less selling costs to determine potential impairment. Vanguard tests for impairment of long-lived assets at the lowest level for which cash flows are measurable. These impairment tests are heavily influenced by assumptions and estimates that are subject to change as additional information becomes available. Given the relatively few number of hospitals Vanguard owns and the significant amounts of long-lived assets attributable to those hospitals, an impairment of the long-lived assets for even a single hospital could materially adversely impact its operating results or financial position.

Goodwill also represents a significant portion of Vanguard's total assets. Vanguard reviews goodwill for impairment annually during its fourth fiscal quarter or more frequently if certain impairment indicators arise under the provisions of SFAS 142, *Goodwill and Other Intangible Assets*. Vanguard reviews goodwill at the reporting unit level, which is one level below an operating segment. Vanguard compares the carrying value of the net assets of each reporting unit to the net present value of estimated discounted future cash flows of the reporting unit. If the carrying value exceeds the net present value of estimated discounted future cash flows, an impairment indicator exists and an estimate of the impairment loss is calculated. The fair value calculation includes multiple assumptions

and estimates, including the projected cash flows and discount rates applied. Changes in these assumptions and estimates could result in goodwill impairment that could materially adversely impact Vanguard's results of operations or statement of position.

Amortization of Intangible Assets

Amounts allocated to contract-based intangible assets are amortized over their useful lives, which equal 10 years. No amortization is recorded for indefinite-lived intangible assets. Deferred loan costs and syndication costs are amortized over the life of the applicable credit facility or notes using the effective interest method. Physician income and service agreement guarantee intangible assets are recorded based upon the estimated future payments under the contracts and are amortized over the applicable contract service periods.

Income Taxes

Vanguard accounts for income taxes using the asset and liability method in accordance with SFAS No. 109, *Accounting for Income Taxes* ("SFAS 109") and FASB Interpretation No. 48, *Accounting for Uncertainty in Income Taxes – An Interpretation of FASB Statement No. 109* ("FIN 48"). These guidelines require the recognition of deferred tax assets and liabilities for the expected future tax consequences of temporary differences between the carrying amounts and the tax bases of assets and liabilities.

Vanguard believes that its tax return provisions are accurate and supportable, but certain tax matters require interpretations of tax law that may be subject to future challenge and may not be upheld under tax audit. To reflect the possibility that all of its tax positions may not be sustained, Vanguard maintains tax reserves that are subject to adjustment as updated information becomes available or as circumstances change. Vanguard records the impact of tax reserve changes to its income tax provision in the period in which the additional information, including the progress of tax audits, is obtained.

Vanguard assesses the realization of its deferred tax assets to determine whether an income tax valuation allowance is required. Based on all available evidence, both positive and negative, and the weight of that evidence to the extent such evidence can be objectively verified, Vanguard determines whether it is more likely than not that all or a portion of the deferred tax assets will be realized. The factors used in this determination include the following:

- Cumulative losses in recent years
- Income/losses expected in future years
- Unsettled circumstances that, if favorably resolved, would adversely affect future operations
- Availability, or lack thereof, of taxable income in prior carryback periods that would limit realization of tax benefits
- Carryforward period associated with the deferred tax assets and liabilities
- Prudent and feasible tax planning strategies

In addition, financial forecasts used in determining the need for or amount of federal and state valuation allowances are subject to changes in underlying assumptions and fluctuations in market conditions that could significantly alter Vanguard's recoverability analysis and thus have a material adverse impact on Vanguard's consolidated financial condition, results of operations or cash flows.

Medical Claims Reserves

During the years ended June 30, 2006, 2007 and 2008, medical claims expense was $270.3 million, $297.0 million and $328.2 million, respectively, primarily representing medical claims of PHP. Vanguard estimates PHP's reserve for medical claims using historical claims experience (including cost per member and payment lag time) and other actuarial data including number of enrollees and certain enrollee demographic information. The reserve for medical claims, including incurred but not reported claims, for all Vanguard health plans combined was approximately $61.4 million and $51.1 million as of June 30, 2007 and 2008, respectively. While management believes that its estimation methodology effectively captures trends in medical claims costs, actual payments could differ significantly from its estimates given changes in the healthcare cost structure or adverse experience. During the years ended June 30, 2006, 2007 and 2008, approximately $40.0 million, $34.2 million and $31.2 million,

respectively, of accrued and paid claims for services provided to Vanguard's health plan enrollees by its hospitals and its other healthcare facilities were eliminated in consolidation. Vanguard's operating results and cash flows could be materially affected by increased or decreased utilization of its healthcare facilities by enrollees in its health plans.

Employee Health Insurance

As of June 30, 2008, Vanguard maintained self-insured medical and dental plans for a limited number of its employees. Claims are accrued under the self-insured plans as the incidents that give rise to them occur. Unpaid claims accruals are based on the estimated ultimate cost of settlement, including claim settlement expenses, in accordance with an average lag time and historical experience. The reserve for self-insured medical and dental plans was approximately $1.2 million and $1.5 million as of June 30, 2007 and 2008, respectively, and is included in accrued salaries and benefits in the accompanying consolidated balance sheets. Effective July 1, 2008, Vanguard began covering all of its employees under its self-insured medical and dental plans, which will subject it to higher risks and reserve levels. Vanguard mitigated this risk by purchasing stop-loss coverage for catastrophic claims at a $500,000 per enrollee annual limit.

Insurance Reserves

Given the nature of its operating environment, Vanguard is subject to professional and general liability and workers compensation claims and related lawsuits in the ordinary course of business. For professional and general liability claims incurred from June 1, 2002 to May 31, 2006, Vanguard's wholly owned captive subsidiary insured its professional and general liability risks at a $10.0 million retention level. For professional and general liability claims incurred subsequent to May 31, 2006, Vanguard self-insures the first $9.0 million per claim, and the captive subsidiary insures the next $1.0 million per claim. Vanguard maintains excess coverage from independent third party insurers on a claims-made basis for individual claims exceeding $10.0 million up to $75.0 million, but limited to total annual payments of $65.0 million in the aggregate.

Vanguard insures its excess coverage under a retrospectively rated policy, and premiums under this policy are recorded based on Vanguard's historical claims experience. Vanguard self-insures its workers compensation claims up to $1.0 million per claim and purchases excess insurance coverage for claims exceeding $1.0 million.

The following tables summarize Vanguard's professional and general liability and workers compensation reserve balances as of June 30, 2007 and 2008 and its total provision for professional and general liability and workers compensation losses and related claims payments during the years ended June 30, 2006, 2007 and 2008.

	Professional and General Liability	Workers Compensation
	(In millions)	
Reserve balance:		
June 30, 2007	$ 64.6	$ 18.5
June 30, 2008	$ 74.3	$ 18.8
Provision for claims losses:		
Fiscal Year 2006	$ 21.0	$ 8.9
Fiscal Year 2007	$ 20.2	$ 9.4
Fiscal Year 2008	$ 21.8	$ 5.3
Claims paid:		
Fiscal Year 2006	$ 12.7	$ 6.4
Fiscal Year 2007	$ 14.4	$ 6.2
Fiscal Year 2008	$ 12.1	$ 5.0

Vanguard utilizes actuarial information to estimate its reserves for professional and general liability and workers compensation claims. Each reserve is comprised of estimated indemnity and expense payments related to: (1) reported events ("case reserves") and (2) incurred but not reported ("IBNR") events as of the end of the period. Management uses information from its risk managers and its best judgment to estimate case reserves. Actuarial IBNR estimates are dependent on multiple variables including Vanguard's risk exposures, its self-insurance limits, geographic locations in which it operates, the severity of its historical losses compared to industry averages and the reporting pattern of its historical losses compared to industry averages, among others. Most of these variables require judgment, and changes in these variables could result in significant period over period fluctuations in Vanguard's estimates. Vanguard discounts its workers compensation reserve using actuarial estimates of projected cash payments in future periods. Vanguard adjusts these reserves from time to time as it receives updated information. During its fiscal years ended June 30, 2006, 2007 and 2008, due to changes in historical loss trends, Vanguard decreased its professional and general liability reserve related to prior fiscal years by $6.9 million, $4.5 million and $0.6 million, respectively. Similarly, Vanguard decreased its workers compensation reserve related to prior fiscal years by $2.3 million during its fiscal year ended June 30, 2008. Adjustments to the workers compensation reserve related to prior years during fiscal years ended June 30, 2006 and 2007 were not significant. Additional adjustments to prior year estimates may be necessary in future periods as Vanguard's reporting history and loss portfolio matures.

Market and Labor Risks

Vanguard operates primarily in four geographic markets. If economic or other factors limit its ability to provide healthcare services in one or more of these markets, Vanguard's cash flows and results of operations could be materially adversely impacted. Approximately 1,600 full-time employees in Vanguard's Massachusetts hospitals are subject to collective organizing agreements. This group represents approximately 9% of Vanguard's workforce. During fiscal 2007, Vanguard entered into a new three-year contract with the union representing the majority of this group that ends on December 31, 2009. If Vanguard experiences significant future labor disruptions related to these unionized employees, its cash flows and results of operations could be materially adversely impacted.

Stock-Based Compensation

Vanguard accounts for stock-based employee compensation granted prior to July 1, 2006 under the provisions of Statement of Financial Accounting Standards No. 123, *Accounting for Stock-Based Compensation* ("SFAS 123"). Effective July 1, 2003, Vanguard adopted SFAS 123 on a prospective basis, an acceptable transition method set forth in SFAS No. 148, *Accounting for Stock-Based Compensation Transition and Disclosure* ("SFAS 148"). For grants dated July 1, 2006 and subsequent, Vanguard accounts for stock-based employee compensation under the provisions of Statement of Financial Accounting Standards No. 123(R), *Share-Based Payment* ("SFAS 123(R)"). Vanguard also adopted SFAS 123(R) on a prospective basis and such adoption did not significantly impact Vanguard's results of operations or cash flows.

The following table sets forth the weighted average assumptions utilized in the minimum value pricing model for stock option grants under the 2004 Option Plan prior to July 1, 2006 and those utilized in the Black-Scholes-Merton valuation model for grants under the 2004 Option Plan subsequent to July 1, 2006.

	Minimum Value	Black-Scholes-Merton
Risk-free interest rate	4.5%	4.0%
Dividend yield	0.0%	0.0%
Volatility (annual)	N/A	30.2%
Expected option life	10 years	6.5 years

For stock options included in the Black-Scholes-Merton valuation model, Vanguard used historical stock price information of certain peer group companies for a period of time equal to the expected option life period to determine estimated volatility. Vanguard determined the expected life of the stock options by averaging the contractual life of the options and the vesting period of the options. The estimated fair value of options is amortized to expense on a straight-line basis over the options' vesting period.

Fair Value of Financial Instruments

Cash and Cash Equivalents and Restricted Cash

The carrying amounts reported for cash and cash equivalents and restricted cash approximate fair value because of the short-term maturity of these instruments.

Marketable Securities

The carrying amounts reported for marketable securities approximate fair value because of the expected liquidation of these securities during the fiscal year ending June 30, 2009 at par value.

Accounts Receivable and Accounts Payable

The carrying amounts reported for accounts receivable and accounts payable approximate fair value because of the short-term maturity of these instruments.

Long-Term Debt

The fair values of Vanguard's 9.0% Notes, and 11.25% Notes and term debt as of June 30, 2008 were approximately $577.9 million, $190.1 million and $750.8, respectively, based upon stated market prices. The fair values are subject to change as market conditions change.

Interest Rate Swap

The fair value of Vanguard's interest rate swap as of June 30, 2008 was an asset of $2.8 million, net of taxes, based upon information obtained from the counterparty.

Recently Issued Accounting Pronouncements

In May 2008, the Financial Accounting Standards Board ("FASB") issued Statement of Financial Accounting Standards No. 163, *Accounting for Financial Guarantee Insurance Contracts* ("SFAS 163"). SFAS 163 requires that an insurance entity recognize a claim liability prior to the occurrence of an insured event when evidence of credit deterioration within an insured financial obligation exists. SFAS 163 also sets forth guidance related to the recognition and measurement to be used to account for premium revenues and claim liabilities and provides expanded disclosure requirements. SFAS 163 is effective for Vanguard's fiscal year ending June 30, 2009 and all interim periods within that fiscal year with early application not permitted. Vanguard does not expect the adoption of SFAS 163 to significantly impact its financial position, results of operations or cash flows.

In March 2008, the FASB issued Statement of Financial Accounting Standards No. 161, *Disclosure About Derivative Instruments and Hedging Activities – an amendment of FASB Statement No. 133* ("SFAS 161"). SFAS 161 requires enhanced disclosures about an entity's derivative and hedging activities to improve the financial reporting for these derivative instruments. These disclosures include how and why an entity uses derivative instruments, the accounting treatment of the instruments under SFAS 133 and related interpretations and how the instruments affect the entity's financial position, results of operations and cash flows. SFAS 161 also requires tabular presentation of the fair values of derivatives and their related gains and losses. SFAS 161 is effective for Vanguard's fiscal quarter beginning January 1, 2009 with early adoption permitted. Other than additional required disclosures, Vanguard does not expect adoption of SFAS 161 to impact its consolidated financial statements.

In December 2007, the FASB issued Statement of Financial Accounting Standards No. 141(R), *Business Combinations* ("SFAS 141(R)"). SFAS 141(R) applies to all transactions or other events in which an entity obtains control of one or more businesses even if the acquirer does not acquire 100% of all interests of the target. Under SFAS 141(R) the acquirer recognizes 100% of the fair values of acquired assets, including goodwill, and assumed liabilities with only limited exceptions. This methodology replaces the previous cost-allocation process set forth in SFAS No. 141 that often resulted in the measurement of assets and liabilities at values other than fair value at the acquisition date. SFAS 141(R) also requires contingent consideration to be measured at fair value at acquisition date

with subsequent adjustments measured in future periods. Transactions costs are not considered part of the acquired assets and thus are expensed as incurred under SFAS 141(R). The acquisition date is deemed to be the date on which the acquisition is completed, not when the acquisition agreement is executed. Vanguard will adopt SFAS 141(R) prospectively for acquisitions completed on or after July 1, 2009. However, SFAS 141(R) requires changes to estimates of deferred taxes arising from business combinations to be adjusted through earnings even if the business combination occurred prior to the effective date of SFAS 141(R). SFAS 141(R) will affect Vanguard's future financial position, results of operations or cash flows to the extent Vanguard completes a business combination on or subsequent to July 1, 2009 and could significantly impact Vanguard's future results of operations should deferred tax estimates attributable to the Blackstone merger differ significantly from their ultimate resolution.

In December 2007, the FASB issued Statement of Financial Accounting Standards No. 160, *Noncontrolling Interests in Consolidated Financial Statements* ("SFAS 160"). SFAS 160 amended Accounting Research Bulletin No. 51, *Consolidated Financial Statements*, to establish a single method of accounting for non-controlling interests in subsidiaries, or previously referred to as minority interests. SFAS 160 requires that the noncontrolling interest in a subsidiary be reported as a component of stockholder's equity in the consolidated balance sheet. SFAS 160 also requires that consolidated net income include both the parent and noncontrolling interest's portion of the operating results of the subsidiary with separate disclosure on the statement of operations of the amounts attributable to the parent versus the noncontrolling interest. Changes in the parent's ownership interest that do not result in deconsolidation are treated as equity transactions under SFAS 160. Vanguard will adopt SFAS 160 prospectively on July 1, 2009 with retrospective presentation for comparative periods shown. Vanguard does not expect SFAS 160 to have a material impact on its future financial position, results of operations or cash flows.

In February 2007, the FASB issued Statement of Financial Accounting Standards No. 159, *The Fair Value Option for Financial Assets and Financial Liabilities* ("SFAS 159"). SFAS 159 gives entities the option to voluntarily choose, at certain election dates, to measure many financial assets and liabilities at fair value. Elections are made on an instrument by instrument basis and are irrevocable once made. Subsequent changes to the fair value of any instrument for which an election is made are reflected through earnings. SFAS 159 is effective for Vanguard as of July 1, 2008 with early adoption permitted. Vanguard does not expect SFAS 159 to significantly impact its future financial position, results of operations or cash flows.

On September 15, 2006, the FASB issued Statement of Financial Accounting Standards No. 157, *Fair Value Measurement* ("SFAS 157"). SFAS 157 sets forth comprehensive guidance for measuring fair value of assets and liabilities. Under the provisions of SFAS 157, fair value should be based on the assumptions market participants would use to complete the sale of an asset or transfer of a liability. SFAS 157 provides a hierarchy of information to be used to determine the applicable market assumptions, and fair value measurements would be separately disclosed under each applicable layer of the hierarchy. SFAS 157 does not expand or restrict the use of fair value for measuring assets and liabilities but provides a single methodology to be used when fair value accounting is applied. For those financial assets and financial liabilities defined in SFAS 159, SFAS 157 is effective for Vanguard's fiscal year beginning July 1, 2008 with early adoption permitted. For non-recurring nonfinancial assets and nonfinancial liabilities, SFAS 157 is effective for Vanguard's fiscal year beginning July 1, 2009. Vanguard does not expect the adoption of SFAS 157 to significantly impact its future financial position, results of operations or cash flows.

3. Discontinued Operations

On March 8, 2006, certain subsidiaries of Vanguard sold medical office buildings in California to an independent third party for net sales proceeds of approximately $28.7 million. The net book value of the property, plant and equipment sold was approximately $14.8 million, and Vanguard allocated approximately $2.8 million of existing goodwill to the disposed assets. Vanguard recognized a gain on the sale of approximately $11.1 million ($8.3 million net of taxes) related to this transaction during fiscal 2006.

On October 1, 2006, certain of Vanguard's subsidiaries completed the sale of their three hospitals in Orange County, California (West Anaheim Medical Center, Huntington Beach Hospital and La Palma Intercommunity Hospital) to subsidiaries of Prime Healthcare, Inc. for net proceeds of $40.0 million, comprised of cash proceeds of $37.0 million and $3.0 million of proceeds placed in escrow which was distributed to a subsidiary of Vanguard on July 2, 2007. Approximately $12.8 million of retained working capital, including $25.3 million of patient accounts receivable, was excluded from the sale.

The operations of the California hospitals and medical office buildings are included in discontinued operations, net of taxes, in the accompanying statements of operations for all periods presented in accordance with SFAS 144, *Accounting for the Impairment or Disposal of Long-Lived Assets* ("SFAS 144") and EITF 03-13, *Applying the Conditions of Paragraph 42 of FASB Statement No. 144 in Determining Whether to Report Discontinued Operations* ("EITF 03-13"). The post-transaction direct cash flows that previously precluded the California medical office buildings operations from being included in discontinued operations under EITF 03-13 were eliminated upon the sale of the California hospitals.

During fiscal 2006, prior to the sale of the California hospitals, Vanguard recorded an impairment charge of $15.0 million ($9.4 million net of taxes) to write down its basis in the net property, plant and equipment of these hospitals to estimated fair value using a discounted cash flows model. This impairment charge is included in discontinued operations, net of taxes in the accompanying consolidated statement of operations for the year ended June 30, 2006.

In June 2007, Vanguard ceased providing acute care services at Phoenix Memorial Hospital ("PMH") and began leasing certain floors of the building to various third party healthcare providers. The leases are 5-year and 7-year leases with renewal options. When comparing the projected lease income to the historical total revenues of PMH, Vanguard determined that the expected cash inflows under the leases were insignificant and deemed indirect cash flows. Thus, the acute care operations of PMH are included in discontinued operations, net of taxes in the accompanying statements of operations for all periods presented in accordance with SFAS 144 and EITF 03-13.

The following table sets forth the components of discontinued operations, net of taxes for the years ended June 30, 2006, 2007 and 2008, respectively (in millions).

	Year ended June 30,		
	2006	2007	2008
Total revenues	$ 234.1	$ 91.7	$ (1.5)
Operating expenses	239.3	115.9	(1.6)
Allocated interest	7.2	2.7	–
Impairment loss	15.0	–	–
Loss (gain) on sale of assets	(11.1)	1.7	0.6
Income tax benefit	(7.3)	(9.5)	(0.2)
Loss from discontinued operations, net of taxes	$ 9.0	$ 19.1	$ 0.3

The interest allocations to discontinued operations for the years ended June 30, 2006 and 2007 were based upon the ratio of net assets to be divested to the sum of total net assets and Vanguard's outstanding debt. Income taxes were calculated using an effective tax rate of approximately 44.8%, 33.2% and 40.0% for the years ended June 30, 2006, 2007 and 2008, respectively.

4. Prepaid Expenses and Other Current Assets

Prepaid expenses and other current assets in the accompanying consolidated balance sheets consist of the following at June 30, 2007 and 2008 (in millions).

	2007	2008
Prepaid insurance	$ 6.0	$ 5.2
Other prepaid expenses	10.1	10.5
Deferred tax assets	8.9	24.5
Interest rate swap receivable	–	2.8
Third party settlements	6.7	4.4
Other receivables	32.7	32.9
	$ 64.4	$ 80.3

5. Impairment of Long-Lived Assets

During the second quarter of fiscal 2007, as a result of certain trends in the business climate at its Chicago hospitals including payer mix shifts, Vanguard performed an impairment test of the long-lived assets of these two hospitals under SFAS 144 and SFAS 142, *Goodwill and Other Intangible Assets*. Based upon independent estimates of the fair value of the hospitals, Vanguard recorded a $123.8 million ($110.5 million, net of tax benefit) impairment charge during the quarter and six months ended December 31, 2006. The independent fair value estimates were developed using a discounted net cash flows approach and two market-based approaches. As a result of the impairment charge, Vanguard reduced goodwill for its acute care services segment by $123.8 million. Goodwill related to the Chicago hospitals was approximately $40.6 million as of June 30, 2008.

Vanguard will continue to monitor the operations of its Chicago hospitals due to the sensitivity of the projected cash flows of this reporting unit to the goodwill impairment analysis. If projected future cash flows become less favorable than those projected by management, an additional impairment charge may become necessary that could have a material adverse impact on Vanguard's financial position and results of operations.

6. Goodwill and Intangible Assets

The following table provides information regarding the intangible assets, including deferred loan costs, included in the accompanying consolidated balance sheets as of June 30, 2007 and 2008 (in millions).

	Gross Carrying Amount		Accumulated Amortization	
Class of Intangible Asset	2007	2008	2007	2008
Amortized intangible assets:				
Deferred loan costs	$ 43.8	$ 43.8	$ 11.2	$ 16.1
Contracts	31.4	31.4	8.6	11.8
Physician income and other guarantees	13.8	22.2	5.4	12.1
Other	1.3	1.3	0.3	0.5
Subtotal	90.3	98.7	25.5	40.5
Indefinite-lived intangible assets:				
License and accreditation	3.2	3.2	–	–
Total	$ 93.5	$ 101.9	$ 25.5	$ 40.5

Amortization expense for the contract-based intangibles, which represent PHP's contract with AHCCCS and PHP's various contracts with network providers, during each of the years ended June 30, 2006, 2007 and 2008 was approximately $3.2 million. Vanguard expects amortization expense for the contract intangible assets to approximate $3.2 million during each of the fiscal years ending June 30, 2009 through June 30, 2012. Amortization of deferred loan costs of $4.0 million, $4.4 million and $4.9 million during the years ended June 30, 2006, 2007 and 2008, respectively, is included in net interest. Amortization of physician income and other guarantees of $0.2 million, $5.1 million and $6.7 million during the years ended June 30, 2006, 2007 and 2008, respectively, is included in purchased services or other operating expenses. The useful lives over which intangible assets are amortized range from two years to eleven years. The following table presents the changes in the carrying amount of goodwill from June 30, 2006 through June 30, 2008 (in millions).

	Acute Care Services	Health Plans	Total
Balance as of June 30, 2006	$ 733.4	$ 79.4	$ 812.8
Chicago hospitals goodwill impairment	(123.8)	–	(123.8)
Acquisition of physician practice	0.2	–	0.2
Balance as of June 30, 2007 and 2008	$ 609.8	$ 79.4	$ 689.2

Vanguard completed its annual impairment test of goodwill and indefinite-lived intangible assets during the fourth quarter of fiscal 2008 noting no impairment. Approximately $148.6 million of Vanguard's goodwill is deductible for tax purposes.

7. Other Accrued Expenses and Current Liabilities

The following table presents summaries of items comprising other accrued expenses and current liabilities in the accompanying consolidated balance sheets as of June 30, 2007 and 2008 (in millions).

	2007	2008
Property taxes	$ 15.3	$ 14.6
Current portion of insurance risks	21.5	19.0
Construction retention payable	1.7	–
Accrued income guarantees	4.3	4.4
Income taxes payable	–	2.4
Other	23.7	9.2
	$ 66.5	$ 49.6

8. Long-Term Debt

A summary of Vanguard's long-term debt at June 30, 2007 and 2008 follows (in millions).

	2007	2008
9.0% Senior Subordinated Notes	$ 575.0	$ 575.0
11.25% Senior Discount Notes	168.9	188.4
Term loans payable under credit facility	781.9	774.1
Other	2.9	–
	1,528.7	1,537.5
Less: current maturities	(8.0)	(8.0)
	$ 1,520.7	$ 1,529.5

9.0% Notes

In connection with the Blackstone acquisition of Vanguard by merger on September 23, 2004 (the "Blackstone merger"), two of Vanguard's wholly owned subsidiaries, Vanguard Health Holding Company II, LLC and Vanguard Holding Company II, Inc. (collectively, the "Issuers"), completed a private placement of $575.0 million 9% Senior Subordinated Notes due 2014 ("9.0% Notes"). Interest on the 9.0% Notes is payable semi-annually on October 1 and April 1 of each year. The 9.0% Notes are general unsecured senior subordinated obligations and rank junior in right of payment to all existing and future senior indebtedness of the Issuers. All payments on the 9.0% Notes are guaranteed jointly and severally on a senior subordinated basis by Vanguard and its domestic subsidiaries, other than those subsidiaries that do not guarantee the obligations of the borrowers under the senior credit facilities.

Prior to October 1, 2009, the Issuers may redeem the 9.0% Notes, in whole or in part, at a price equal to 100% of the principal amount thereof plus a make-whole premium. On or after October 1, 2009, the Issuers may redeem all or part of the 9.0% Notes at various redemption prices given the date of redemption as set forth in the indenture governing the 9.0% Notes. The initial redemption price for the 9.0% Notes on October 1, 2009 is equal to 104.50% of their principal amount, plus accrued and unpaid interest. The redemption price declines each year after 2009. The redemption price will be 100% of the principal amount, plus accrued and unpaid interest, beginning on October 1, 2012.

On January 26, 2005, Vanguard exchanged all of its outstanding 9.0% senior subordinated notes due 2014 for new 9.0% senior subordinated notes due 2014 with identical terms and conditions, except that they were registered under the Securities Act of 1933. Terms and conditions of the exchange offer were set forth in Vanguard's registration statement on Form S-4 filed with the Securities and Exchange Commission that became effective on December 23, 2004.

11.25% Notes

In connection with the Blackstone merger on September 23, 2004, two of Vanguard's wholly owned subsidiaries, Vanguard Health Holding Company I, LLC and Vanguard Holding Company I, Inc. (collectively, the "Discount Issuers"), completed a private placement of $216.0 million aggregate principal amount at maturity ($124.7 million in gross proceeds) of 11.25% Senior Discount Notes due 2015 ("11.25% Notes"). The 11.25% Notes accrete at the stated rate compounded semi-annually on April 1 and October 1 of each year to, but not including, October 1, 2009. Subsequent to October 1, 2009, cash interest on the 11.25% Notes will accrue at 11.25% per annum, and will be payable on April 1 and October 1 of each year, commencing on April 1, 2010 until maturity. The 11.25% Notes are general senior unsecured obligations and rank junior in right of payment to all existing and future senior indebtedness of the Discount Issuers but senior to any of the Discount Issuers' future senior subordinated indebtedness. All payments on the 11.25% Notes are guaranteed by Vanguard as a holding company guarantee.

Prior to October 1, 2009, the Discount Issuers may redeem the 11.25% Notes, in whole or in part, at a price equal to 100% of the accreted value thereof, plus accrued and unpaid interest, plus a make-whole premium. On or after October 1, 2009, the Discount Issuers may redeem all or a part of the 11.25% Notes at various redemption prices given the date of redemption as set forth in the indenture governing the 11.25% Notes. The initial redemption price for the 11.25% Notes on October 1, 2009 is equal to 105.625% of their principal amount, plus accrued and unpaid interest. The redemption price declines each year after 2009. The redemption price will be 100% of the principal amount, plus accrued and unpaid interest, beginning on October 1, 2012.

On January 26, 2005, Vanguard exchanged all of its outstanding 11.25% senior discount notes due 2015 for new 11.25% senior discount notes due 2015 with identical terms and conditions, except that they were registered under the Securities Act of 1933. Terms and conditions of the exchange offer were set forth in Vanguard's registration statement on Form S-4 filed with the Securities and Exchange Commission that became effective on December 23, 2004.

Credit Facility Debt

In connection with the Blackstone merger on September 23, 2004, two of Vanguard's wholly owned subsidiaries, Vanguard Health Holding Company II, LLC and Vanguard Holding Company II, Inc. (collectively, the "Co-borrowers"), entered into new senior secured credit facilities (the "merger credit facilities") with various lenders and Bank of America, N.A. as administrative agent and Citicorp North America, Inc. as syndication agent, and repaid all amounts outstanding under its previous credit facility. The merger credit facilities include a seven-year term loan facility in the aggregate principal amount of $800.0 million (of which $475.0 million was funded at closing) and a six-year $250.0 million revolving credit facility. Of the $325.0 million unfunded term loans, $150.0 million was made available to finance the acquisition of hospitals and related businesses provided that the acquisition occurred on or prior to February 20, 2005, and to fund capital expenditures and other corporate needs. Also, $175.0 million was made available for working capital, capital expenditures and other general corporate purposes until September 23, 2005. Vanguard borrowed all $325.0 million delayed draw term loans at various times during its fiscal years 2005 and 2006.

On September 26, 2005, the Co-borrowers refinanced and repriced all $795.7 million of the then outstanding term loans under the merger credit facilities by borrowing $795.7 million of replacement term loans that also mature on September 23, 2011 (the "2005 term loan facility"). In addition, upon the occurrence of certain events, the Co-borrowers may request an incremental term loan facility to be added to the 2005 term loan facility in an amount not to exceed $300.0 million in the aggregate, subject to receipt of commitments by existing lenders or other financing institutions and to the satisfaction of certain other conditions. The revolving loan facility under the merger credit facilities did not change in connection with the term loan refinancing. As of June 30, 2008, $774.1 million of indebtedness was outstanding under the 2005 term loan facility. Vanguard's remaining borrowing capacity under the revolving credit facility, net of letters of credit outstanding, was $222.0 million as of June 30, 2008.

The 2005 term loan facility borrowings bear interest at a rate equal to, at Vanguard's option, LIBOR plus 2.25% per annum or a base rate plus 1.25% per annum. These interest rates reflect a savings of 1.00% per annum over the interest rate options for term loan borrowings under the merger credit facilities. Borrowings under the revolving credit facility currently bear interest at a rate equal to, at Vanguard's option, LIBOR plus 2.25% per annum or a base rate plus 1.25% per annum, subject to an increase of up to 0.25% per annum should Vanguard's leverage ratio increase over certain designated levels. Vanguard also pays a commitment fee to the lenders under the revolving credit facility in respect of unutilized commitments thereunder at a rate equal to 0.50% per annum. Vanguard also pays customary letter of credit fees under this facility. Vanguard makes quarterly principal payments equal to one-fourth of one percent of the outstanding principal balance of the 2005 term loan facility, and will continue to make such payments until maturity of the term debt.

Vanguard is subject to certain restrictive and financial covenants under the credit agreement governing the 2005 term loan facility and the revolving credit facility including a total leverage ratio, senior leverage ratio, interest coverage ratio and capital expenditure restrictions. Vanguard was in compliance with each of these financial covenants as of June 30, 2008. Obligations under the credit agreement are unconditionally guaranteed by Vanguard and Vanguard Health Holding Company I, LLC ("VHS Holdco I") and, subject to certain exceptions, each of VHS Holdco I's wholly-owned domestic subsidiaries (the "U.S. Guarantors"). Obligations under the credit agreement are also secured by substantially all of the assets of Vanguard Health Holding Company II, LLC ("VHS Holdco II") and the U.S. Guarantors including a pledge of 100% of the membership interests of VHS Holdco II, 100% of the capital stock of substantially all U.S. Guarantors (other than VHS Holdco I) and 65% of the capital stock of each of VHS Holdco II's non-U.S. subsidiaries that are directly owned by VHS Holdco II or one of the U.S. Guarantors and a security interest in substantially all tangible and intangible assets of VHS Holdco II and each U.S. Guarantor.

Interest Rate Swap Agreement

During April 2008, Vanguard entered into an interest rate swap agreement with Bank of America, N.A. (the "counterparty") that went into effect on June 30, 2008. Given the turbulence in the credit markets and the attractive swap rates then available, Vanguard executed the swap agreement to hedge its cash flows related to a portion of the 2005 term loan facility against potential market fluctuations to the variable 90-day LIBOR interest rate. Vanguard will continue to make its normal quarterly interest payments under the 2005 term loan facility as described above.

However, Vanguard will also begin making quarterly fixed interest payments on September 30, 2008 at a rate equal to 2.785% on a notional $450.0 million of the 2005 term loan facility in exchange for payments to Vanguard from the counterparty based upon the applicable variable 90-day LIBOR rate on the same notional amount. Vanguard will account for this swap as a highly effective cash flow hedge with critical terms that substantially match the underlying term debt and will measure any ineffectiveness using the hypothetical derivative method. Vanguard deems the counterparty to be creditworthy. As of June 30, 2008, the estimated fair value of the interest rate swap was an asset for Vanguard of approximately $2.8 million (net of taxes of $1.8 million), which is included in prepaid expenses and other current assets and accumulated other comprehensive income on the accompanying balance sheet. Vanguard will make quarterly adjustments to other comprehensive income equal to the change in the fair value of the swap from quarter to quarter until the maturity of the swap on March 31, 2010 with any ineffectiveness included in earnings.

Deferred Loan Costs

In connection with the Blackstone merger, Vanguard incurred $43.8 million of deferred offering and loan costs related to the 9.0% Notes, the 11.25% Notes and term and revolving loan borrowings under the merger credit facilities and the 2005 term loan facility. Vanguard incurred $4.0 million, $4.5 million and $4.9 million of interest expense, respectively, during the years ended June 30, 2006, 2007 and 2008 related to the amortization of these offering and loan costs.

Future Maturities

Future maturities of Vanguard's debt as of June 30, 2008 follow (in millions).

Fiscal Year	Amount
2009	$ 8.0
2010	7.9
2011	8.0
2012	750.2
2013	–
Thereafter	791.0
	$ 1,565.1

Other Information

Vanguard conducts substantially all of its business through its subsidiaries. Most of Vanguard's subsidiaries jointly and severally guarantee the 9.0% Notes on an unsecured senior subordinated basis. Certain of Vanguard's other consolidated wholly-owned and non wholly-owned entities do not guarantee the 9.0% Notes in conformity with the provisions of the indenture governing the 9.0% Notes and do not guarantee Vanguard's 2005 term loan facility in conformity with the provisions thereof. The condensed consolidating financial information for the parent company, the issuers of the 9.0% Notes, the issuers of the 11.25% Notes, the guarantor subsidiaries, the combined non-guarantor subsidiaries, certain eliminations and consolidated Vanguard as of June 30, 2007 and 2008, and for the years ended June 30, 2006, 2007 and 2008, follows.

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING BALANCE SHEETS
June 30, 2007

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
ASSETS							
Current assets:							
Cash and cash equivalents	$ –	$ –	$ –	$ 11.7	$ 108.4	$ –	$ 120.1
Restricted cash	–	–	–	4.4	1.8	–	6.2
Accounts receivable, net	–	–	–	260.0	27.3	–	287.3
Inventories	–	–	–	41.8	5.0	–	46.8
Prepaid expenses and other current assets	0.1	–	–	44.5	22.4	(2.6)	64.4
Total current assets	0.1	–	–	362.4	164.9	(2.6)	524.8
Property, plant and equipment, net	–	–	–	1,112.1	74.5	–	1,186.6
Goodwill	–	–	–	605.6	83.6	–	689.2
Intangible assets, net	–	29.2	3.4	11.1	24.3	–	68.0
Investments in consolidated subsidiaries	608.8	–	–	–	26.6	(635.4)	–
Other assets	–	–	–	69.4	0.1	–	69.5
Total assets	$ 608.9	$ 29.2	$ 3.4	$ 2,160.6	$ 374.0	$ (638.0)	$ 2,538.1
LIABILITIES AND STOCKHOLDERS' EQUITY							
Current liabilities:							
Accounts payable	$ –	$ –	$ –	$ 132.8	$ 11.3	$ –	$ 144.1
Accrued expenses and other current liabilities	–	13.4	–	130.5	87.9	(15.5)	216.3
Current maturities of long-term debt	–	8.0	–	(0.2)	0.2	–	8.0
Total current liabilities	–	21.4	–	263.1	99.4	(15.5)	368.4
Other liabilities	–	–	–	50.6	45.3	(4.3)	91.6
Long-term debt, less current maturities	–	1,348.9	168.9	2.9	–	–	1,520.7
Intercompany	51.5	(1,013.2)	(120.9)	1,368.3	51.8	(337.5)	–
Stockholders' equity	557.4	(327.9)	(44.6)	475.7	177.5	(280.7)	557.4
Total liabilities and stockholders' equity	$ 608.9	$ 29.2	$ 3.4	$ 2,160.6	$ 374.0	$ (638.0)	$ 2,538.1

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING BALANCE SHEETS
June 30, 2008

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
ASSETS							
Current assets:							
Cash and cash equivalents	$ –	$ –	$ –	$ 82.0	$ 59.6	$ –	$ 141.6
Restricted cash	–	–	–	0.3	1.8	–	2.1
Marketable securities	–	–	–	–	26.3	–	26.3
Accounts receivable, net	–	–	–	275.7	24.7	–	300.4
Inventories	–	–	–	44.3	4.9	–	49.2
Prepaid expenses and other current assets	0.1	–	–	62.5	20.0	(2.3)	80.3
Total current assets	0.1	–	–	464.8	137.3	(2.3)	599.9
Property, plant and equipment, net	–	–	–	1,106.4	67.6	–	1,174.0
Goodwill	–	–	–	605.6	83.6	–	689.2
Intangible assets, net	–	24.5	3.2	12.9	20.8	–	61.4
Investments in consolidated subsidiaries	608.8	–	–	–	16.7	(625.5)	–
Other assets	–	–	–	57.6	0.2	–	57.8
Total assets	$ 608.9	$ 24.5	$ 3.2	$ 2,247.3	$ 326.2	$ (627.8)	$ 2,582.3
LIABILITIES AND STOCKHOLDERS' EQUITY							
Current liabilities:							
Accounts payable	$ –	$ –	$ –	$ 144.9	$ 17.9	$ –	$ 162.8
Accrued expenses and other current liabilities	–	13.2	–	125.2	72.9	–	211.3
Current maturities of long-term debt	–	8.0	–	(0.2)	0.2	–	8.0
Total current liabilities	–	21.2	–	269.9	91.0	–	382.1
Other liabilities	–	–	–	70.6	38.7	(3.2)	106.1
Long-term debt, less current maturities	–	1,341.1	188.4	–	–	–	1,529.5
Intercompany	44.3	(900.0)	(120.8)	1,373.9	(51.9)	(345.5)	–
Stockholders' equity	564.6	(437.8)	(64.4)	532.9	248.4	(279.1)	564.6
Total liabilities and stockholders' equity	$ 608.9	$ 24.5	$ 3.2	$ 2,247.3	$ 326.2	$ (627.8)	$ 2,582.3

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF OPERATIONS
For the year ended June 30, 2006

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Patient service revenues	$ –	$ –	$ –	$ 1,929.0	$ 144.5	$ (29.9)	$ 2,043.6
Premium revenues	–	–	–	47.9	358.9	(31.8)	375.0
Total revenues	–	–	–	1,976.9	503.4	(61.7)	2,418.6
Salaries and benefits	1.7	–	–	914.8	74.9	–	991.4
Supplies	–	–	–	369.3	24.8	–	394.1
Medical claims expense	–	–	–	29.1	271.1	(29.9)	270.3
Purchased services	–	–	–	110.1	18.0	–	128.1
Provision for doubtful accounts	–	–	–	149.7	7.1	–	156.8
Other operating expenses	0.2	–	–	179.5	43.1	(31.8)	191.0
Rents and leases	–	–	–	27.2	6.7	–	33.9
Depreciation and amortization	–	–	–	86.0	14.3	–	100.3
Interest, net	–	109.5	15.9	(22.3)	0.7	–	103.8
Management fees	–	–	–	(6.7)	6.7	–	–
Debt extinguishment costs	0.1	–	–	–	–	–	0.1
Other	–	–	–	8.4	0.7	–	9.1
Total costs and expenses	2.0	109.5	15.9	1,845.1	468.1	(61.7)	2,378.9
Income (loss) from continuing operations before income taxes	(2.0)	(109.5)	(15.9)	131.8	35.3	–	39.7
Income tax expense (benefit)	17.8	–	–	6.7	7.6	(14.3)	17.8
Equity in earnings of subsidiaries	32.7	–	–	–	–	(32.7)	–
Income (loss) from continuing operations	12.9	(109.5)	(15.9)	125.1	27.7	(18.4)	21.9
Loss from discontinued operations, net of taxes	–	–	–	(7.8)	(1.2)	–	(9.0)
Net income (loss)	$ 12.9	$ (109.5)	$ (15.9)	$ 117.3	$ 26.5	$ (18.4)	$ 12.9

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF OPERATIONS
For the year ended June 30, 2007

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Patient service revenues	$ –	$ –	$ –	$ 2,053.9	$ 150.9	$ (25.5)	$ 2,179.3
Premium revenues	–	–	–	56.5	345.3	(0.4)	401.4
Total revenues	–	–	–	2,110.4	496.2	(25.9)	2,580.7
Salaries and benefits	1.2	–	–	986.6	80.1	–	1,067.9
Supplies	–	–	–	394.1	27.7	–	421.8
Medical claims expense	–	–	–	35.6	286.9	(25.5)	297.0
Purchased services	–	–	–	126.6	14.6	–	141.2
Provision for doubtful accounts	–	–	–	169.2	6.0	–	175.2
Other operating expenses	0.2	–	–	171.2	25.4	(0.4)	196.4
Rents and leases	–	–	–	30.8	6.6	–	37.4
Depreciation and amortization	–	–	–	104.1	14.5	–	118.6
Interest, net	–	119.5	17.7	(8.2)	(5.2)	–	123.8
Management fees	–	–	–	(8.2)	8.2	–	–
Impairment loss	–	–	–	120.1	3.7	–	123.8
Other	–	–	–	2.8	–	–	2.8
Total costs and expenses	1.4	119.5	17.7	2,124.7	468.5	(25.9)	2,705.9
Income (loss) from continuing operations before income taxes	(1.4)	(119.5)	(17.7)	(14.3)	27.7	–	(125.2)
Income tax expense (benefit)	(11.6)	–	–	–	2.1	(2.1)	(11.6)
Equity in earnings of subsidiaries	(142.9)	–	–	–	–	142.9	–
Income (loss) from continuing operations	(132.7)	(119.5)	(17.7)	(14.3)	25.6	145.0	(113.6)
Loss from discontinued operations, net of taxes	–	–	–	(6.0)	(13.1)	–	(19.1)
Net income (loss)	$ (132.7)	$ (119.5)	$ (17.7)	$ (20.3)	$ 12.5	$ 145.0	$ (132.7)

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF OPERATIONS
For the year ended June 30, 2008

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Patient service revenues	$ –	$ –	$ –	$ 2,212.2	$ 150.8	$ (22.5)	$ 2,340.5
Premium revenues	–	–	–	57.7	392.7	(0.2)	450.2
Total revenues	–	–	–	2,269.9	543.5	(22.7)	2,790.7
Salaries and benefits	2.5	–	–	1,068.7	81.5	–	1,152.7
Supplies	–	–	–	405.8	28.7	–	434.5
Medical claims expense	–	–	–	35.8	314.9	(22.5)	328.2
Purchased services	–	–	–	136.5	13.0	–	149.5
Provision for doubtful accounts	–	–	–	196.9	8.7	–	205.6
Other operating expenses	0.2	–	–	182.4	32.1	(0.2)	214.5
Rents and leases	–	–	–	34.8	7.0	–	41.8
Depreciation and amortization	–	–	–	116.8	14.2	–	131.0
Interest, net	–	109.9	19.8	(9.3)	1.7	–	122.1
Management fees	–	–	–	(8.2)	8.2	–	–
Other	–	–	–	63.5	(54.0)	–	9.5
Total costs and expenses	2.7	109.9	19.8	2,223.7	456.0	(22.7)	2,789.4
Income (loss) from continuing operations before income taxes	(2.7)	(109.9)	(19.8)	46.2	87.5	–	1.3
Income tax expense (benefit)	1.7	–	–	–	13.4	(13.4)	1.7
Equity in earnings of subsidiaries	3.7	–	–	–	–	(3.7)	–
Income (loss) from continuing operations	(0.7)	(109.9)	(19.8)	46.2	74.1	9.7	(0.4)
Income (loss) from discontinued operations, net of taxes	–	–	–	2.9	(3.2)	–	(0.3)
Net income (loss)	$ (0.7)	$ (109.9)	$ (19.8)	$ 49.1	$ 70.9	$ 9.7	$ (0.7)

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS
For the year ended June 30, 2006

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Operating activities:							
Net income (loss)	$ 12.9	$ (109.5)	$ (15.9)	$ 117.3	$ 26.5	$ (18.4)	$ 12.9
Adjustments to reconcile net income (loss) to net cash provided by (used in) operating activities							
Loss from discontinued operations	–	–	–	7.8	1.2	–	9.0
Depreciation and amortization	–	–	–	86.0	14.3	–	100.3
Provision for doubtful accounts	–	–	–	149.7	7.1	–	156.8
Deferred income taxes	10.1	–	–	–	–	–	10.1
Amortization of loan costs	–	3.8	0.2	–	–	–	4.0
Accretion of principal on senior discount notes	–	–	15.7	–	–	–	15.7
Loss (gain) on disposal of assets	–	–	–	6.1	(4.6)	–	1.5
Stock compensation	1.7	–	–	–	–	–	1.7
Debt extinguishment costs	0.1	–	–	–	–	–	0.1
Changes in operating assets and liabilities, net of effects of acquisitions:							
Equity in earnings of subsidiaries	(31.1)	–	–	–	–	31.1	–
Accounts receivable	–	–	–	(158.5)	(3.9)	–	(162.4)
Inventories	–	–	–	(5.5)	0.3	–	(5.2)
Prepaid expenses and other current assets	11.7	–	–	(40.0)	31.9	–	3.6
Accounts payable	–	–	–	4.4	(2.0)	–	2.4
Accrued expenses and other liabilities	(5.4)	(1.1)	–	39.2	(31.9)	(12.7)	(11.9)
Net cash provided by (used in) operating activities – continuing operations	–	(106.8)	–	206.5	38.9	–	138.6
Net cash provided by operating activities - discontinued operations	–	–	–	4.4	6.3	–	10.7
Net cash provided by (used in) operating activities	–	(106.8)	–	210.9	45.2	–	149.3
Investing activities:							
Acquisitions	–	–	–	(1.2)	–	–	(1.2)
Capital expenditures	–	–	–	(264.7)	(10.8)	–	(275.5)
Proceeds from asset dispositions	–	–	–	11.1	–	–	11.1
Purchases of short-term investments	–	–	–	–	(128.4)	–	(128.4)
Sales of short-term investments	–	–	–	–	128.4	–	128.4
Other	–	–	–	(17.8)	(4.2)	22.6	0.6
Net cash used in investing activities-continuing operations	–	–	–	(272.6)	(15.0)	22.6	(265.0)
Net cash provided by (used in) operating activities – discontinued operations	–	–	–	24.3	(4.7)	–	19.6
Net cash used in investing activities	–	–	–	(248.3)	(19.7)	22.6	(245.4)

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS
For the year ended June 30, 2006
(continued)

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Financing activities:							
Payments of long-term debt	–	175.0	–	–	–	–	175.0
Payments of long-term debt and capital leases	–	(30.0)	–	(0.8)	(0.6)	–	(31.4)
Payments of loan costs and debt termination fees	–	–	–	(0.7)	–	–	(0.7)
Payments to retire stock and stock options	(2.5)	–	–	–	–	–	(2.5)
Cash provided by (used in) intercompany activity	1.6	(38.2)	–	83.3	(24.1)	(22.6)	–
Exercise of stock options	0.1	–	–	–	–	–	0.1
Net cash provided by (used in) financing activities	(0.8)	106.8	–	81.8	(24.7)	(22.6)	140.5
Net increase (decrease) in cash and cash equivalents	(0.8)	–	–	44.4	0.8	–	44.4
Cash and cash equivalents, beginning of period	0.8	–	–	(5.9)	84.3	–	79.2
Cash and cash equivalents, end of period	$ –	$ –	$ –	$ 38.5	$ 85.1	$ –	$ 123.6

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS
For the year ended June 30, 2007

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Operating activities:							
Net income (loss)	$ (132.7)	$ (119.5)	$ (17.7)	$ (20.3)	$ 12.5	$ 145.0	$ (132.7)
Adjustments to reconcile net income (loss) to net cash provided by (used in) operating activities							
Loss from discontinued operations	–	–	–	6.0	13.1	–	19.1
Depreciation and amortization	–	–	–	104.1	14.5	–	118.6
Provision for doubtful accounts	–	–	–	169.2	6.0	–	175.2
Deferred income taxes	(12.7)	–	–	–	–	–	(12.7)
Amortization of loan costs	–	4.3	0.2	–	–	–	4.5
Accretion of principal on senior discount notes	–	–	17.5	–	–	–	17.5
Gain on disposal of assets	–	–	–	(4.1)	–	–	(4.1)
Stock compensation	1.2	–	–	–	–	–	1.2
Impairment loss	–	–	–	120.1	3.7	–	123.8
Changes in operating assets and liabilities, net of effects of acquisitions:							
Equity in earnings of subsidiaries	142.9	–	–	–	–	(142.9)	–
Accounts receivable	–	–	–	(206.9)	2.9	–	(204.0)
Inventories	–	–	–	(2.9)	1.0	–	(1.9)
Prepaid expenses and other current assets	–	–	–	(28.5)	(1.5)	–	(30.0)
Accounts payable	–	–	–	11.2	(3.8)	–	7.4
Accrued expenses and other liabilities	1.3	0.1	–	61.3	(22.8)	(2.1)	37.8
Net cash provided by (used in) operating activities – continuing operations	–	(115.1)	–	209.2	25.6	–	119.7
Net cash provided by operating activities - discontinued operations	–	–	–	0.5	3.1	–	3.6
Net cash provided by (used in) operating activities	–	(115.1)	–	209.7	28.7	–	123.3
Investing activities:							
Acquisitions	–	–	–	(0.2)	–	–	(0.2)
Capital expenditures	–	–	–	(153.3)	(11.0)	–	(164.3)
Proceeds from asset dispositions	–	–	–	9.5	–	–	9.5
Purchases of short-term investments	–	–	–	–	(120.0)	–	(120.0)
Sales of short-term investments	–	–	–	–	120.0	–	120.0
Other	–	–	–	1.8	0.2	–	2.0
Net cash used in investing activities-continuing operations	–	–	–	(142.2)	(10.8)	–	(153.0)
Net cash provided by (used in) operating activities – discontinued operations	–	–	–	36.3	(1.8)	–	34.5
Net cash used in investing activities	–	–	–	(105.9)	(12.6)	–	(118.5)

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS
For the year ended June 30, 2007
(continued)

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Financing activities:							
Payments of long-term debt and capital leases	–	(7.9)	–	–	(0.1)	–	(8.0)
Payments to retire stock, equity incentive units and stock options	–	–	–	(0.5)	–	–	(0.5)
Cash provided by (used in) intercompany activity	–	123.0	–	(130.3)	7.3	–	–
Exercise of stock options	–	–	–	0.2	–	–	0.2
Net cash provided by (used in) financing activities	–	115.1	–	(130.6)	7.2	–	(8.3)
Net increase (decrease) in cash and cash equivalents	–	–	–	(26.8)	23.3	–	(3.5)
Cash and cash equivalents, beginning of period	–	–	–	38.5	85.1	–	123.6
Cash and cash equivalents, end of period	$ –	$ –	$ –	$ 11.7	$ 108.4	$ –	$ 120.1

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS
For the year ended June 30, 2008

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Operating activities:							
Net income (loss)	$ (0.7)	$ (109.9)	$ (19.8)	$ 49.1	$ 70.9	$ 9.7	$ (0.7)
Adjustments to reconcile net income (loss) to net cash provided by (used in) operating activities							
Loss (income) from discontinued operations	–	–	–	(2.9)	3.2	–	0.3
Depreciation and amortization	–	–	–	116.8	14.2	–	131.0
Provision for doubtful accounts	–	–	–	196.9	8.7	–	205.6
Deferred income taxes	(2.2)	–	–	–	–	–	(2.2)
Amortization of loan costs	–	4.6	0.3	–	–	–	4.9
Accretion of principal on senior discount notes	–	–	19.5	–	–	–	19.5
Loss on disposal of assets	–	–	–	0.9	–	–	0.9
Stock compensation	2.5	–	–	–	–	–	2.5
Changes in operating assets and liabilities, net of effects of acquisitions:							
Equity in earnings of subsidiaries	(3.7)	–	–	–	–	3.7	–
Accounts receivable	–	–	–	(217.5)	(6.1)	–	(223.6)
Inventories	–	–	–	(4.3)	0.2	–	(4.1)
Prepaid expenses and other current assets	(4.5)	–	–	(17.6)	2.4	–	(19.7)
Accounts payable	–	–	–	13.3	6.6	–	19.9
Accrued expenses and other liabilities	4.9	(0.2)	–	67.6	(21.6)	(13.4)	37.3
Net cash provided by (used in) operating activities – continuing operations	(3.7)	(105.5)	–	202.3	78.5	–	171.6
Net cash provided by operating activities – discontinued operations	–	–	–	0.2	1.3	–	1.5
Net cash provided by (used in) operating activities	(3.7)	(105.5)	–	202.5	79.8	–	173.1
Investing activities:							
Acquisitions	–	–	–	(0.2)	–	–	(0.2)
Capital expenditures	–	–	–	(118.1)	(3.5)	–	(121.6)
Purchases of marketable securities	–	–	–	–	(90.0)	–	(90.0)
Sales of marketable securities	–	–	–	–	63.7	–	63.7
Other	–	–	–	–	1.5	–	1.5
Net cash used in investing activities – continuing operations	–	–	–	(118.3)	(28.3)	–	(146.6)
Net cash provided by (used in) operating activities – discontinued operations	–	–	–	3.1	(0.3)	–	2.8
Net cash used in investing activities	–	–	–	(115.2)	(28.6)	–	(143.8)

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS
For the year ended June 30, 2008
(continued)

	Parent	Issuers of 9.0% Notes	Issuers of 11.25% Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Financing activities:							
Payments of long-term debt	–	(7.8)	–	–	–	–	(7.8)
Payments to retire stock, equity incentive units and stock options	–	–	–	(0.2)	–	–	(0.2)
Cash provided by (used in) intercompany activity	3.7	113.3	–	(17.0)	(100.0)	–	–
Exercise of stock options	–	–	–	0.2	–	–	0.2
Net cash provided by (used in) financing activities	3.7	105.5	–	(17.0)	(100.0)	–	(7.8)
Net increase (decrease) in cash and cash equivalents	–	–	–	70.3	(48.8)	–	21.5
Cash and cash equivalents, beginning of period	–	–	–	11.7	108.4	–	120.1
Cash and cash equivalents, end of period	$ –	$ –	$ –	$ 82.0	$ 59.6	$ –	$ 141.6

9. Income Taxes

Significant components of income tax expense/benefit attributable to continuing operations are as follows (in millions):

	2006	2007	2008
Current:			
Federal	$ 2.2	$ 0.9	$ 1.5
State	(0.3)	0.1	2.4
	1.9	1.0	3.9
Deferred:			
Federal	15.2	(13.7)	(1.2)
State	(3.9)	(4.8)	(8.6)
	11.3	(18.5)	(9.8)
Increase in valuation allowance	4.6	5.9	7.6
Total	$ 17.8	$ (11.6)	$ 1.7

The following table presents the income taxes associated with continuing operations and discontinued operations as reflected in the accompanying consolidated statements of operations (in millions).

	2006	2007	2008
Continuing operations	$ 17.8	$ (11.6)	$ 1.7
Discontinued operations	(7.3)	(9.5)	(0.2)
Total	$ 10.5	$ (21.1)	$ 1.5

The increases in the valuation allowance during all three years presented result from state net operating loss carryforwards that may not ultimately be utilized because of the uncertainty regarding Vanguard's ability to generate taxable income in certain states. The effective income tax rate differed from the federal statutory rate for the years ended June 30, 2006, 2007 and 2008 as follows:

	2006	2007	2008
Income tax expense at federal statutory rate	35.0%	35.0%	35.0%
Income tax expense at state statutory rate	(3.8)	3.6	(564.6)
Nondeductible expenses and other	1.9	(0.6)	44.0
Increase in valuation allowance	11.7	(4.7)	616.4
Nondeductible impairment loss	–	(24.0)	–
Effective income tax rate	44.8%	9.3%	130.8%

Deferred income taxes reflect the net tax effects of temporary differences between the carrying amounts of assets and liabilities for financial reporting purposes and the amounts used for income tax purposes. Significant components of Vanguard's deferred tax assets and liabilities as of June 30, 2007 and 2008, were approximately as follows (in millions):

	2007	2008
Deferred tax assets:		
Net operating loss carryover	$ 77.4	$ 69.7
Excess tax basis over book basis of accounts receivable	5.9	8.2
Accrued expenses and other	12.8	24.7
Deferred loan costs	2.5	2.3
Professional liabilities reserves	10.7	16.4
Self-insurance reserves	10.1	9.4
Alternative minimum tax credit and other credits	2.3	3.4
Total deferred tax assets	121.7	134.1
Valuation allowance	(22.5)	(29.9)
Total deferred tax assets, net of valuation allowance	99.2	104.2
Deferred tax liabilities:		
Depreciation, amortization and fixed assets basis differences	29.7	29.3
Excess book basis over tax basis of prepaid assets and other	7.9	8.0
Total deferred tax liabilities	37.6	37.3
Net deferred tax assets and liabilities	$ 61.6	$ 66.9

Net non-current deferred tax assets of $52.7 million and $42.4 million as of June 30, 2007 and 2008, respectively, are included in the accompanying consolidated balance sheets in other assets. Net current deferred tax assets were $8.9 million and $24.5 million as of June 30, 2007 and 2008, respectively.

As of June 30, 2008, Vanguard had generated net operating loss ("NOL") carryforwards for federal income tax purposes and state income tax purposes of approximately $107.0 million and $596.0 million, respectively. The federal and state NOL carryforwards expire from 2020 to 2027 and 2008 to 2027, respectively. Approximately $2.8 million of these NOLs are subject to annual limitations for federal purposes. These limitations are not expected to significantly affect Vanguard's ability to ultimately recognize the benefit of these NOLs in future years.

Effective July 1, 2007, Vanguard adopted the provisions of FIN 48. In connection with the adoption of FIN 48, Vanguard recorded a $0.4 million net liability for unrecognized tax benefits, accrued interest and penalties, which was comprised of the following (in millions).

Reclassification from income taxes payable	$ 0.3
Increase to non-current deferred tax assets	2.7
Cumulative impact of change recorded to retained earnings	(2.6)
	$ 0.4

The provisions of FIN 48 allow for the classification election of interest on an underpayment of income taxes, when the tax law requires interest to be paid, and penalties, when a tax position does not meet the minimum statutory threshold to avoid payment of penalties, in income taxes, interest expense or another appropriate expense classification based on the accounting policy election of the entity. Vanguard has elected to continue its historical practice of classifying interest and penalties as a component of income tax expense.

Approximately $0.3 million of the $0.4 million of unrecognized tax benefits existing upon adoption of FIN 48, if recognized, would impact the effective tax rate, while the remaining $0.1 million of unrecognized tax benefits, if recognized, would increase goodwill. The unrecognized tax benefits increased by $0.2 million during the year ended June 30, 2008 to $0.6 million. Due to the insignificant changes in Vanguard's unrecognized tax benefits during the year ended June 30, 2008, a tabular reconciliation is not warranted.

Vanguard's U.S. federal income tax returns for tax years 2005 and beyond remain subject to examination by the Internal Revenue Service.

On May 18, 2006, Texas repealed its current income tax and replaced it with a gross margins tax to be accounted for as an income tax. Vanguard became subject to the Texas margins tax on July 1, 2006. On July 3, 2008, Massachusetts enacted corporate tax reform legislation that will become effective for Vanguard for its fiscal year ending June 30, 2010. State deferred tax assets increased by $1.0 million during the fiscal year ended June 30, 2008 to reflect the impact of the Massachusetts corporate tax reform legislation.

10. Stockholders' Equity

Vanguard has the authority to issue 1,000,000 shares of common stock, par value $.01 per share.

Common Stock of Vanguard and Class A Membership Units of Holdings

In connection with the Blackstone merger, Blackstone, MSCP, management and other investors purchased $624.0 million of Class A Membership Units of Holdings. Holdings then invested the $624.0 million in the common stock of Vanguard, and in addition Blackstone invested $125.0 million directly in the common stock of Vanguard. In February 2005, other investors purchased approximately $0.6 million of Class A membership units of Holdings. Holdings then invested the $0.6 million in the common stock of Vanguard.

Equity Incentive Membership Units of Holdings

In connection with the Blackstone merger, certain members of senior management purchased Class B, Class C and Class D membership units in Holdings (collectively the "equity incentive units") for approximately $5.7 million pursuant to the Amended and Restated Limited Liability Company Operating Agreement of Holdings dated September 23, 2004 ("LLC Agreement"). Vanguard determined the value of the equity incentive units by utilizing appraisal information. The Class B and D units vest 20% on each of the first five anniversaries of the purchase date, while the Class C units vest on the eighth anniversary of the purchase date subject to accelerated vesting upon the occurrence of a sale by Blackstone of at least 25% of its Class A units at a price per unit exceeding 2.5 times the per unit price paid on September 23, 2004. Upon a change of control (as defined in the LLC Agreement), all Class B and D units fully vest, and Class C units fully vest if the change in control constitutes a liquidity event (as defined in the LLC Agreement). In exchange for a cash payment of $5.7 million, Vanguard issued to Holdings 83,890 warrants with an exercise price of $1,000 per share and 35,952 warrants with an exercise price of $3,000 per share to purchase Vanguard's common stock. The warrants may be exercised at any time. Vanguard reserved 119,842 shares of its common stock to be issued upon exercise of the warrants.

During fiscal 2006 and fiscal 2007, Vanguard and Holdings repurchased a total of 33,708 outstanding equity incentive units from former executive officers for approximately $1.7 million. The purchase price for unvested units was based upon the lower of cost or fair market value (determined by an independent appraisal) or the lower of cost or fair market value less a 25% discount, as set forth in the LLC Agreement. The purchase price for vested units was fair market value or fair market value less a 25% discount.

Put and Call Features of Acquisition Subsidiary Stock

For a period of 30 days commencing June 1, 2007 and each June 1 thereafter, University of Chicago Hospitals ("UCH") has the right to require Vanguard to purchase its shares in the subsidiary that acquired Louis A. Weiss Memorial Hospital for a purchase price equal to four times the acquisition subsidiary's Adjusted EBITDA (as defined in the shareholders agreement between the parties) for the most recent 12 months of operations less all indebtedness of the acquisition subsidiary (including capital leases) at such time, multiplied by UCH's percentage

interest in the acquisition subsidiary on the date of purchase. Similarly, during the same 30-day periods, Vanguard has the right to require UCH to sell to it UCH's shares in the acquisition subsidiary for a purchase price equal to the greater of (i) six times the acquisition subsidiary's Adjusted EBITDA (as defined in the shareholders agreement among the parties) for the most recent 12 months of operations less all indebtedness of the acquisition subsidiary (including capital leases) at such time, times UCH's percentage interest in the acquisition subsidiary on the date of purchase, and (ii) the price paid by UCH for its interest in the acquisition subsidiary minus dividends or other distributions to UCH in respect of that interest.

11. Stock Based Compensation

As previously discussed, Vanguard used the minimum value pricing model permitted under SFAS 123 to determine stock compensation costs related to stock option grants prior to July 1, 2006. On July 1, 2006, Vanguard adopted the provisions of SFAS 123(R), to account for stock option grants subsequent to July 1, 2006. Vanguard adopted SFAS 123(R) on a prospective basis as required for companies that chose to adopt SFAS 123 using the transition guidance set forth in SFAS 148. During fiscal years 2006, 2007 and 2008, Vanguard incurred stock compensation of $1.7 million and $1.2 million and $2.5 million, respectively, related to grants under its 2004 Stock Incentive Plan.

2004 Stock Incentive Plan

After the Blackstone merger, Vanguard adopted the 2004 Stock Incentive Plan ("the 2004 Option Plan"). As of June 30, 2008, the 2004 Option Plan, as amended, allows for the issuance of up to 101,117 options to purchase common stock of Vanguard to its employees, members of its Board of Directors or other service providers of Vanguard or any of its affiliates. The stock options may be granted as Liquidity Event Options, Time Options or Performance Options at the discretion of the Board. The Liquidity Event Options vest 100% at the eighth anniversary of the date of grant and have an exercise price per share as determined by the Board or a committee thereof. The Time Options vest 20% at each of the first five anniversaries of the date of grant and have an exercise price per share as determined by the Board or a committee thereof. The Performance Options vest 20% at each of the first five anniversaries of the date of grant and have an exercise price equal to $3,000 per share or as determined by the Board. The Time Options and Performance Options immediately vest upon a change of control, while the Liquidity Event Options immediately vest only upon a qualifying Liquidity Event, as defined in the Plan Document. As of June 30, 2008, 88,698 options were outstanding under the 2004 Option Plan, as amended.

The following tables summarize options transactions during the years ended June 30, 2006, 2007 and 2008.

	2004 Stock Incentive Plan	
	# of Options	Wtd Avg Exercise Price
Options outstanding at June 30, 2005	38,184	$ 1,600.00
Options granted	41,297	1,675.81
Options exercised	(141)	1,000.00
Options cancelled	(8,683)	1,611.03
Options outstanding at June 30, 2006	70,657	1,644.12
Options granted	10,110	1,715.06
Options exercised	(195)	1,000.00
Options cancelled	(14,998)	1,624.81
Options outstanding at June 30, 2007	65,574	1,661.39
Options granted	30,583	1,611.90
Options exercised	(168)	1,038.49
Options cancelled	(7,291)	1,667.85
Options outstanding at June 30, 2008	88,698	$ 1,644.97
Options available for grant at June 30, 2008	11,915	$ 1,600.00
Options exercisable at June 30, 2008	16,993	$ 1,960.54

The following table provides information relating to the 2004 Option Plan during each period presented.

	Year ended June 30,		
	2006	2007	2008
Weighted average fair value of options granted during each year	$ 407.62	$ 590.70	$ 408.59
Intrinsic value of options exercised during each year (in millions)	$ 0.1	$ 0.1	$ 0.1
Fair value of outstanding options that vested during each year (in millions)	$ 0.5	$ 1.4	$ 1.7

The following table sets forth certain information regarding vested options at June 30, 2008, options expected to vest subsequent to June 30, 2008 and the total options expected to vest over the life of all options granted.

	Currently Vested	Additional Expected to Vest	Total Expected to Vest
Number of options at June 30, 2008	16,993	44,058	61,051
Weighted average exercise price	$ 1,960.54	$ 1,622.31	$ 1,716.45
Aggregate intrinsic value at June 30, 2008 (in millions)	$ 3.6	$ 13.1	$ 16.7
Weighted average remaining contractual term	7.0 years	8.1 years	7.8 years

12. Defined Contribution Plan

Effective June 1, 1998, Vanguard adopted its defined contribution employee benefit plan, the Vanguard 401(k) Retirement Savings Plan (the "401(k) Plan"). The 401(k) Plan is a multiple employer defined contribution plan whereby employees who are age 21 or older are eligible to participate.

The 401(k) Plan allows eligible employees to make contributions of 2% to 20% of their annual compensation. Employer matching contributions, which vary by employer, vest 20% after two years of service and continue vesting at 20% per year until fully vested. For purposes of determining vesting percentages in the 401(k) Plan, many employees received credit for years of service with their respective predecessor companies. Vanguard's matching expense for the years ended June 30, 2006, 2007 and 2008 was approximately $11.7 million, $13.8 million and $14.5 million, respectively.

13. Leases

Vanguard leases certain real estate properties and equipment under operating leases having various expiration dates. Future minimum operating lease payments at June 30, 2008 are approximately as follows (in millions).

	Operating Leases
2009	$ 33.6
2010	29.0
2011	24.6
2012	21.1
2013	15.9
Thereafter	55.8
Total minimum lease payments	$ 180.0

During the years ended June 30, 2006, 2007 and 2008, rent expense was approximately $33.9 million, $37.4 million and $41.8 million, respectively.

14. Contingencies and Healthcare Regulation

Contingencies

Vanguard is presently, and from time to time, subject to various claims and lawsuits arising in the normal course of business. In the opinion of management, the ultimate resolution of these matters will not have a material adverse effect on Vanguard's financial position or results of operations.

Reimbursement

Final determination of amounts earned under prospective payment and cost-reimbursement activities is subject to review by appropriate governmental authorities or their agents. In the opinion of Vanguard's management, adequate provision has been made for any adjustments that may result from such reviews.

Laws and regulations governing the Medicare and Medicaid and other federal healthcare programs are complex and subject to interpretation. Vanguard's management believes that it is in compliance with all applicable laws and regulations in all material respects and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing related to Medicare and Medicaid programs. While no such regulatory inquiries have been made, Vanguard's compliance with such laws and regulations is subject to future government review and interpretation. Non-compliance with such laws and regulations could result in significant regulatory action including fines, penalties, and exclusion from the Medicare, Medicaid and other federal healthcare programs.

Acquisitions

Vanguard has acquired and may continue to acquire businesses with prior operating histories. Acquired companies may have unknown or contingent liabilities, including liabilities for failure to comply with healthcare laws and regulations, such as billing and reimbursement, fraud and abuse and similar anti-referral laws. Although Vanguard institutes policies designed to conform practices to its standards following the completion of its acquisitions, there can be no assurance that it will not become liable for past activities of prior owners that may later be asserted to be improper by private plaintiffs or government agencies. Although Vanguard generally seeks to obtain indemnification from prospective sellers covering such matters, there can be no assurance that any such matter will be covered by indemnification, or if covered, that such indemnification will be adequate to cover potential losses and fines.

Employment-Related Agreements

Effective June 1, 1998, Vanguard executed employment agreements with three of its current senior executive officers. Vanguard executed an employment agreement with a fourth current senior executive officer on September 1, 1999. The employment agreements were amended on September 23, 2004 to extend the term of each employment agreement another 5 years and to provide that the Blackstone merger did not constitute a change of control, as defined in the agreements. On November 15, 2007, Vanguard entered into written employment agreements with two other executive officers for terms expiring on November 15, 2012. The employment agreements will renew automatically for additional one-year periods, unless terminated by Vanguard or the executive officer. The employment agreements provide, among other things, for minimum salary levels, for participation in bonus plans, and for amounts to be paid as liquidated damages in the event of a change in control or termination by Vanguard without cause.

Vanguard has executed severance protection agreements ("severance agreements") between Vanguard and each of its other officers who do not have employment agreements. The severance agreements are automatically extended for successive one year terms at the discretion of Vanguard unless a change in control occurs, as defined in the severance agreement, at which time the severance agreement continues in effect for a period of not less than three years beyond the date of such event. Vanguard may be obligated to pay severance payments as set forth in the

severance agreements in the event of a change in control and the termination of the executive's employment of Vanguard.

Guarantees

Physician Guarantees

Vanguard has entered into multiple physician relocation agreements and service agreements under which it provides minimum monthly revenues or collections guarantees or maximum expense guarantees to physicians during a specified period of time (typically 12 months to 24 months). In return for the physician guarantee payments, the physicians are required to practice in the community for a stated period of time (typically 3 to 5 years) or else return the payments to Vanguard. No community commitment provision or repayment provision exists for the service guarantees. In January 2006, Vanguard adopted Financial Accounting Standards Board Staff Position No. FIN 45-3, *Application of FASB Interpretation No. 45 to Minimum Revenue Guarantees Granted to a Business or Its Owners* ("FSP 45-3"). FSP 45-3 requires that a liability be recorded at fair value for all guarantees entered into on or after January 1, 2006. Vanguard determines this liability and an offsetting intangible asset by calculating an estimate of expected payments to be made over the guarantee period. Vanguard reduces the liability as it makes guarantee payments and amortizes the intangible asset over the term of the physicians' relocation or service agreements. As of June 30, 2008, Vanguard had a net intangible asset of $9.5 million and a remaining liability of $4.4 million related to these physician guarantees. The maximum amount of Vanguard's unpaid physician income and service guarantees under FSP 45-3 as of June 30, 2008 was approximately $6.7 million.

Other Guarantees

As part of its contract with AHCCCS, PHP is required to maintain a performance guarantee in the amount of $22.0 million, an amount determined based upon PHP's membership and capitation premiums received. As of June 30, 2008, Vanguard maintained this $22.0 million performance guarantee entirely in the form of surety bonds with independent third party insurers that expire on September 30, 2008. Vanguard is required to arrange for $2.9 million in letters of credit to collateralize its $22.0 million in surety bonds with the third party insurers. Vanguard expects this performance guarantee obligation to increase significantly when the new PHP AHCCCS contract commences on October 1, 2008. As of June 30, 2008, Vanguard provided a $0.6 million guarantee of the debt of a joint venture accounted for as an equity method investment and also from time to time enters into parent-subsidiary guarantee arrangements in the ordinary course of operating its business.

Variable Interest Entities

Vanguard is a party to one contractual agreement whereby it may be required to make monthly payments to the developer and manager of a medical office building located on one of its hospital campuses through a minimum rent revenue guarantee. Vanguard entered into this agreement to provide an incentive to the developer to fund the construction of a medical office building and manage the building upon its completion in order to make physician office space available near the hospital campus. The contract commenced in April 2005 for a period of 12 years. Vanguard deemed this contract a variable interest entity in which Vanguard is not the primary beneficiary. The maximum annual amount Vanguard would pay under the contract assuming zero occupancy would be approximately $1.5 million. Vanguard currently expects to make no rental shortfall payments during fiscal 2009 under this contract given current and expected future occupancy levels in the medical office building.

As of June 30, 2007, Vanguard had another minimum rent guarantee arrangement with an entity owning another medical office building located on the campus of another of its hospitals. Due to the significance of Vanguard's historical minimum rent revenue payments to the operations of the medical office building, Vanguard consolidated this entity for financial reporting purposes. During the quarter ended September 30, 2007, the entity that owned the medical office building sold the building to a third party, which terminated Vanguard's minimum rent guarantee obligation. Thus, Vanguard no longer included this entity in its consolidated financial statements as of June 30, 2008.

15. Related Party Transactions

Pursuant to the Blackstone merger agreement, Vanguard entered into a transaction and monitoring fee agreement with Blackstone and Metalmark Subadvisor LLC ("Metalmark"). Under the terms of the agreement, Vanguard agreed to pay Blackstone and Metalmark an annual monitoring fee of $4.0 million and $1.2 million, respectively, plus out of pocket expenses. The monitoring fee represents compensation to Blackstone and Metalmark for their advisory and consulting services with respect to financing transactions, strategic decisions, dispositions or acquisitions of assets and other Vanguard affairs from time to time. Blackstone also has the option under the agreement to elect at any time in anticipation of a change in control or initial public offering to require Vanguard to pay both Blackstone and Metalmark a lump sum monitoring fee, calculated as the net present value of future annual monitoring fees assuming a remaining ten-year payment period, in lieu of the remaining annual monitoring fee payments. If Blackstone chooses a lump sum payment, Metalmark is entitled to receive not less than 15% of the sum of the initial $20.0 million Blackstone transaction fee and the cumulative monitoring fees and lump sum monitoring fee paid to Blackstone less the cumulative aggregate monitoring fees paid to Metalmark to date. During both fiscal 2006 and 2007, Vanguard paid $4.0 million and $1.2 million in monitoring fees to Blackstone and Metalmark, respectively. During fiscal 2008, Vanguard paid approximately $5.2 million and $1.2 million in monitoring fees and expenses to Blackstone and Metalmark, respectively.

Blackstone and Metalmark have the ability to control Vanguard's policies and operations, and their interests may not in all cases be aligned with Vanguard's interests. Vanguard also conducts business with other entities controlled by Blackstone or Metalmark. Vanguard's results of operations could be materially different as a result of Blackstone and Metalmark's control than such results would be if Vanguard were autonomous.

16. Segment Information

Vanguard's acute care hospitals and related healthcare businesses are similar in their activities and economic environments in which they operate (i.e. urban markets). Accordingly, Vanguard's reportable operating segments consist of 1) acute care hospitals and related healthcare businesses, collectively, and 2) health plans consisting of MacNeal Health Providers, a contracting entity for MacNeal Hospital and Weiss Memorial Hospital in the metropolitan Chicago area, Phoenix Health Plan, a Medicaid managed health plan operating in Arizona, and Abrazo Advantage Health Plan, a Medicare and Medicaid dual eligible managed health plan operating in Arizona. The following tables provide financial information by business segment for the years ended June 30, 2006, 2007 and 2008.

	For the Year Ended June 30, 2006			
	Health Plans	Acute Care Services	Eliminations	Consolidated
		(In millions)		
Patient service revenues (1)	$ –	$ 2,043.6	$ –	$ 2,043.6
Premium revenues	375.0	–	–	375.0
Inter-segment revenues	–	40.0	(40.0)	–
Total revenues	375.0	2,083.6	(40.0)	2,418.6
Salaries and benefits (excludes stock compensation of $1.7 million)	13.6	976.1	–	989.7
Supplies	0.2	393.9	–	394.1
Medical claims expense (1)	270.3	–	–	270.3
Provision for doubtful accounts	–	156.8	–	156.8
Other operating expenses – external	18.3	334.7	–	353.0
Operating expenses – inter-segment	40.0	–	(40.0)	–
Total operating expenses	342.4	1,861.5	(40.0)	2,163.9
Segment EBITDA (2)	32.6	222.1	–	254.7
Depreciation and amortization	4.3	96.0	–	100.3
Interest, net	(2.3)	106.1	–	103.8
Minority interests	–	2.6	–	2.6
Equity method income	–	(0.2)	–	(0.2)
Stock compensation	–	1.7	–	1.7
Debt extinguishment costs	–	0.1	–	0.1
Loss on disposal of assets	–	1.5	–	1.5
Monitoring fees and expenses	–	5.2	–	5.2
Income from continuing operations before income taxes	$ 30.6	$ 9.1	$ –	$ 39.7
Segment assets	$ 161.9	$ 2,488.6	$ –	$ 2,650.5
Capital expenditures	$ 0.2	$ 275.3	$ –	$ 275.5

(1) Vanguard eliminates in consolidation those patient service revenues earned by its hospitals and related healthcare facilities attributable to services provided to enrollees in its owned health plans and also eliminates the corresponding medical claims expenses incurred by the health plans for those services.

(2) Segment EBITDA is defined as income before interest expense (net of interest income), income taxes, depreciation and amortization, minority interests, equity method income or loss, stock compensation, debt extinguishment costs, gain or loss on disposal of assets, monitoring fees and expenses, impairment loss and discontinued operations. Management uses Segment EBITDA to measure performance for Vanguard's segments and to develop strategic objectives and operating plans for those segments. Segment EBITDA eliminates the uneven effect of non-cash depreciation of tangible assets and amortization of intangible assets, much of which results from acquisitions accounted for under the purchase method of accounting. Segment EBITDA also eliminates the effects of changes in interest rates which management believes relate to general trends in global capital markets, but are not necessarily indicative of the operating performance of Vanguard's segments. Management believes that Segment EBITDA provides useful information about the financial performance of Vanguard's segments to investors, lenders, financial analysts and rating agencies. Additionally, management believes that investors and lenders view Segment EBITDA as an important factor in making investment decisions and assessing the value of Vanguard. Segment EBITDA is not a substitute for net income, operating cash flows or other cash flow statement data determined in accordance with accounting principles generally accepted in the United States. Segment EBITDA, as presented, may not be comparable to similarly titled measures of other companies.

	For the Year Ended June 30, 2007			
	Health Plans	Acute Care Services	Eliminations	Consolidated
		(In millions)		
Patient service revenues (1)	$ –	$ 2,179.3	$ –	$ 2,179.3
Capitation premiums	401.4	–	–	401.4
Inter-segment revenues	–	34.2	(34.2)	–
Total revenues	401.4	2,213.5	(34.2)	2,580.7
Salaries and benefits (excludes stock compensation of $1.2 million)	14.7	1,052.0	–	1,066.7
Supplies	0.2	421.6	–	421.8
Medical claims expense (1)	297.0	–	–	297.0
Provision for doubtful accounts	–	175.2	–	175.2
Other operating expenses – external	27.3	347.7	–	375.0
Operating expenses – inter-segment	34.2	–	(34.2)	–
Total operating expenses	373.4	1,996.5	(34.2)	2,335.7
Segment EBITDA (2)	28.0	217.0	–	245.0
Depreciation and amortization	4.3	114.3	–	118.6
Interest, net	(5.8)	129.6	–	123.8
Minority interests	–	2.6	–	2.6
Equity method income	–	(0.9)	–	(0.9)
Stock compensation	–	1.2	–	1.2
Gain on disposal of assets	–	(4.1)	–	(4.1)
Impairment loss	–	123.8	–	123.8
Monitoring fees and expenses	–	5.2	–	5.2
Income (loss) from continuing operations before income taxes	$ 29.5	$ (154.7)	$ –	$ (125.2)
Segment assets	$ 197.3	$ 2,340.8	$ –	$ 2,538.1
Capital expenditures	$ 0.2	$ 164.1	$ –	$ 164.3

(1) Vanguard eliminates in consolidation those patient service revenues earned by its hospitals and related healthcare facilities attributable to services provided to enrollees in its owned health plans and also eliminates the corresponding medical claims expenses incurred by the health plans for those services.

(2) Segment EBITDA is defined as income before interest expense (net of interest income), income taxes, depreciation and amortization, minority interests, equity method income or loss, stock compensation, debt extinguishment costs, gain or loss on disposal of assets, monitoring fees and expenses, impairment loss and discontinued operations. Management uses Segment EBITDA to measure performance for Vanguard's segments and to develop strategic objectives and operating plans for those segments. Segment EBITDA eliminates the uneven effect of non-cash depreciation of tangible assets and amortization of intangible assets, much of which results from acquisitions accounted for under the purchase method of accounting. Segment EBITDA also eliminates the effects of changes in interest rates which management believes relate to general trends in global capital markets, but are not necessarily indicative of the operating performance of Vanguard's segments. Management believes that Segment EBITDA provides useful information about the financial performance of Vanguard's segments to investors, lenders, financial analysts and rating agencies. Additionally, management believes that investors and lenders view Segment EBITDA as an important factor in making investment decisions and assessing the value of Vanguard. Segment EBITDA is not a substitute for net income, operating cash flows or other cash flow statement data determined in accordance with accounting principles generally accepted in the United States. Segment EBITDA, as presented, may not be comparable to similarly titled measures of other companies.

	For the Year Ended June 30, 2008			
	Health Plans	Acute Care Services	Eliminations	Consolidated
		(In millions)		
Patient service revenues (1)	$ –	$ 2,340.5	$ –	$ 2,340.5
Capitation premiums	450.2	–	–	450.2
Inter-segment revenues	–	31.2	(31.2)	–
Total revenues	450.2	2,371.7	(31.2)	2,790.7
Salaries and benefits (excludes stock compensation of $2.5 million)	16.0	1,134.2	–	1,150.2
Supplies	0.2	434.3	–	434.5
Medical claims expense (1)	328.2	–	–	328.2
Provision for doubtful accounts	–	205.6	–	205.6
Other operating expenses – external	29.9	375.9	–	405.8
Operating expenses – inter-segment	31.2	–	(31.2)	–
Total operating expenses	405.5	2,150.0	(31.2)	2,524.3
Segment EBITDA (2)	44.7	221.7	–	266.4
Depreciation and amortization	4.2	126.8	–	131.0
Interest, net	(4.5)	126.6	–	122.1
Minority interests	–	3.0	–	3.0
Equity method income	–	(0.7)	–	(0.7)
Stock compensation	–	2.5	–	2.5
Loss on disposal of assets	–	0.9	–	0.9
Monitoring fees and expenses	–	6.3	–	6.3
Income (loss) from continuing operations before income taxes	$ 45.0	$ (43.7)	$ –	$ 1.3
Segment assets	$ 181.5	$ 2,400.8	$ –	$ 2,582.3
Capital expenditures	$ 0.6	$ 121.0	$ –	$ 121.6

(1) Vanguard eliminates in consolidation those patient service revenues earned by its hospitals and related healthcare facilities attributable to services provided to enrollees in its owned health plans and also eliminates the corresponding medical claims expenses incurred by the health plans for those services.

(2) Segment EBITDA is defined as income before interest expense (net of interest income), income taxes, depreciation and amortization, minority interests, equity method income or loss, stock compensation, debt extinguishment costs, gain or loss on disposal of assets, monitoring fees and expenses, impairment loss and discontinued operations. Management uses Segment EBITDA to measure performance for Vanguard's segments and to develop strategic objectives and operating plans for those segments. Segment EBITDA eliminates the uneven effect of non-cash depreciation of tangible assets and amortization of intangible assets, much of which results from acquisitions accounted for under the purchase method of accounting. Segment EBITDA also eliminates the effects of changes in interest rates which management believes relate to general trends in global capital markets, but are not necessarily indicative of the operating performance of Vanguard's segments. Management believes that Segment EBITDA provides useful information about the financial performance of Vanguard's segments to investors, lenders, financial analysts and rating agencies. Additionally, management believes that investors and lenders view Segment EBITDA as an important factor in making investment decisions and assessing the value of Vanguard. Segment EBITDA is not a substitute for net income, operating cash flows or other cash flow statement data determined in accordance with accounting principles generally accepted in the United States. Segment EBITDA, as presented, may not be comparable to similarly titled measures of other companies.

17. Unaudited Quarterly Operating Results

The following table presents summarized unaudited quarterly results of operations for the fiscal years ended June 30, 2007 and 2008. Management believes that all necessary adjustments have been included in the amounts stated below for a fair presentation of the results of operations for the periods presented when read in conjunction with Vanguard's consolidated financial statements for the fiscal years ended June 30, 2007 and 2008. Results of operations for a particular quarter are not necessarily indicative of results of operations for an annual period and are not predictive of future periods (in millions).

	September 30, 2006	December 31, 2006	March 31, 2007	June 30, 2007
Total revenues	$ 618.3	$ 638.4	$ 672.9	$ 651.1
Net income (loss)	$ (7.7)	$ (118.7)	$ 3.3	$ (9.6)

	September 30, 2007	December 31, 2007	March 31, 2008	June 30, 2008
Total revenues	$ 662.5	$ 686.0	$ 725.6	$ 716.6
Net income (loss)	$ (6.9)	$ 0.5	$ 6.5	$ (0.8)

Total revenues disclosed above for the first three quarters during fiscal 2007 differ from the amounts disclosed in our previously filed fiscal 2007 Quarterly Reports on Form 10-Q due to the reclassification of PMH total revenues to discontinued operations as presented below (in millions).

	September 30, 2006	December 31, 2006	March 31, 2007
As previously reported	$ 634.9	$ 652.9	$ 684.5
Reclassification of PMH revenues	16.6	14.5	11.6
As disclosed above	$ 618.3	$ 638.4	$ 672.9

Item 9. Changes in and Disagreements With Accountants on Accounting and Financial Disclosure.

None.

Item 9A(T). Controls and Procedures.

Evaluation of Disclosure Control and Procedures

As of the end of the period covered by this report, our management conducted an evaluation, with the participation of our chief executive officer and chief financial officer, of the effectiveness of our disclosure controls and procedures (as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934 (the "Exchange Act")). Based on this evaluation, our chief executive officer and chief financial officer have concluded that our disclosure controls and procedures are effective to ensure that information required to be disclosed by us in the reports that we file or submit under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in Securities and Exchange Commission's rules and forms and that such information is accumulated and communicated to management, including our chief executive officer and chief financial officer, as appropriate to allow timely decisions regarding required disclosure.

Report of Management on Internal Control over Financial Reporting

The management of Vanguard Health Systems, Inc. is responsible for the preparation, integrity and fair presentation of the consolidated financial statements appearing in our periodic filings with the Securities and Exchange Commission. The consolidated financial statements were prepared in conformity with generally accepted accounting principles appropriate in the circumstances and, accordingly, include certain amounts based on our best judgments and estimates.

Management is also responsible for establishing and maintaining adequate internal control over financial reporting as such term is defined in Rules 13a-15(f) under the Securities and Exchange Act of 1934. Internal control over financial reporting is a process to provide reasonable assurance regarding the reliability of our financial reporting in accordance with accounting principles generally accepted in the United States of America. Our internal control over financial reporting includes a program of internal audits and appropriate reviews by management, written policies and guidelines, careful selection and training of qualified personnel including a dedicated Compliance department and a written Code of Business Conduct and Ethics adopted by our Board of Directors, applicable to all of our directors, officers and employees.

Internal control over financial reporting includes maintaining records that in reasonable detail accurately and fairly reflect our transactions; providing reasonable assurance that transactions are recorded as necessary for preparation of our financial statements; providing reasonable assurance that receipts and expenditures of company assets are made in accordance with management authorization; and providing reasonable assurance that unauthorized acquisition, use or disposition of company assets that could have a material effect on our financial statements would be prevented or detected in a timely manner. Because of its inherent limitations, including the possibility of human error and the circumvention or overriding of control procedures, internal control over financial reporting is not intended to provide absolute assurance that a misstatement of our financial statements would be prevented or detected. Therefore, even those internal controls determined to be effective can provide only reasonable assurance with respect to financial statement preparation and presentation.

Management conducted an evaluation of the effectiveness of our internal control over financial reporting based on the framework in *Internal Control – Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission. Based on this evaluation, management concluded that the Company's internal control over financial reporting was effective as of June 30, 2008.

This annual report does not include an attestation report of the Company's independent registered public accounting firm regarding internal control over financial reporting. Management's report was not subject to attestation by the Company's independent registered public accounting firm pursuant to temporary rules of the United States Securities and Exchange Commission that permit the Company to provide only management's report in this annual report for the year ended June 30, 2008.

Changes in Internal Control Over Financial Reporting

There was no change in our internal control over financial reporting during our fiscal quarter ended June 30, 2008 that materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

Item 9B. Other Information.

None.

PART III

Item 10. Directors, Executive Officers and Corporate Governance.

The table below presents information with respect to the members of our board of directors and our executive officers and their ages as of September 1, 2008.

Name	Age	Position
Charles N. Martin, Jr.	65	Chairman of the Board & Chief Executive Officer; Director
Kent H. Wallace	53	President & Chief Operating Officer
Keith B. Pitts	51	Vice Chairman
Joseph D. Moore	61	Executive Vice President
Phillip W. Roe	47	Executive Vice President, Chief Financial Officer & Treasurer
Ronald P. Soltman	62	Executive Vice President, General Counsel & Secretary
Dan F. Ausman	53	Senior Vice President-Operations
Reginald M. Ballantyne III	64	Senior Vice President-Market Strategy & Government Affairs
Bruce F. Chafin	52	Senior Vice President-Compliance & Ethics
Karen Flinn	47	Senior Vice President-Physician & Ambulatory Services
James Johnston	64	Senior Vice President-Human Resources
Joseph J. Mullany	44	Senior Vice President-Operations
Harold H. Pilgrim III	47	Senior Vice President-Operations
James H. Spalding	49	Senior Vice President, Assistant General Counsel & Assistant Secretary
Alan G. Thomas	54	Senior Vice President-Operations Finance
Thomas M. Ways	58	Senior Vice President-Managed Care
Gary D. Willis	43	Senior Vice President, Controller & Chief Accounting Officer
Deanna L. Wise	39	Senior Vice President & Chief Information Officer
Michael A. Dal Bello	37	Director
M. Fazle Husain	44	Director
Alan M. Muney, M.D.	55	Director
Michael J. Parsons	53	Director
James A. Quella	58	Director
Neil P. Simpkins	42	Director

Charles N. Martin, Jr. has served as Chairman of the board of directors and Chief Executive Officer of Vanguard since July 1997. Until May 31, 2001, he was also Vanguard's President. From January 1992 until January 1997, Mr. Martin was Chairman, President and Chief Executive Officer of OrNda HealthCorp ("OrNda"), a hospital management company. Prior thereto Mr. Martin was President and Chief Operating Officer of HealthTrust, Inc., a hospital management company, from September 1987 until October 1991. Mr. Martin is also a director of several privately held companies.

Kent H. Wallace has served as Vanguard's President & Chief Operating Officer since September 2005. Prior thereto he was a Senior Vice President - Operations of Vanguard from February 2003 until September 2005. Prior thereto from July 2001 to December 2002 he was Regional Vice President of Province Healthcare Company of Brentwood, Tennessee, an owner and operator of 20 non-urban, acute care hospitals in 13 states of the United States. During this time Mr. Wallace had managerial responsibility for seven of these hospitals. From June 1999 until June 2001 Mr. Wallace was President and Chief Executive Officer of Custom Curb, Inc. of Chattanooga, Tennessee, a family owned company which manufactured roof accessories. Prior thereto from January 1997 until May 1999 Mr. Wallace was a Vice President - Acquisitions and Development of Tenet Healthcare Corporation of Dallas, Texas, a hospital management company ("Tenet").

Keith B. Pitts has been Vanguard's Vice Chairman since May 2001, was a director of Vanguard from August 1999 until September 2004, and was an Executive Vice President of Vanguard from August 1999 until May 2001. Prior thereto, from November 1997 until June 1999, he was the Chairman and Chief Executive Officer of Mariner Post-Acute Network, Inc. and its predecessor, Paragon Health Network, Inc., which is a nursing home

management company. Prior thereto from August 1992 until January 1997, Mr. Pitts served as Executive Vice President and Chief Financial Officer of OrNda.

Joseph D. Moore has served as an Executive Vice President of Vanguard since November 2007. He served as Executive Vice President, Chief Financial Officer and Treasurer of Vanguard from July 1997 until November 2007 and was a director of Vanguard from July 1997 until September 2004. From February 1994 to April 1997, he was Senior Vice President - Development of Columbia/HCA Healthcare Corporation ("Columbia"), a hospital management company. Mr. Moore first joined Hospital Corporation of America (a predecessor of Columbia) in April 1970, rising to Senior Vice President - Finance and Development in January 1993.

Phillip W. Roe has been Executive Vice President, Chief Financial Officer and Treasurer since November 2007. He was Senior Vice President, Controller and Chief Accounting Officer of Vanguard from July 1997 to November 2007. Prior thereto he was Senior Vice President, Controller and Chief Accounting Officer of OrNda from September 1996 until January 1997 and was Vice President, Controller and Chief Accounting Officer of OrNda from October 1994 until September 1996.

Ronald P. Soltman has been Vanguard's Executive Vice President, General Counsel and Secretary since July 1997 and was a director of Vanguard from July 1997 until September 2004. From April 1994 until January 1997, he was Senior Vice President, General Counsel and Secretary of OrNda. From February 1994 until March 1994, he was Vice President and Assistant General Counsel of Columbia. From 1984 until February 1994, he was Vice President and Assistant General Counsel of Hospital Corporation of America.

Dan F. Ausman has served as a Senior Vice President - Operations of Vanguard since February 2006. Prior thereto from May 2005 to February 2006 he was Vice President - Operations of Vanguard. From 1998 to April 2005 Mr. Ausman was the President & Chief Executive Officer of Irvine Regional Hospital and Medical Center, a 176-bed acute care hospital in Irvine, CA which is owned by an affiliate of Tenet.

Reginald M. Ballantyne III, joined Vanguard in May 2001 and has served as Senior Vice President - Market Strategy & Government Affairs of Vanguard since January 2002. From 1984 to 2001, he served as President of PMH Health Resources, Inc., an Arizona based multi-unit healthcare system. Prior to 1984, Mr. Ballantyne served as President of Phoenix Memorial Hospital in Phoenix, Arizona. Mr. Ballantyne served as Chairman of the American Hospital Association ("AHA") in 1997 and as Speaker of the AHA House of Delegates in 1998. He is a Fellow of the American College of Healthcare Executives ("ACHE") and a recipient of the ACHE Gold Medal Award for Management Excellence. Mr. Ballantyne also served as a member of the national Board of Commissioners for the Joint Commission on Accreditation of Healthcare Organizations and as Chairman of the AHA Committee of Commissioners from 1992 until 1995. Mr. Ballantyne previously served as a director of Superior Consultant Holdings Corporation and is currently a director of several privately held companies.

Bruce F. Chafin has served as Senior Vice President - Compliance & Ethics of Vanguard since July 1997. Prior thereto, from April 1995 to January 1997, he served as Vice President - Compliance & Ethics of OrNda.

Karen Flinn has served as Senior Vice President - Physician & Ambulatory Services of Vanguard since September 11, 2007. Prior thereto from May 1999 until July 2007 she was Vice President - Physician Integration/Managed Care of Triad Hospitals, Inc., an investor owned hospital management company headquartered in Plano, Texas. Prior thereto from May 1996 until May 1999 she was Vice President - Physician Integration/Managed Care of the Central and Pacific Group of Columbia.

James Johnston has served as Senior Vice President - Human Resources of Vanguard since July 1997. Prior thereto from November 1995 to January 1997, he served as Senior Vice President - Human Resources of OrNda.

Joseph J. Mullany has served as a Senior Vice President - Operations of Vanguard since September 2005. Prior thereto from October 2002 to August 2005 he was a Regional Vice President of Essent Healthcare, Inc. of Nashville, TN, an investor-owned hospital management company, responsible for its New England Division. Prior thereto from October 1998 to October 2002 Mr. Mullany was a Division Vice President of Health Management

Associates, Inc. of Naples, Florida, an investor-owned hospital management company, responsible for its Mississippi Division.

Harold H. Pilgrim III has served as a Senior Vice President - Operations of Vanguard since September 2005. Prior thereto from February 2003 to September 2005 he was Vice President - Business Development of Vanguard, responsible for development for Vanguard's Texas operations. Prior thereto from November 2001 to January 2003 Mr. Pilgrim was Vanguard's Vice President - Investor Relations, and during that period he was also involved in Vanguard's acquisitions and development activities. From January 1, 2001 to October 2001 Mr. Pilgrim was Chief Development Officer for Velocity Health Capital, Inc., a Nashville, TN - based investment banking firm focused on the health care and bio-sciences industries.

James H. Spalding has served as Senior Vice President, Assistant General Counsel and Assistant Secretary of Vanguard since November 1998. Prior thereto he was Vice President, Assistant General Counsel and Assistant Secretary of Vanguard from July 1997 until November 1998. Prior thereto from April 1994 until January 1997, he served as Vice President, Assistant General Counsel and Assistant Secretary of OrNda.

Alan G. Thomas has been Senior Vice President - Operations Finance of Vanguard since July 1997. Prior thereto, Mr. Thomas was Senior Vice President - Hospital Financial Operations of OrNda from April 1995 until January 1997. Prior thereto he was Vice President - Reimbursement and Revenue Enhancement of OrNda from June 1994 until April 1995.

Thomas M. Ways has served as Senior Vice President - Managed Care of Vanguard since March 1998. Prior thereto from February 1997 to February 1998, he was Chief Executive Officer of MSO/Physician Practice Development for the Southern California Region of Tenet. Prior thereto from August 1994 to January 1997, he was Vice President - Physician Integration of OrNda.

Gary D. Willis has served as Senior Vice President, Controller and Chief Accounting Officer of Vanguard since May 2008. From February 2006 to May 2008, he was Senior Vice President and Chief Accounting Officer of LifePoint Hospitals ("LifePoint"), a hospital management company based in Brentwood, Tennessee. From December 2002 to February 2006, he was Vice President and Controller of LifePoint.

Deanna L. Wise has served as Senior Vice President and Chief Information Officer of Vanguard since November 2006. Prior thereto from August 2004 to October 2006 she was the Chief Information Officer of Vanguard's operating region managing its Phoenix-area healthcare facilities. From November 2002 until August 2004 she was chief information officer of the Maricopa Integrated Health System in Phoenix, Arizona, which was a county integrated health care system including an acute care hospital, health clinics and health plans. Prior thereto, from October 1997 to November 2002 she was the director of applications of Ascension Health –Central Indiana Health System in Indianapolis, Indiana, a regional healthcare management organization supervising the operations of twelve acute care hospitals.

Michael A. Dal Bello became a member of Vanguard's board of directors on September 23, 2004. Mr. Dal Bello has been a Principal in the Private Equity Group of Blackstone since December 2005 and from 2002 until December 2005, he was an Associate in this Group. While at Blackstone, Mr. Dal Bello has been actively involved in Blackstone's healthcare investment activities. Prior to joining Blackstone, Mr. Dal Bello received an M.B.A. from Harvard Business School in 2002. Mr. Dal Bello worked at Hellman & Friedman LLC from 1998 to 2000 and prior thereto at Bain & Company. He currently serves on the board of representatives or directors of Team Finance LLC, Biomet, Inc., Catalent Pharma Solutions, Inc. and Sithe Global.

M. Fazle Husain became a member of Vanguard's board of directors on November 7, 2007. Mr. Husain is a Managing Director of Metalmark Capital, the private equity division of Citigroup Alternative Investments. Prior to joining Metalmark, Mr. Husain was with Morgan Stanley & Co. for 18 years, where he was a Managing Director in the private equity and venture capital investment business. Mr. Husain currently also serves on the board of directors of Allscripts Healthcare Solutions, Inc. and SouthernCare Hospice.

Alan M. Muney, M.D. became a member of Vanguard's board of directors on May 6, 2008. Dr. Muney has served as an Executive Director in the Private Equity Group of Blackstone since October 2007. Before joining Blackstone Dr. Muney was the executive vice president and chief medical officer of Oxford Health Plans and the chief medical officer of United Healthcare (Northeast region) from 1998 to September 2007. He also currently serves as a member of the board of representatives of Team Finance LLC.

Michael J. Parsons became a member of Vanguard's board of directors on May 6, 2008. He is a private investor. From May 1999 until July 2007 he served as Executive Vice President and Chief Operating Officer of Triad Hospitals, Inc., an investor owned hospital management company headquartered in Plano, Texas, which was acquired by Community Health Systems, Inc. in July 2007.

James A. Quella became a member of Vanguard's board of directors on September 11, 2007. Mr. Quella is a Senior Managing Director and Senior Operating Partner in the Private Equity Group at Blackstone. Prior to joining Blackstone in 2004, Mr. Quella was a Managing Director and Senior Operating Partner with DLJ Merchant Banking Partners-CSFB Private Equity from June 2000 to February 2004. Prior to that, Mr. Quella worked at Mercer Management Consulting and Strategic Planning Associates, its predecessor firm, from September 1981 to January 2000 where he served as a Senior Consultant to chief executive officers and senior management teams, and was Co-Vice Chairman with shared responsibility for overall management of the firm. Mr. Quella currently serves as a director of Allied Waste Industries, Inc., Graham Packaging Holdings Company, Intelenet Global Services, The Nielsen Company and Michaels Stores, Inc.

Neil P. Simpkins became a member of Vanguard's board of directors on September 23, 2004. Mr. Simpkins has served as a Senior Managing Director in the Private Equity Group of Blackstone since December 1999. From 1993 until the time he joined Blackstone, Mr. Simpkins was a Principal at Bain Capital. Prior to joining Bain Capital, Mr. Simpkins was a consultant at Bain & Company in London and the Asia Pacific region. He currently serves as Chairman of the board of directors of TRW Automotive Holdings Corp. and is a member of the board of representatives of Team Finance LLC.

Composition of the Board of Directors

General

As of the date of this report, the board of directors of Vanguard consists of seven members, four of whom were nominated by Blackstone, one of whom was nominated by MSCP, one of whom is our chief executive officer (and, if our chief executive officer is not Charles N. Martin, Jr., such other person designated by senior management (the "Manager Representative")) and one independent director. Blackstone has the right to increase the size of Vanguard's board from seven to nine members, with one additional director to be designated by Blackstone and one additional director to be an independent person identified by our chief executive officer and acceptable to Blackstone. MSCP and, subject to the conditions above, senior management, will each continue to be entitled to nominate and elect one director unless and until the respective group ceases to own at least 50.0% of the Class A membership units in VHS Holdings LLC ("Holdings") owned on September 23, 2004. Holdings acquired Vanguard pursuant to a merger (the "Merger") on September 23, 2004. See "Item 1. Business – The Merger".

Committees

Our board of directors currently does not have any standing committees, including an audit committee. Our entire board of directors is acting as our audit committee to oversee our accounting and financial reporting processes and the audits of our financial statements, as allowed under the Securities Exchange Act of 1934 for issuers without securities listed on a national securities exchange or on an automated national quotation system. Additionally, because our securities are not so listed, our board of directors is not required to have on it a person who qualifies under the rules of the Securities and Exchange Commission as an "audit committee financial expert" or as having accounting or financial management expertise under the similar rules of the national securities exchanges. While our board of directors has not designated any of its members as an audit committee financial expert, we believe that each of the current board members is fully qualified to address any accounting, financial reporting or audit issues that may come before it.

Code of Ethics

We have adopted a Code of Business Conduct and Ethics that applies to all of our officers and employees, including our principal executive officer, principal financial officer and principal accounting officer, which has been posted on our Internet website at www.vanguardhealth.com/pdfs/codeofbusinessconductandethics.pdf. Our Code of Business Conduct and Ethics is a "code of ethics", as defined in Item 406(b) of Regulation S-K of the Securities and Exchange Commission. Please note that our Internet website address is provided as an inactive textual reference only. We will make any legally required disclosures regarding amendments to, or waivers of, provisions of our code of ethics on our Internet website.

Item 11. Executive Compensation.

COMPENSATION DISCUSSION AND ANALYSIS

Overview

This section discusses the principles underlying our executive compensation policies and decisions. It provides qualitative information regarding the manner in which compensation is earned by our executive officers and places in context the data presented in the tables that follow. In addition, in this section, we address the compensation paid or awarded during fiscal year 2008 to: Charles N. Martin, Jr., our Chief Executive Officer (principal executive officer); Phillip W. Roe, our Chief Financial Officer (principal financial officer); and three other executive officers who were our three other most highly compensated executive officers in fiscal year 2008, Keith B. Pitts, our Vice Chairman; Kent H. Wallace, our President and Chief Operating Officer; and Joseph D. Moore, one of our Executive Vice Presidents. We refer to these five executive officers as our "named executive officers."

On September 23, 2004, we were acquired in the Merger by private equity investment funds associated with Blackstone Group who invested $494.4 million in our equity for a 66% equity interest, with private equity funds associated with our former equity sponsor, MSCP, retaining a 17.3% equity interest in us by reinvesting $130 million in our equity and with 13 of our 16 current executive officers retaining a 11.8% equity interest in us by reinvesting $88.4 million in us (such $88.4 million exclusive of amounts invested by our executive officers in Holdings' Class B, C and D units, as discussed below). As a result of the Merger, we are privately held and controlled by private equity funds associated with Blackstone and MSCP (the "Sponsors") with a board of directors made up of five representatives of the Sponsors, one independent director and our Chief Executive Officer. As discussed in more detail below, various aspects of named executive officer compensation were negotiated and determined at the time of the Merger.

As a privately-owned company with a relatively small board of directors, our entire board of directors acts as our Compensation Committee (hereinafter referred to either as the "Committee", the "Compensation Committee" or the "board of directors"). Our executive compensation program is overseen and administered by the Compensation Committee. The Compensation Committee operates somewhat informally without a written charter and has responsibility for discharging the responsibilities of the board of directors relating to the compensation of our executive officers and related duties. As a member of the Compensation Committee, our Chief Executive Officer presents cash, equity and benefits compensation recommendations to the Compensation Committee for its consideration and approval. The Compensation Committee reviews these proposals and makes all final compensation decisions for executive officers by exercising its discretion in accepting, modifying or rejecting any such recommendations.

Philosophy of Executive Compensation Programs

Our overall executive compensation objective is to provide a comprehensive plan designed to focus on our strategic business initiatives, financial performance objectives and the creation and maintenance of equity value. The following are the principal objectives in the design of our executive compensation programs:

- Attract, retain, and motivate superior management talent critical to our long-term success with compensation that is competitive within the marketplace;

- Maintain a reasonable balance among base salary, annual incentive payments and long-term equity-based incentive compensation and other benefits;
- Ensure compensation levels reflect the internal value and future potential of each executive within the Company and the achievement of outstanding individual results;
- Link executive compensation to the creation and maintenance of long-term equity value;
- Promote equity ownership by executives in order to align their interests with the interests of our equity holders; and
- Ensure that incentive compensation is linked to the achievement of specific financial and strategic objectives, which are established in advance and approved by the Committee.

To meet these objectives, our compensation program balances short-term and long-term performance goals and mixes fixed and at-risk compensation that is directly related to stockholder value and overall performance.

During our fiscal year ended June 30, 2008, the Committee did not retain the services of any external compensation consultant. Our Chief Executive Officer, Charles N. Martin, Jr., as a member of the board of directors, is also a member of the Committee, presents his recommendations to the Committee on all executive compensation matters and participates in discussions and deliberations of the Committee. While other named executive officers may also attend the Committee meetings and participate in Committee discussions, they would do so only if and when required by the Committee and such attendance has been rare in recent years. Any deliberations and decisions by the Committee regarding compensation for Mr. Martin or other named executive officers take place while the Committee is in executive session without such persons in attendance.

The Committee believes that compensation to its executive officers should be aligned closely with our short-term and long-term financial performance goals. As a result, a portion of executive compensation is "at risk" and is tied to the attainment of previously established financial goals. However, the Committee also believes that it is prudent to provide competitive base salaries and benefits to attract and retain superior talent in order to achieve our strategic objectives.

Elements of Our Executive Compensation Program

In fiscal year 2008, the principal elements of our compensation for our executive officers, including our named executive officers were:

- Base Salary;
- Annual cash incentive opportunities;
- Long-term equity based incentives; and
- Benefits and executive perquisites.

Detail regarding each of these elements is discussed below.

Base Salaries

Annual base salaries reflect the compensation for an executive's ongoing contribution to the operating performance of his or her functional area of responsibility with us. We believe that base salaries must be competitive based upon the scope of responsibilities and market compensation of similar executives. We utilize as a tool the database provided by Salary.com's Job Analyzer. Job Analyzer includes data about 2,900 standard jobs using data from 7,500 organizations representing all industries of all types and sizes, both public and private companies. Other factors such as internal equity and comparability are also considered when establishing a base salary for a given executive. The Committee utilizes the experience, market knowledge and insight of its members in evaluating the

competitiveness of current salary levels. Our Human Resources Department is also a resource for such additional information as needed.

Generally, base salaries of all executive officers, including the named executive officers, are reviewed and adjusted by the Committee effective January 1 of each year based upon the recommendations of our Chief Executive Officer. In turn, our Chief Executive Officer bases his recommendations upon his assessment of each executive's performance and our overall budgetary guidelines. Upon the recommendation of our Chief Executive Officer, the Committee gave none of the named executive officers base salary increases as of January 1, 2008, but gave most of our other executive officers base salary increases as of January 1, 2008 which averaged 3.6% for all executive officers. In addition, based upon the recommendations of our Chief Executive Officer, the Committee may adjust base salaries at other times during the year in connection with promotions, increased responsibilities or to maintain competitiveness within the market. Thus, the Committee raised the base salary of one of our named executive officers, Phillip W. Roe, from $375,000 to $475,000, effective the November 7, 2007 date upon which he was promoted to the position of our Chief Financial Officer. The salary for each named executive officer for our fiscal year ended June 30, 2008 is reported in the Summary Compensation Table below.

Annual Incentive Compensation

Annual incentive awards are available to the named executive officers, as well as to Vanguard's other executive officers, under the Vanguard Health Systems, Inc. 2001 Annual Incentive Plan (the "Annual Incentive Plan"). The Annual Incentive Plan is designed to reward management for the achievement of annual financial performance level targets and other operational goals, which are linked to the creation of long-term equity value.

Each year under the Annual Incentive Plan the Committee establishes specific earnings-related or operations-related goals for all of our executive officers, including the named executive officers, for the fiscal year based upon the recommendations of our Chief Executive Officer. The executive officers are eligible to receive a cash award or awards based primarily on the extent to which the Company meets its pre-established earnings and/or cash flow and/or other operations-related goals. The Committee determines one or more target awards for each executive officer, designates a Company performance level or levels required to earn each target award and may also determine threshold performance levels at which minimum awards are earned and performance levels that result in maximum awards to be paid. Target awards may vary among executives based on competitive market practices for comparable positions, their decision-making authority and their ability to affect financial and operational performance. In addition to performance-related awards, the Committee may make and pay out discretionary awards at any time. Also, the Committee has the discretion to adjust the annual performance targets during the year in the event of acquisitions and divestitures, restructured or discontinued operations, or other extraordinary or unusual issues occurring during the year. The Committee evaluates the allocation factors within the Annual Incentive Plan on an annual basis and has the flexibility to adjust the structure including allocation percentages as needed in order to better align the incentives under the Annual Incentive Plan.

For fiscal year 2008, Annual Incentive Plan target awards for most executive officers (including all five of the named executive officers, Messrs. Martin, Roe, Moore, Pitts, and Wallace) were 50% based on the Company achieving a certain consolidated Adjusted EBITDA performance level target goal and 50% upon achieving a certain consolidated free cash flow performance level target goal. Award target levels for these executive officers ranged from 30% to 50% of their base salaries for meeting the Adjusted EBITDA target and 30% to 50% of their base salaries for meeting the free cash flow target. Award target levels for Mr. Martin were 50% of his base salary for meeting the Adjusted EBITDA target and 50% of his base salary for meeting the free cash flow target. Award target levels for Messrs. Pitts and Wallace were 45% of their respective base salaries for meeting the Adjusted EBITDA target and 45% of their respective base salaries for meeting the free cash flow target. Award target levels for Messrs. Moore and Roe were 35% of their respective base salaries for meeting the Adjusted EBITDA target and 35% of their respective base salaries for meeting the free cash flow target.

For executive officers responsible only for the operations of our various regions, their Annual Incentive Plan target awards were 50% based upon regional Adjusted EBITDA targets and 50% based upon their hospitals achieving certain specified quality, employee engagement and patient and physician satisfaction goals, with their target awards and maximum awards being set at 70% and 108%, respectively, of their base salaries depending on the

Adjusted EBITDA levels actually obtained by their operating regions as well as their attainment of the quality and satisfaction goals.

All of our five named executive officers earned their target awards with respect to their financial performance level target goals under our Annual Incentive Plan for fiscal year 2008. These target awards were approved by the Committee and paid to the named executive officers in September 2008 in the individual amounts set forth in the column of the Summary Compensation Table entitled "Non-Equity Incentive Plan Compensation". In addition, two of our named executive officers (Messrs. Pitts and Wallace) were also granted discretionary awards by the Committee under our Annual Incentive Plan for fiscal year 2008 at its September 2008 meeting in the individual amounts set forth in the column of the Summary Compensation Table entitled "Bonus" and such discretionary awards were paid to Messrs. Pitts and Wallace also in September 2008.

The Committee has historically attempted to maintain consistency year over year with respect to the difficulty of achieving the target performance levels under our Annual Incentive Plan. The financial performance targets used by the Committee in recent years for the annual incentive awards for most of our executive officers (Adjusted EBITDA and free cash flow) are identical to or derived from our consolidated annual Adjusted EBITDA and capital expenditures budgets approved each July by our board of directors. Our annual Adjusted EBITDA budget, and, thus, the annual Adjusted EBITDA financial target, typically increases each year to promote continuous growth consistent with our business plan. Despite such increase, the financial performance targets are designed to be realistic and attainable though slightly aggressive, requiring in each fiscal year strong performance and execution that in our view provides an annual incentive firmly aligned with stockholder interests. This balance is reflected in the fact that none of these named executive officers earned any awards under the Plan for fiscal year 2007 when our Company's financial performance was not strong, but, as stated above, they did earn their target awards under the Plan for fiscal year 2008 when our Company's financial performance was much stronger.

Long Term Incentive Compensation

The Committee provides equity incentives to executive officers and other key employees in order to directly align their interests with the long term interests of the other equity holders who are principally the Sponsors.

Holdings LLC Units Plan

Holdings acquired Vanguard in the Merger on September 23, 2004. The following contains a summary of the material terms of the Holdings LLC Units Plan, which we refer to as the 2004 Unit Plan, pursuant to which Holdings granted the right to purchase units to members of our management on September 23, 2004 in connection with consummation of the Merger. All of our named executive officers, and certain other members of our management, have been granted the right to purchase units under the 2004 Units Plan.

General

The 2004 Unit Plan permits the grant of the right to purchase Class A Units, Class B Units, Class C Units and Class D Units to employees of Holdings or its affiliates. A maximum of 117,067 Class A Units, 41,945 Class B Units, 41,945 Class C Units and 35,952 Class D Units may be subject to awards under the 2004 Unit Plan. Units covered by awards that expire, terminate or lapse will again be available for option or grant under the 2004 Unit Plan. On September 23, 2004, certain members of management purchased all 117,067 Class A Units for an aggregate purchase price of $117,067,000 and all 41,945 Class B units, all 41,945 Class C Units and all 35,952 of the Class D Units for an aggregate purchase price of $5.7 million.

Administration

The 2004 Unit Plan is administered by a committee of Holdings' board of representatives or, in the board of representatives' discretion, the board of representatives. The committee has the sole discretion to determine the employees to whom awards may be granted under the 2004 Unit Plan, the number and/or class of Units to be covered by an award, the purchase price, if any, of such awards, determine the terms and conditions of any award and determine under what circumstances awards may be settled or cancelled. The committee is authorized to interpret the 2004 Unit Plan, to establish, amend and rescind any rules and regulations relating to the 2004 Unit

Plan, and to make any other determinations that it deems necessary or desirable for the administration of the plan. The committee may correct any defect or supply any omission or reconcile any inconsistency in the 2004 Unit Plan in the manner and to the extent the committee deems necessary or desirable.

Adjustments Upon Certain Events

In the event of any changes in the Units by reason of any reorganization, recapitalization, merger, unit exchange or any other similar transaction, the board of representatives, in its sole discretion, may adjust (1) the number or kind of Units or other securities that may be issued or reserved for issuance pursuant to the 2004 Unit Plan or pursuant to any outstanding awards or (2) any other affected terms of such awards.

Amendment and Termination

The Holdings board of representatives may amend or terminate the 2004 Unit Plan at any time, provided that no amendment or termination is permitted that would diminish any rights of a management member pursuant to a previously granted award without his or her consent, subject to the committee's authority to adjust awards upon certain events as described in the previous paragraph. No awards may be made under the 2004 Unit Plan after the tenth anniversary of the effective date of the plan.

Holdings LLC Units Held by Certain of our Managers

The units of Holdings consist of Class A units, Class B units, Class C units and Class D units. As of September 1, 2008, approximately 59.2% of Holdings' Class A Units were held by Blackstone, approximately 20.8% were held by MSCP, approximately 15.4% were held by certain members of our management and approximately 4.6% were held by other investors. The Class B units, Class C units and Class D units are held exclusively by members of our senior management and all such units were purchased on September 23, 2004.

Of our named executive officers, Charles N. Martin, Jr. owns 40,000 class A units, 8,913 class B units, 8,913 class C units and 7,640 class D units; Kent H. Wallace owns 850 class A units, 2,622 class B units, 2,622 class C units and 2,247 class D units; Keith B. Pitts owns 11,000 class A units, 5,243 class B units, 5,243 class C units and 4,494 class D units; Joseph D. Moore owns 10,450 class A units, 3,146 class B units, 3,146 class C units and 2,696 class D units; and Phillip W. Roe owns 3,030 class A units, 2,097 class B units, 2,097 class C units and 1,798 class D units. As of September 1, 2008, none of the class C units are vested, but 60% of the Class B and D units are vested; and an additional 20% of such class B and D units will vest on September 23, 2008. See the vesting provisions in respect of the class A, B, C and D units in the discussion immediately below.

Terms of the Holdings' Class A Units, Class B Units, Class C Units and Class D Units

The following is a summary of certain terms of the Holdings' Class A units, Class B units, Class C units and Class D units and certain rights and restrictions applicable to those units.

Class A units have economic characteristics that are similar to those of shares of common stock in a private corporation. Subject to applicable law, only the holders of Class A units are entitled to vote on any matter. Class A units are fully vested. The Class B units, Class C units and Class D units are subject to the vesting provisions described below.

Class B units vest in five equal annual installments on the first five anniversaries of the date of purchase, subject to an employee's continued service with Holdings and its affiliates. However, the Class B units will vest earlier upon a change of control of Holdings. In the event of an employee's termination of employment with Vanguard, other than due to termination by Vanguard for "cause" or by the employee without "good reason", the employee shall be deemed vested in any Class B unit that would otherwise have vested in the calendar year in which such termination of employment occurs. No employee who holds Class B units will receive any distributions until the holders of the Class A units receive the aggregate amount invested for their Class A units. Following return of the aggregate amount invested for the Class A units, the holders of Class B units will be entitled to receive the amount of their investment in the Class B units and, once all the aggregate investment amount invested for all of the

units has been returned to their holders, the vested Class B units will share in any distributions pro rata with the Class A units and vested Class C units.

Class C units vest on the eighth anniversary of the date of purchase, subject to the employee's continued service with Holdings and its affiliates. However, the Class C units will vest earlier upon the occurrence of a sale by Blackstone of at least 25.0% of its Class A Units at a price per Class A unit exceeding two and one-half times the price per Class A Unit invested by Blackstone in connection with the Merger. No employee who holds Class C units will receive any distributions until the holders of the Class A units receive the aggregate amount invested for their Class A units. Following return of the aggregate amount invested for the Class A units, the holders of Class C units will be entitled to receive the amount of their investment in the Class C units and, once all the aggregate investment amount invested for all of the units has been returned to their holders, the vested Class C units will share in any distributions pro rata with the Class A units and vested Class B units.

Class D units vest in five equal annual installments on the fifth anniversary of the date of purchase, subject to an employee's continued service with Holdings and its affiliates. However, the Class D units will vest earlier upon a change of control of Holdings. In the event of an employee's termination of employment with Vanguard, other than due to termination by Vanguard for "cause" or by the employee without "good reason", the employee shall be deemed vested in any Class D unit that would otherwise have vested in the calendar year in which such termination of employment occurs. No employee who holds Class D units will receive any distributions until the holders of the Class A units receive the aggregate amount invested for their Class A units. Following return of the aggregate amount invested for the Class A units, the holders of Class D units will be entitled to receive the amount of their investment in the Class D units and, once all the aggregate investment amount invested for all of the units has been returned to their holders and the holders of the Class A units have received an amount representing a 300% return on their aggregate investment along with pro rata distributions to the vested Class B and Class C units, the vested Class D units will share in any distributions pro rata with the Class A units, the vested Class B units and the vested Class C units.

Certain Rights and Restrictions Applicable to the Units Held by Our Managers

The units held by members of our management are not transferable for a limited period of time except in certain circumstances. In addition, the units (other then Class A units) may be repurchased by Holdings, and in certain cases, Blackstone, in the event that the employees cease to be employed by us. Blackstone has the ability to force the employees to sell their units along with Blackstone if Blackstone decides to sell its units.

The employees that hold units are entitled to participate in certain sales by Blackstone. In addition, in the event that Holdings were to make a public offering of its equity securities, the employees would have limited rights to participate in subsequent registered public offerings.

Our 2004 Stock Incentive Plan

General

Since all Units have been granted under the 2004 Unit Plan, we intend for our option program pursuant to our 2004 Stock Incentive Plan to be the primary vehicle currently for offering long-term incentives and rewarding our executive officers, managers and key employees. Because of the direct relationship between the value of an option and the value of our stock, we believe that granting options is the best method of motivating our executive officers to manage our Company in a manner that is consistent with our interests and our stockholders' interests. We also regard our option program as a key retention tool.

We adopted the 2004 Stock Incentive Plan upon consummation of the Merger which permits the grant of non-qualified stock options, incentive stock options, stock appreciation rights, restricted stock and other stock-based awards to our employees or our affiliates' employees. The awards available under the 2004 Stock Incentive Plan, together with Holdings' equity incentive units, represent 20.0% of our fully-diluted equity at the closing of the Merger. Shares covered by awards that expire, terminate or lapse are again available for option or grant under the 2004 Stock Incentive Plan. The total number of shares of our common stock which may be issued under the 2004

Stock Incentive Plan is 101,117. All of our previous option plans were terminated upon consummation of the Merger on September 23, 2004.

Administration

The 2004 Stock Incentive Plan is administered by a committee of the board of directors or, in the sole discretion of the board of directors, the board of directors. The committee has the sole discretion to determine the employees, representatives and consultants to whom awards may be granted under the 2004 Stock Incentive Plan and the manner in which such awards will vest. Options, stock appreciation rights, restricted stock and other stock-based awards will be granted by the committee to employees, representatives and consultants in such numbers and at such times during the term of the 2004 Stock Incentive Plan as the committee shall determine. The committee is authorized to interpret the 2004 Stock Incentive Plan, to establish, amend and rescind any rules and regulations relating to the 2004 Stock Incentive Plan, and to make any other determinations that it deems necessary or desirable for the administration of the plan. The committee may correct any defect or supply any omission or reconcile any inconsistency in the 2004 Stock Incentive Plan in the manner and to the extent the committee deems necessary or desirable.

Stock Options and Stock Appreciation Rights

Options granted under the 2004 Stock Incentive Plan are vested and exercisable at such times and upon such terms and conditions as may be determined by the committee, but in no event will an option be exercisable more than 10 years after it is granted. Under the 2004 Stock Incentive Plan, the exercise price per share for any option awarded is determined by the committee, but may not be less than 100% of the fair market value of a share on the day the option is granted with respect to incentive stock options.

Stock option grants under the 2004 Stock Incentive Plan are generally made at the commencement of employment and occasionally following a significant change in job responsibilities or on a periodic basis to meet other special retention or performance objectives. All stock options granted by our board of directors to date under the 2004 Stock Incentive Plan have been granted at or above the fair market value of our common stock at the grant date based upon the most recent appraisal of our common stock. We have not back-dated any option awards.

As a privately-owned company, there has been no market for our common stock. Accordingly, in fiscal year 2007, we had no program, plan or practice pertaining to the timing of stock option grants to executive officers, coinciding with the release of material non-public information.

An option may be exercised by paying the exercise price in cash or its equivalent, and/or, to the extent permitted by the committee, shares, a combination of cash and shares or, if there is a public market for the shares, through the delivery of irrevocable instruments to a broker to sell the shares obtained upon the exercise of the option and to deliver to us an amount equal to the exercise price.

The committee may grant stock appreciation rights independent of or in conjunction with an option. The exercise price of a stock appreciation right is an amount determined by the committee. Generally, each stock appreciation right entitles a participant upon exercise to an amount equal to (i) the excess of (1) the fair market value on the exercise date of one share over (2) the exercise price, times (ii) the number of shares covered by the stock appreciation right. Payment will be made in shares or in cash or partly in shares and partly in cash (any shares valued at fair market value), as determined by the committee.

As of June 30, 2008, options to purchase 88,698 shares of our common stock (the "New Options") were outstanding under the 2004 Stock Incentive Plan. The New Options were granted in part as "time options," and in part as "performance options" which vest and become exercisable ratably on a yearly basis on each of the first five anniversaries following the date of grant (or earlier upon a change of control). 35% of the options granted were time options with an exercise price equal to the greater of the fair market price per share or $1,000 per share at the time of grant (a range of $1,000 to $1,167.50 per share). 30% of the options granted were performance options with an exercise price of $3,000 per share. 35% of the options granted were "liquidity options" with an exercise price equal to greater of the fair market price per share or $1,000 per share at the time of grant (a range of $1,000 to $1,167.50 per share) that become fully vested and exercisable upon the completion of any of certain designated business events

("liquidity events"), and in any event on the eighth anniversary of the date of grant. Any common stock for which such options are exercised are governed by a stockholders agreement, which is described below under "Item 13. Certain Relationships and Related Transactions - Stockholders Agreement."

Of our named executive officers, Messrs. Martin and Moore have been granted no New Options as of September 1, 2008, Mr. Pitts has been granted 1,500 New Options, Mr. Roe has been granted 3,008 New Options and Mr. Wallace has been granted 8,500 New Options. During fiscal year 2008 the Committee granted 2,000 New Options to Mr. Roe, 1,500 New Options to Mr. Pitts and 1,500 New Options to Mr. Wallace.

Other Stock-Based Awards

The committee, in its sole discretion, may grant restricted stock, stock awards, stock appreciation rights, unrestricted stock and other awards that are valued in whole or in part by reference to, or are otherwise based on the fair market value of our shares. Such other stock-based awards shall be in such form, and dependent on such conditions, as the committee shall determine, including, without limitation, the right to receive, or vest with respect to, one or more shares (or the equivalent cash value of such shares) upon the completion of a specified period of service, the occurrence of an event and/or the attainment of performance objectives.

Adjustments Upon Certain Events

In the event of any stock dividend or split, reorganization, recapitalization, merger, share exchange or any other similar transaction, the committee, in its sole discretion, may adjust (i) the number or kind of shares or other securities that may be issued or reserved for issuance pursuant to the 2004 Stock Incentive Plan or pursuant to any outstanding awards, (ii) the option price or exercise price and/or (iii) any other affected terms of such awards. In the event of a change of control, the committee may, in its sole discretion, provide for the (i) termination of an award upon the consummation of the change of control, but only if such award has vested and been paid out or the participant has been permitted to exercise the option in full for a period of not less than 30 days prior to the change of control, (ii) acceleration of all or any portion of an award, (iii) payment of a cash amount in exchange for the cancellation of an award, which, in the case of options and stock appreciation rights, may equal the excess, if any, of the fair market value of the shares subject to such options or stock appreciation rights over the aggregate option price or grant price of such option or stock appreciation rights, and/or (iv) issuance of substitute awards that will substantially preserve the otherwise applicable terms of any affected awards previously granted hereunder.

Amendment and Termination

The committee may amend or terminate the 2004 Stock Incentive Plan at any time, provided that no amendment or termination shall diminish any rights of a participant pursuant to a previously granted award without his or her consent, subject to the committee's authority to adjust awards upon certain events (described under "Adjustments Upon Certain Events" above). No awards may be made under the 2004 Stock Incentive Plan after the tenth anniversary of the effective date of the plan.

Benefits and Executive Perquisites

The Committee believes that attracting and retaining superior management talent requires an executive compensation program that is competitive in all respects with the programs provided at similar companies. In addition to salaries, incentive bonus and equity awards, competitive executive compensation programs include retirement and welfare benefits and reasonable executive perquisites.

Retirement Benefits

Substantially all of our salaried employees, including our named executive officers, participate in our 401(k) savings plan. Employees are permitted to defer a portion of their income under the 401(k) plan. At our discretion, we may make a matching contribution of either (1) up to 50%, subject to annual limits established under the Internal Revenue Code, of the first 6% of an employee's contributions under this 401(k) plan as determined each year or (2) in respect of a few of our employees who came to us with plans in place having a larger match than this match, a match of 100% of the first 5% of an employee's contributions under this 401(k) plan. Most recently, we

authorized such maximum discretionary amounts as a match on employees' aggregate 401(k) Plan contributions for calendar year 2007, including the named executive officers. Employee contributions are fully vested immediately. Our matching contributions vest to the employee's account over time related to the employee's years of service with us, with 20% of our contribution vesting after 2 years of service, 40% after 3 years, 60% after 4 years, 80% after 5 years and 100% after 6 years. Participants may receive distribution of their 401(k) accounts any time after they cease service with us.

We maintain no defined benefit plans.

Other Benefits

All executive officers, including the named executive officers, are eligible for other benefits including: medical, dental, life insurance, and short term disability. The executives participate in these plans on the same basis, terms, and conditions as other administrative employees. In addition, we provide long-term disability insurance coverage on behalf of the named executive officers at an amount equal to 60% of current base salary (up to $10,000 per month). The named executive officers also participate in our vacation, holiday and sick program which provides paid leave during the year at various amounts based upon the executive's position and length of service.

Perquisites

Our executive officers may have limited use of our corporate plane for personal purposes as well as very modest other usual and customary perquisites. All of such perquisites are reflected in the All Other Compensation column of the Summary Compensation Table and the accompanying footnotes.

Our Employment Agreements with Certain Named Executive Officers

We have entered into written employment agreements with all five of our named executive officers. On June 1, 1998, we entered into written employment agreements with our Chief Executive Officer and then Chief Financial Officer (Messrs. Martin and Moore, respectively), which were amended and restated on September 23, 2004, to extend the term of the employment agreements for five years, and to provide that the Merger did not constitute a change in control under the agreements. On September 1, 1999, we entered into a written employment agreement with Keith B. Pitts to be our Executive Vice President for a term expiring on September 1, 2004. Effective May 31, 2001, Mr. Pitts was promoted to the position of Vice Chairman, and on September 23, 2004, his employment agreement was amended and restated to extend the term of the employment agreement for five years, and to provide that the Merger did not constitute a change in control under the agreement. On November 15, 2007, we entered into written employment agreements with our Chief Operating Officer and our new Chief Financial Office (Messrs. Wallace and Roe, respectively) for terms expiring on November 15, 2012.

The term of each employment agreement will renew automatically for additional one-year periods, unless any such agreement is terminated by us or by the officer by delivering notice of termination no later than 90 days before the end of any such renewal term. The base salaries of Messrs. Martin, Moore, Pitts, Wallace and Roe under such written employment agreements are, during calendar year 2008, $1,050,291, $525,146, $641,844, $600,000 and $475,000, respectively. Pursuant to these agreements the officers are eligible to participate in an annual bonus plan giving each of them an opportunity to earn an annual bonus in such amount as our board of directors should determine, as well as pension, medical and other customary employee benefits. The terms of these agreements state that if the officer terminates his employment for Good Reason (as defined in the agreements) or if we terminate the officer's employment without Cause (as defined in the agreements), he will receive within a specified time after the termination a payment of up to three times the sum of (i) his annual salary plus (ii) the average of the bonuses given to him in the two years immediately preceding his termination.

Our Severance Protection Agreements

We provide our officers at the Vice President level and above (other than Messrs. Martin, Moore, Wallace and Roe and Ronald P. Soltman (our General Counsel), who each have a written employment agreement containing severance provisions) with severance protection agreements granting them severance payments in amounts of 200% to 250% of annual salary and bonus. Generally, severance payments are due under these agreements if a change in

control (as defined in the agreements) should occur and employment of the officer is terminated during the term of the agreement by us (or our successor) without Cause (as defined in the agreements) or by the executive for Good Reason (as defined in the agreement). In addition, these agreements state that in the event of a Potential Change in Control (defined as the time at which an agreement which would result in a change in control is signed, an acquisition attempt relating to us is publicly announced or there is an increase in the number of shares owned by one of our 10% shareholders by 5% or more), the executives have an obligation to remain in our employ until the earliest of (1) six months after the Potential Change in Control; (2) a change in control; (3) a termination of employment by us; or (4) a termination of employment by the employee for Good Reason (treating Potential Change in Control as a change in control for the purposes of determining whether the executive had a Good Reason) or due to death, disability or retirement. On September 23, 2004, all the outstanding severance protection agreements were amended and restated to provide that the Merger did not constitute a change in control under the agreements, and that we would not terminate the agreements prior to the third anniversary of the closing of the Merger.

Stock Ownership

We do not have a formal policy requiring stock ownership by management. Our senior managers, including all of our named executive officers, however, have committed significant personal capital to our Company in connection with the consummation of the Merger. See the beneficial ownership chart below under Item 12, "Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters". Our stock is not publicly traded and is subject to a stockholder agreement that limits a stockholder's ability to transfer his or her shares. See "Holdings Limited Liability Company Agreement" and "Stockholders Agreement" under Item 13, "Certain Relationships and Related Transactions, and Director Independence."

Impact of Tax and Accounting Rules

The forms of our executive compensation are largely dictated by our capital structure and have not been designed to achieve any particular accounting treatment. We do take tax considerations into account, both to avoid tax disadvantages, and obtain tax advantages where reasonably possible consistent with our compensation goals. (Tax advantages for our executives benefit us by reducing the overall compensation we must pay to provide the same after-tax income to our executives.) Thus our severance pay plans are designed or are being reviewed to take account of and avoid "parachute" excise taxes under Section 280G of the Internal Revenue Code. Similarly we have taken steps to structure and assure that our executive compensation program is applied in compliance with Section 409A of the Internal Revenue Code. Since we currently have no publicly traded common stock, we are not currently subject to the $1,000,000 limitation on deductions for certain executive compensation under Section 162(m) of the Internal Revenue Code, though that rule will be considered if our common stock becomes publicly traded. Incentives paid to executives under our annual incentive plan are taxable at the time paid to our executives.

The expenses associated with the stock options issued by us to our executive officers and other key employees are reflected in our consolidated financial statements. In the first quarter of the fiscal year ended June 30, 2007, we began accounting for these stock-based payments in accordance with the requirements of SFAS 123(R), which requires all share-based payments to employees, including grants of employee stock options, to be recognized as expense in the consolidated financial statements based on their fair values. For further discussion see "ITEM 8, Note 2-Summary of Critical and Significant Accounting Policies" under the heading "Stock-Based Compensation." We previously accounted for these awards under the provisions of SFAS 123, which allowed us to estimate the fair value of options using the minimum value method.

Recovery of Certain Awards

We do not have a formal policy for recovery of annual incentives paid on the basis of financial results which are subsequently restated. Under the Sarbanes-Oxley Act, our chief executive officer and chief financial officer must forfeit incentive compensation paid on the basis of financial statements for which they were responsible and which have to be restated. In that event we would expect to recover such bonuses and incentive compensation. If and when the situation arises in other events, we would consider our course of action in light of the particular facts and circumstances, including the culpability of the individuals involved.

Compensation Committee Report

The Committee has reviewed and discussed the Compensation Discussion and Analysis with management. Based upon the review and discussions, the Committee directed that the Compensation Discussion and Analysis be included in this annual report on Form 10-K.
Compensation Committee:

Michael Dal Bello
M. Fazle Husain
Charles N. Martin, Jr.
Alan M. Muney, M.D.
James A. Quella
Michael J. Parsons
Neil P. Simpkins

Summary Compensation Table

The following table sets forth, for the fiscal years ended June 30, 2008 and 2007, the compensation earned by the Chief Executive Officer and Chief Financial Officer and the three other most highly compensated executive officers of the registrant, Vanguard, at the end of Vanguard's last fiscal year ended June 30, 2008. We refer to these persons as our named executive officers.

Name and Principal Position	Year	Salary ($)	Bonus($)	Non-Equity Incentive Plan Compensation ($)(a)	Option Awards($)(b)	All Other Compensation ($)(c)	Total ($)
Charles N. Martin, Jr. Chairman of the Board & Chief Executive Officer	2008	1,050,291	–	1,050,291	–	13,608	2,114,190
	2007	1,050,291	–	–	–	10,164	1,060,455
Phillip W. Roe Executive Vice President, Chief Financial Officer & Treasurer	2008	440,192	–	332,500	9,359	7,620	789,671
	2007	350,000	–	–	4,683	7,410	362,093
Keith B. Pitts Vice Chairman	2008	641,845	100,000	577,661	3,507	7,992	1,331,005
	2007	641,845	–	–	–	7,410	649,255
Kent H. Wallace President & Chief Operating Officer	2008	600,000	100,000	540,000	35,827	7,992	1,283,819
	2007	600,000	–	–	32,319	230,212	862,531
Joseph D. Moore Executive Vice President	2008	583,495	–	408,447	–	3,564	995,506
	2007	583,495	–	–	–	3,564	587,059

(a) The Compensation Committee has determined the amount of the Annual Incentive Plan compensation that was earned by each of these named executive officers for fiscal year 2008. This amount was paid to the named executive officers in September 2008.

(b) Option Awards reflect the compensation expense recognized in our financial statements for fiscal years 2008 and 2007 in accordance with SFAS 123(R) with respect to options to purchase shares of our common stock which have been awarded under our 2004 Stock Incentive Plan in our 2006 and 2008 fiscal years to three of our named executive officers. See Note 12 to our consolidated financial statements for assumptions used in calculation of these amounts. The actual number of Option Awards granted in fiscal year 2008 is shown in the "Grants of Plan Based Awards in Fiscal Year 2008" table included below in this report. Because these amounts represent expense for financial reporting purposes, they are not representative of the actual value that the named executive officer would receive upon exercise of these options.

(c) The amounts disclosed under All Other Compensation in the Summary Compensation Table represent for the named executive officers in fiscal 2008 (i) the following amounts of our matching contributions made under our 401(k) Plan: Mr. Martin: $6,750; Mr. Roe: $6,750; Mr. Pitts: $6,750; Mr. Wallace $6,750; and Mr. Moore: $0; and (ii) the following amounts of insurance premiums paid by Vanguard with respect to group term life insurance: Mr. Martin: $6,858; Mr. Roe: $870; Mr. Pitts: $1,242; Mr. Wallace: $1,242; and Mr. Moore: $3,564. No amounts for perquisites and other personal benefits, or property, have been included in this column for 2008 for Messrs. Martin, Roe, Pitts, Wallace and Moore because the aggregate value thereof for each of these named executive officers was below the $10,000 reporting threshold established by the Securities and Exchange Commission for this column.

Grants of Plan-Based Awards in Fiscal Year 2008

Name	Grant Date	Estimated Future Payouts Under Non-Equity Incentive Plan Awards (a) Target	All Other Option Awards: Number of Securities Underlying Options(b)	Exercise or Base Price of Option Awards ($/sh)(b)	Grant Date Fair Value of Option Awards(b)
Charles N. Martin, Jr.	n/a	$ 1,050,291	–	–	–
Phillip W. Roe	n/a	$ 332,500	–	–	–
	2/5/08		700	$1,000.00	$244,293
	2/5/08		700	$1,000.00	$293,391
	2/5/08		600	$3,000.00	$ 0
Keith B. Pitts	n/a	$ 577,661	–	–	–
	2/5/08		525	$1,000.00	$183,220
	2/5/08		525	$1,000.00	$220,043
	2/5/08		450	$3,000.00	$ 0
Kent H. Wallace	n/a	$ 540,000	–	–	–
	2/5/08		525	$1,000.00	$183,220
	2/5/08		525	$1,000.00	$220,043
	2/5/08		450	$3,000.00	$ 0
Joseph D. Moore	n/a	$ 408,447	–	–	–

(a) There is solely a target award under the Annual Incentive Plan for the named executive officers. For fiscal year 2008 the named executive officers earned these target awards, the Committee approved them and they were paid in cash to the named executive officers in September 2008 and these amounts are reflected in the Summary Compensation Table. See the "Compensation Discussion and Analysis – Annual Incentive Compensation," for a detailed description of the Annual Incentive Plan.

(b) Stock options awarded under the 2004 Stock Incentive Plan by the Committee as part of the named executive officer's long term equity incentive award. None of these options were granted with exercise prices below the fair market value of the underlying common stock on the date of grant. Since we are a privately-held company, the Committee determines the fair market value of our common stock primarily from an independent appraisal of our common stock which we obtain no less frequently than annually. The terms of these option awards are described in more detail under "Compensation Discussion and Analysis – Long Term Incentive Compensation – Our 2004 Stock Incentive Plan." We utilize a Black-Scholes-Merton model to estimate the fair value of options granted. The compensation expense recognized in our financial statements for fiscal year 2008 in accordance with SFAS 123(R) with respect to these option grants is reflected in the "Option Awards" column of the Summary Compensation Table.

Outstanding Equity Awards at Fiscal 2008 Year-End

The following table summarizes the outstanding equity awards held by each named executive officer at June 30, 2008. The table reflects options to purchase common stock of Vanguard which were granted under the Vanguard Health Systems, Inc. 2004 Stock Incentive Plan.

Name	Number of Securities Underlying Unexercised Options (#) Exercisable(a)	Number of Securities Underlying Unexercised Options (#) Unexercisable(b)	Option Exercise Price ($)(c)	Option Expiration Date
Charles N. Martin, Jr.	–	–	–	–
Phillip W. Roe	142(d)	211(d)	1,150.37	11/3/15
	–	353(e)	1,150.37	11/3/15
	122(d)	180(d)	3,000.00	11/3/15
	–	700(f)	1,000.00	2/5/18
	–	700(g)	1,000.00	2/5/18
	–	600(f)	3,000.00	2/5/18
Keith B. Pitts	–	525(f)	1,000.00	2/5/18
	–	525(g)	1,000.00	2/5/18
	–	450(f)	3,000.00	2/5/18
Kent H. Wallace	344(d)	514(d)	1,150.37	11/3/15
	–	858(e)	1,150.37	11/3/15
	295(d)	441(d)	3,000.00	11/3/15
	638(h)	954(h)	1,150.37	11/28/15
	–	1,592(i)	1,150.37	11/28/15
	546(h)	818(h)	3,000.00	11/28/15
	–	525(f)	1,000.00	2/5/18
	–	525(g)	1,000.00	2/5/18
	–	450(f)	3,000.00	2/5/18
Joseph D. Moore	–	–	–	–

(a) This column represents the number of stock options that had vested and were exercisable as of June 30, 2008.

(b) This column represents the number of stock options that had not vested and were not exercisable as of June 30, 2008.

(c) The exercise price for the options was never less than the grant date fair market value of a share of Vanguard common stock as determined by the Compensation Committee.

(d) 20% of the options represented by this option grant vest and become exercisable on each of the first five anniversaries of the November 3, 2005 grant date of these options (or earlier upon a change of control). 40% of this option grant was vested as of June 30, 2008.

(e) 100% of the options represented by this option grant vest and become exercisable on the eighth anniversary of the November 3, 2005 grant date of these options (or earlier upon a liquidity event).

(f) 20% of the options represented by this option grant vest and become exercisable on each of the first five anniversaries of the February 5, 2008 grant date of these options (or earlier upon a change of control). None of this option grant was vested as of June 30, 2008.

(g) 100% of the options represented by this option grant vest and become exercisable on the eighth anniversary of the February 5, 2008 grant date of these options (or earlier upon a liquidity event).

(h) 20% of the options represented by this option grant vest and become exercisable on each of the first five anniversaries of the November 28, 2005 grant date of these options (or earlier upon a change of control). 40% of this option grant was vested as of June 30, 2008.

(i) 100% of the options represented by this option grant vest and become exercisable on the eighth anniversary of the November 28, 2005 grant date of these options (or earlier upon a liquidity event).

Option Exercises and Stock Vested

No named executive officer exercised any stock options of Vanguard during fiscal 2008 nor were any restricted stock awards vested during fiscal 2008. Vanguard has made no restricted stock awards of its common stock since the Merger.

Pension Benefits

Vanguard maintains a 401(k) plan as previously discussed in the Compensation Discussion and Analysis. Vanguard maintains no defined benefit plans.

Nonqualified Deferred Compensation

None of the named executive officers receive nonqualified deferred compensation benefits.

Employment and Severance Protection Agreements

As discussed above, we have entered into definitive employment or severance protection agreements with each of the named executive officers. The terms of these agreements are described above under Compensation Discussion and Analysis.

Potential Payments Upon Termination or Change of Control

The following table describes the potential payments and benefits under our compensation and benefit plans and arrangements to which the named executive officers would be entitled upon a termination of their employment under their employment agreement, if they have an employment agreement, or if they do not have an employment agreement, under their severance protection agreement. In accordance with SEC disclosure rules, dollar amounts below assume a termination of employment on June 30, 2008 (the last business day of our last completed fiscal year).

Current	Cash Severance Payment ($)	Continuation of Medical/Welfare Benefits (present value) ($)	Total Termination Benefits ($)
Charles N. Martin, Jr.			
·Voluntary retirement	0	0	0
·Involuntary termination	4,201,164	25,947	4,227,111
·Involuntary or Good Reason termination after change in control	6,301,746	25,947	6,327,693
Phillip W. Roe			
·Voluntary retirement	0	0	0
·Involuntary termination	1,615,000	25,848	1,640,848
·Involuntary or Good Reason termination after change in control	2,422,500	25,848	2,448,348
Keith B. Pitts			
·Voluntary retirement	0	0	0
·Involuntary termination	2,439,012	25,947	2,464,959
·Involuntary or Good Reason termination after change in control	3,658,518	25,947	3,684,465
Kent H. Wallace			
·Voluntary retirement	0	0	0
·Involuntary termination	2,280,000	25,947	2,305,947
·Involuntary or Good Reason termination after change in control	3,420,000	25,947	3,445,947
Joseph D. Moore			
·Voluntary retirement	0	0	0
·Involuntary termination	1,750,486	17,855	1,768,341
·Involuntary or Good Reason termination after change in control	2,625,729	17,855	2,643,584

Accrued Pay and Regular Retirement Benefits. The amounts shown in the table above do not include payments and benefits to the extent they are provided on a non-discriminatory basis to salaried employees generally upon termination of employment. These include:

- Accrued salary and vacation pay and earned but unpaid bonus.
- Distributions of plan balances under our 401(k) plan.

Death and Disability. A termination of employment due to death or disability does not entitle the named executive officers to any payments or benefits that are not available to salaried employees generally.

Involuntary Termination and Change-in-Control Severance Pay Program. As described above under "— Our Employment Agreements," all of the named executive officers are entitled to severance pay in the event that their employment is terminated by us without Cause or if the named executive officer terminates the agreement as a result of our breach of his employment agreement. Additionally, they are entitled to severance pay under their employment agreements in the event they terminate the agreements after a change in control if their termination is for Good Reason.

Under our executive severance pay program, no payments due in respect of a change of control are "single trigger", that is, payments of severance due to the named executive officers merely upon a change of control. All of our change of control payments are "double trigger", due to the executive only subsequent to a change of control and after a termination of employment has occurred.

Under their employment agreements, all of our named executive officers owe the following obligations to us:

- Not to disclose our confidential business information;
- Not to solicit for employment any of our employees for a period expiring two years after the termination of their employment; and
- Not to accept employment with or consult with, or have any ownership interest in, any hospital or hospital management entity for a period expiring two years after the termination of their employment, except there shall be not such prohibitions if (1) we terminate the executive under his employment agreement or (2) the executive terminates his agreement for Good Reason or because we have breached his agreement.

The amounts shown in the table are for such involuntary or Good Reason terminations for the named executive officers and are based on the following assumptions and provisions in the employment agreements.

• *Covered terminations following a Change in Control.* Eligible terminations for all of our named executive officers include an involuntary termination for reasons other than Cause both before and following a change of control, or a voluntary resignation by the executive as a result of Good Reason following a change in control.

• *Definitions of Cause and Good Reason*

A termination of a named executive officer by us is for Cause if it is for any of the following reasons:

(a) the conviction of the executive of a criminal act classified as a felony;

(b) the willful failure by the executive to substantially perform the executive's duties with us (other than any such failure resulting from the executive's incapacity due to physical or mental illness); or

(c) the willful engaging by the executive in conduct which is materially injurious to us monetarily or otherwise.

A termination by the executive officer is for Good Reason if it results from, after a change of control has occurred, one of the following events:

(a) a material diminution in the executive's base compensation;

(b) a material diminution in the executive's authority, duties or responsibilities;

(c) a material diminution in the authority, duties or responsibilities of the supervisor to whom the executive is required to report, including a requirement that the executive's supervisor

report to a corporate officer or employee instead of reporting directly to our Board of Directors;

(d) a material diminution in the budget over which the executive retains authority;

(e) a material change in the geographic location at which the executive must perform services, except for required travel on our business to an extent substantially consistent with his business travel obligations prior to the change in control; or

(f) any other action or inaction that constitutes a material breach by us of the terms of the employment agreement.

• *Cash severance payments; Timing.* Represents, for each of our named executive officers, (1) if it relates to an involuntary termination without Cause by us prior to a change of control, a payment of 2 times the named executive officer's base salary and average annual incentive actually paid during the last two years plus an additional amount equal to such officer's pro rata annual target incentive for the year of termination and (2) if it relates to an involuntary termination without cause by us or a Good Reason termination by the executive after a change of control, payment of 3 times the named executive officer's base salary and average annual incentive actually paid during the last two years plus an additional amount equal to such officer's pro rata annual target incentive for the year of termination. All of these severance payments are "lump sum" payments by us to the named executive officers due within 5 days of termination of employment, except that the amounts of severance described above payable in respect of a termination of their employment prior to a change of control are payable monthly in equal monthly installments starting with the month after employment terminates and ending with the month that their 5-year employment agreements terminate (which is September 2009 for Messrs. Martin, Pitts and Moore and November 2012 for Messrs. Roe and Wallace).

• *Continuation of health, welfare and other benefits.* Represents the value of coverage for 18 months following a covered termination equivalent to our current active employee medical, dental, life, long-term disability insurances and other covered benefits.

Director Compensation

During fiscal 2008, our directors who are either our employees or affiliated with our private equity Sponsors did not receive any fees or other compensation services as our directors. As described in the table below, Michael J. Parsons, a director who is not our employee or an affiliate of our Sponsors, receives our current standardized director compensation plan for our independent directors of $60,000 per annum in cash plus an initial grant, upon election to our board of directors, of 85 stock options pursuant to our 2004 Stock Incentive Plan, as described in this Item under the caption "Our 2004 Stock Incentive Plan". We do, however, reimburse all of our directors for travel expenses and other out-of-pocket costs incurred in connection with attendance at meetings of the board.

The following table summarizes all compensation for our non-employee directors for our fiscal year ended June 30, 2008.

Name	Fees Earned or Paid in Cash(1) ($)	Stock Awards ($)	Option Awards(2)(3) ($)	Non-Equity Incentive Plan Compensation ($)	Change in Pension Value and Nonqualified Deferred Compensation Earnings	All Other Compensation ($)	Total ($)
Michael J. Parsons	$ 10,000	–	$ 83	–	–	–	$ 10,083

(1) The director compensation in the above table reflects an annual cash retainer paid to each independent, non-employee director of $60,000, prorated for Mr. Parsons' election as one of our directors in May 2008. The employee and Sponsor-affiliated directors receive no additional compensation for serving on the board and, as a result, are not listed in the above table.

(2) The amount in this column reflects the dollar amount recorded for financial statement reporting purposes for the fiscal year ended June 30, 2008, in accordance with FAS 123(R), relating to Mr. Parsons' option award granted pursuant to our 2004 Stock Option Plan. Assumptions used in the calculation of this amount are included in Note 2 of the Notes to our consolidated financial statements for the fiscal year ended June 30, 2008 included in this report.

(3) This represents a grant of 85 stock options on May 6, 2008 under our 2004 Stock Option Plan. None of such options were exercisable on June 30, 2008. 30 of the options had an option exercise price of $1,000 per share and become exercisable 20% on each of the first five anniversaries of their May 6, 2008 grant date (or earlier upon a change of control). 30 of the options also had an option exercise price of $1,000 per share and become exercisable on the eighth anniversary of the May 6, 2008 grant date (or earlier upon a liquidity event). 25 of the options had an option exercise price of $3,000 per share and become exercisable 20% on each of the first five anniversaries of their May 6, 2008 grant date (or earlier upon a change of control). The exercise price for the options is not less than the fair market value of a share of our common stock as determined by the Compensation Committee. All of these 85 options have an expiration date of May 6, 2018. For more information about options granted under our 2004 Stock Option Plan, see information in this Item under the caption "Our 2004 Stock Incentive Plan".

Compensation Committee Interlocks and Insider Participation

During fiscal 2008, we had no compensation committee of our board of directors. Charles N. Martin, Jr., one of the named executive officers, participated in deliberations of our board of directors concerning executive officer compensation during fiscal 2008.

Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters.

As of September 1, 2008, VHS Holdings LLC ("Holdings") directly owned 624,550 of the outstanding shares of the common stock of Vanguard (representing a 83.3% ownership interest), certain investment funds affiliated with Blackstone directly owned 125,000 of the outstanding shares of the common stock of Vanguard (representing a 16.7% ownership interest) and no other person or entity had a direct beneficial ownership interest in the common stock of Vanguard, except for certain key employees who held an aggregate of 17,237 exercisable options into 17,237 shares of the common stock of Vanguard as of such date. However, ignoring only the direct ownership of Holdings in the common stock of Vanguard, the following table sets forth information with respect to the direct or indirect beneficial ownership of the common stock of Vanguard as of September 1, 2008 by (1) each person (other than Holdings) known to own beneficially more than 5.0% of the common stock of Vanguard, (2) each named executive officer, (3) each of our directors and (4) all executive officers and directors as a group. The indirect beneficial ownership of the common stock of Vanguard reflects the direct beneficial ownership of all Class A units and all vested Class B and D units of Holdings. None of the shares listed in the table are pledged as security pursuant to any pledge arrangement or agreement. Additionally, there are no arrangements with respect to the share, the operation of which may result in a change in control of Vanguard.

Notwithstanding the beneficial ownership of the common stock of Vanguard presented below, the limited liability company agreement of Holdings governs the holders' exercise of their voting rights with respect to election of Vanguard's directors and certain other material events. See "Item 13. Certain Relationships and Related Transactions - Holdings Limited Liability Company Agreement."

Name of Beneficial Owner	Beneficial Ownership	Ownership Percentage
Blackstone Funds(1)	494,930	66.0%
MSCP Funds(2)	130,000	17.3%
Charles N. Martin Jr.(3)	53,243	7.0%
Phillip W. Roe(4)	6,411	*
Keith B. Pitts(5)	18,791	2.5%
Kent H. Wallace(6)	6,569	*
Joseph D. Moore(7)	15,124	2.0%
M. Fazle Husain(8)	126,750	16.9%
James A. Quella(1)	494,930	66.0%
Neil P. Simpkins (1)	494,930	66.0%
Michael A. Dal Bello	—(9)	—(9)
Alan M. Muney, M.D.	—(9)	—(9)
Michael J. Parsons	—	—
All directors and executive officers as a group (24 persons) (10)	762,636	95.1%

* Less than 1% of shares of common stock outstanding (excluding, in the case of all directors and executive officers as a group, shares beneficially owned by Blackstone and by the MSCP Funds).

(1) Includes common stock interests directly and indirectly owned by each of Blackstone FCH Capital Partners IV L.P., Blackstone FCH Capital Partners IV-A L.P., Blackstone FCH Capital Partners IV-B L.P., Blackstone Capital Partners IV-A L.P., Blackstone Family Investment Partnership IV-A L.P., Blackstone Health Commitment Partners L.P. and Blackstone Health Commitment Partners-A L.P. (the "Blackstone Funds"), for which Blackstone Management Associates IV L.L.C. ("BMA") is the general partner having voting and investment power over the membership interests in Holdings and the shares in Vanguard held or controlled by each of the Blackstone Funds. Messrs. Quella and Simpkins are members of BMA, but disclaim any beneficial ownership of the membership interests or the shares beneficially owned by BMA. Messrs. Peter G. Peterson and Stephen A. Schwarzman are the founding members of BMA and as such may be deemed to share beneficial ownership of the membership interests or shares held or controlled by the Blackstone Funds. Each of BMA and Messrs. Peterson and Schwarzman disclaims beneficial ownership of such membership interests and shares. The address of BMA and the Blackstone Funds is c/o The Blackstone Group L.P., 345 Park Avenue, New York, New York 10154

(2) The MSCP Funds consist of the following six funds: Morgan Stanley Capital Partners III, L.P., MSCP III 892 Investors, L.P., Morgan Stanley Capital Investors, L.P., Morgan Stanley Dean Witter Capital Partners IV, L.P., MSDW IV 892 Investors, L.P., and Morgan Stanley Dean Witter Capital Investors IV, L.P. The address of each of Morgan Stanley Capital Partners III, L.P., MSCP III 892 Investors, L.P., Morgan Stanley Dean Witter Capital Partners IV, L.P. and MSDW IV 892 Investors, L.P. is c/o Metalmark Capital LLC, 1177 Avenue of the Americas, New York, New York 10036. The address of each of Morgan Stanley Capital Investors, L.P. and Morgan Stanley Dean Witter Capital Investors IV, L.P. is c/o Morgan Stanley, 1585 Broadway, New York, New York 10036. Metalmark Capital LLC shares investment and voting power with Morgan Stanley Capital Partners III, L.P., MSCP III 892 Investors, L.P., Morgan Stanley Dean Witter Capital Partners IV, L.P. and MSDW IV 892 Investors, L.P. over 126,750 of these 130,000 shares of Vanguard common stock indirectly owned by these four funds.

(3) Includes 7,131 B units and 6,112 D units in Holdings which are vested or vest within 60 days of September 1, 2008.

(4) Includes 264 options in Vanguard and 1,678 B units and 1,439 D units in Holdings which are vested or vest within 60 days of September 1, 2008.

(5) Includes 4,195 B units and 3,596 D units in Holdings which are vested or vest within 60 days of September 1, 2008.

(6) Includes 1,823 options in Vanguard and 2,098 B units and 1,798 D units in Holdings which are vested or vest within 60 days of September 1, 2008.

(7) Includes 2,517 B units and 2,157 D units in Holdings which are vested or vest within 60 days of September 1, 2008.

(8) Mr. Husain is a Managing Director of Metalmark Capital LLC and exercises shared voting or investment power over the membership interests in Holdings owned by Morgan Stanley Capital Partners III, L.P., MSCP III 892 Investors, L.P., Morgan Stanley Dean Witter Capital Partners IV, L.P., and MSDW IV 892 Investors, L.P. and, as a result, may be deemed to be the beneficial owner of such membership interests and the 126,750 shares of Vanguard common stock indirectly owned by these four funds. Mr. Husain disclaims beneficial ownership of such membership interests and shares of common stock as a result of his employment arrangements with Metalmark, except to the extent of his pecuniary interest therein ultimately realized. Metalmark Capital does not have investment and voting power with respect to 3,250 shares of Vanguard common stock indirectly owned by Morgan Stanley Capital Investors, L.P. and Morgan Stanley Dean Witter Capital Investors IV, L.P. and these 3,250 shares are not included in the 126,750 shares contained in this table for Mr. Husain.

(9) Mr. Dal Bello and Mr. Muney are employees of Blackstone, but do not have investment or voting control over the shares beneficially owned by Blackstone.

(10) Includes 7,741 options in Vanguard and 24,124 B units and 20,678 D units in Holdings which have vested or vest within 60 days of September 1, 2008.

Equity Compensation Plan Information

The following table gives information about our common stock that may be issued upon the exercise of options, warrants and rights under all of Vanguard's existing equity compensation plans as of June 30, 2008.

	Equity Compensation Plan Information		
Plan Category	Number of securities to be issued upon exercise of outstanding options, warrants and rights (a)	Weighted-average exercise price of outstanding options, warrants and rights (b)	Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a)) (c)
Equity compensation plans approved by security holders	88,698 (1)	$1,644.97	11,915 (1)
Equity compensation plans not approved by security holders	0	$ 0	0
Total	88,698	$1,644.97	11,915

(1) The material features of the equity compensation plan under which these options were issued are set forth in this report under "Item 11. Executive Compensation – Our 2004 Stock Incentive Plan."

Item 13. Certain Relationships and Related Transactions, and Director Independence.

Holdings Limited Liability Company Agreement

In the Merger, Blackstone invested, and MSCP, Baptist and the Rollover Management Investors re-invested, in our company by subscribing for and purchasing Class A membership units in Holdings. In addition, at the closing of the Merger, the board of representatives of Holdings issued to certain Rollover Management Investors Class B, C and D membership units in Holdings as part of a new equity incentive program.

Under the limited liability company agreement of Holdings, the board of representatives of Holdings consists of the same five individuals who constitute the sole members of our board of directors. At Blackstone's election, the size of the board of representatives may be increased to nine members, with two additional representatives to be designated by Blackstone and two additional representatives to be independent representatives identified by our chief executive officer and acceptable to Blackstone. If at any time our chief executive officer is not Charles N. Martin, Jr., the Rollover Management Investors shall have the right to designate one representative to the board (the "Manager Representative") so long as the Rollover Management Investors continue to own not less than 50% of the Class A units held by them immediately after the completion of the Merger. MSCP will continue to be entitled to nominate and elect one representative so long as MSCP continues to own not less than 50% of the Class A units it held immediately after the completion of the Merger.

The limited liability company agreement of Holdings also has provisions relating to restrictions on transfer of securities, rights of first refusal, tag-along, drag-along, preemptive rights and affiliate transactions. At the completion of the Merger, the Company issued Class B, C and D warrants to Holdings, exercisable for the proportional percentage of equity represented by the related classes of membership units in Holdings. With respect to the Class B, C and D units only, the limited liability company agreement also has call provisions applicable in the event of certain termination events relating to a Rollover Management Investor's employment.

Stockholders Agreement

Recipients of options to purchase the Company's common stock are required to enter into a stockholders agreement governing such grantees' rights and obligations with respect to the common stock underlying such options. The provisions of the stockholders agreement are, with limited exceptions, similar to those set forth in the

limited liability company agreement of Holdings, including certain restrictions on transfer of shares of common stock, rights of first refusal, call rights, tag-along rights and drag-along rights. The transfer restrictions apply until the earlier of the fifth anniversary of the date the stockholder becomes a party to the stockholders agreement, or a change in control of the Company. The right of first refusal provision gives the Company a right of first refusal at any time after the fifth anniversary of the date the stockholder became a party to the stockholders agreement and prior to the earlier of a change in control of the Company or a registered public offering of our common stock meeting certain specified criteria. The call provisions provide rights with respect to the shares of our common stock held by the stockholder, whether or not such shares were acquired upon the exercise of a New Option, except for shares received upon conversion of or in redemption for Class A membership units in Holdings pursuant to the limited liability company agreement of Holdings. Such call rights are applicable in the event of certain termination events relating to the grantee's employment with the Company.

Transaction and Monitoring Fee Agreement

In connection with the Merger, Vanguard entered into a transaction and monitoring fee agreement with affiliates of Blackstone and Metalmark pursuant to which these affiliates provide certain structuring, advisory and management services to us. Under this agreement, Vanguard paid to Blackstone Management Partners IV L.L.C. ("BMP") upon the closing of the Merger a transaction fee of $20.0 million. In consideration for ongoing consulting and management advisory services, Vanguard is required to pay to BMP an annual fee of $4.0 million. In consideration for on-going consulting and management services Vanguard is required to pay to Metalmark Subadvisor LLC ("Metalmark SA"), an affiliate of Metalmark, an annual fee of $1.2 million for the first five years and thereafter an annual fee of $600,000. In the event or in anticipation of a change of control or initial public offering, BMP may elect at any time to have Vanguard pay to BMP and Metalmark SA lump sum cash payments equal to the present value (using a discount rate equal to the yield to maturity on the date of notice of such event of the class of outstanding U.S. government bonds having a final maturity closest to the tenth anniversary of such written notice) of all then-current and future fees payable to each of BMP and Metalmark SA under the agreement (assuming that the agreement terminates on the tenth anniversary of the closing of the Merger). In the event that BMP receives any additional fees in connection with an acquisition or disposition involving Vanguard, Metalmark SA will receive an additional fee equal to 15.0% of such fees paid to BMP or, if both parties provide equity financing in connection with the transaction, Metalmark SA will receive a portion of the aggregate fees payable by Vanguard, if any, based upon the amount of equity financing provided by Metalmark SA. The transaction and monitoring fee agreement also requires Vanguard to pay or reimburse BMP and Metalmark SA for reasonable out-of-pocket expenses in connection with, and indemnify them for liabilities arising from, the engagement of BMP and Metalmark SA of independent professionals pursuant to and the performance by BMP and Metalmark SA of the services contemplated by the transaction and monitoring fee agreement. The transaction and monitoring fee agreement will remain in effect with respect to each of BMP and Metalmark SA until the earliest of (1) BMP and Metalmark SA, as the case may be, beneficially owning less than 5.0% of Vanguard's common equity on a fully diluted basis, (2) the completion of a lump-sum payout as described above or (3) termination of the agreement upon the mutual consent of BMP and/or Metalmark SA, as the case may be, and Vanguard. Upon termination of Metalmark SA as a party to the agreement, Metalmark SA will be entitled to the excess, if any, of 15.0% of the aggregate amount of fees paid to date to BMP under the agreement minus any monitoring fees already paid to Metalmark SA.

Under the transaction and monitoring fee agreement during fiscal year 2008, Vanguard paid to BMP the annual $4.0 million fee referred to above and reimbursed BMP approximately $1.2 million for expenses incurred by BMP on Vanguard's behalf. BMP is an affiliate of the Blackstone Funds which own 66.0% of the equity of Vanguard. Four of our seven directors, Messrs. Dal Bello, Muney, Quella and Simpkins, are employed by affiliates of BMP.

Under the transaction and monitoring fee agreement during fiscal year 2008, Vanguard paid to Metalmark SA the annual $1.2 million fee referred to above. Metalmark SA is an affiliate of Metalmark Capital LLC which manages the MSCP Funds and the MSCP Funds own 17.3% of the equity of Vanguard.

Registration Rights Agreement

In connection with the Merger, the Company entered into a registration rights agreement with Blackstone, MSCP and other investors and the Rollover Management Investors, pursuant to which Blackstone and MSCP are entitled to certain demand registration rights and pursuant to which Blackstone, MSCP and other investors and the Rollover Management Investors are entitled to certain piggyback registration rights.

Commercial Transactions with Sponsor Portfolio Companies

Blackstone, MSCP and Metalmark each sponsor private equity funds which have ownership interests in a broad range of companies. We have entered into commercial transactions in the ordinary course of our business with some of these companies, including the sale of goods and services and the purchase of goods and services. None of these transactions or arrangements is of great enough value to be considered material to us.

Policy on Transactions with Related Persons

The Vanguard board of directors recognizes the fact that transactions with related persons present a heightened risk of conflicts of interests and/or improper valuation (or the perception thereof). In February 2007, the board of directors adopted a written policy reflecting existing practices to be followed in connection with any transaction between the Company and a "related person."

Any transaction with the Company in which a director, executive officer or beneficial holder of more than 5% of the total equity of the Company, or any immediate family member of the foregoing (each, a "related person") has a direct or indirect material interest, and where the amount involved exceeds $120,000, must be specifically disclosed by the Company in its public filings. Any such transaction would be subject to the Company's written policy respecting the review, approval or ratification of related person transactions.

Under this policy:

- the Company or any of its subsidiaries may employ a related person in the ordinary course of business consistent with the Company's policies and practices with respect to the employment of non-related persons in similar positions; and

- any other related person transaction that would be required to be publicly disclosed must be approved or ratified by the board of directors, a committee thereof or if it is impractical to defer consideration of the matter until a board or committee meeting, by a non-management director who is not involved in the transaction.

If the transaction involves a related person who is a director or an immediate family member of a director, that director may not participate in the deliberations or vote. In approving or ratifying a transaction under this policy, the board of directors, the committee or director considering the matter must determine that the transaction is fair to the Company and may take into account, among other factors deemed appropriate, whether the transaction is on terms not less favorable than terms generally available to an unaffiliated third-party under the same or similar circumstances and the extent of the related person's interest in the transaction.

During fiscal year 2008, there were no transactions between the Company and a related person requiring approval under this policy.

Director Independence

Our board of directors has not made a formal determination as to whether each director is "independent" because we have no equity securities listed for trading on a national securities exchange or in an automated inter-dealer quotation system of a national securities association, which has requirements that a majority of its board of directors be independent. Six of our seven directors have either been appointed by our equity Sponsors or are employed by us (Mr. Martin, our chairman and chief executive officer). Our seventh director (Michael J. Parsons) is neither our employee or otherwise affiliated with us in any significant way. Thus, we do not believe any of our

directors would be considered independent under the New York Stock Exchange's definition of independence, except for Mr. Parsons.

Item 14. Principal Accounting Fees and Services.

Fees Paid to the Independent Auditor

The following table presents fees for professional services rendered by Ernst & Young LLP for the audit of Vanguard's annual financial statements for 2007 and 2008, and fees billed for audit-related services, tax services and all other services rendered by Ernst & Young LLP for 2007 and 2008.

	2007	2008
Audit fees[1]	$ 834,133	$ 856,929
Audit-related fees	–	–
Audit and audit-related fees	834,133	856,929
Tax fees[2]	34,316	64,263
All other fees[3]	1,870,901	1,109,572
Total fees[4]	$ 2,739,350	$ 2,030,764

(1) Audit fees for 2007 and 2008 include fees for the audit of the annual consolidated financial statements, reviews of the condensed consolidated financial statements included Vanguard's quarterly reports and statutory audits.

(2) Tax fees for 2007 and 2008 consisted principally of fees for tax advisory services.

(3) All other fees for 2007 and 2008 consisted of assistance in identification of Medicaid eligible days for inclusion in the Medicare cost reports for Medicare disproportionate share reimbursement; assistance in validating average wage rates in our markets used in Medicare reimbursement; assistance in preparing reports for us relating to payer matters; and assistance in preparing occupational mix survey data in accordance with CMS requirements.

(4) Ernst & Young LLP full time, permanent employees performed all of the professional services described in this chart.

Pre-Approval Policies and Procedures

In February 2004, our board of directors first adopted an audit and non-audit services pre-approval policy and in November 2004 and May 2006 the board amended and restated this policy. This policy sets forth the Board's procedures and conditions pursuant to which services proposed to be performed by the Company's regular independent auditor (and those other independent auditors for whom pre-approvals are legally necessary) are presented to the Board for pre-approval. Normally, the policy would have been approved by the audit committee and ratified by the board of directors, but in February 2004, November 2004 and May 2006 we had no audit committee and, as a result, the full board of directors has the responsibility for all matters that are usually the responsibility of the audit committee.

The policy provides that the board of directors shall pre-approve audit services, audit-related services, tax services and those other services that it believes to be routine and recurring services that do not impair the independence of the auditor. Under the policy, our Chief Accounting Officer is responsible for determining whether services provided by the independent auditor are included as part of those services already pre-approved or whether separate approval from the board of directors is required. All services performed for us by Ernst & Young LLP, our independent registered public accounting firm, subsequent to the adoption of the policy have been pre-approved by the board of directors. The board of directors has concluded that the audit-related services, tax services and other non-audit services provided by Ernst & Young LLP in fiscal year 2008 were compatible with the maintenance of the firm's independence in the conduct of its auditing functions. In addition, to safeguard the continued independence of the independent auditors, the policy prevents our independent auditors from providing services to us that are prohibited under Section 10A(g) of the Securities Exchange Act of 1934, as amended.

PART IV

Item 15. Exhibits and Financial Statement Schedules.

(a) List of documents filed as part of this report.

(1) Financial Statements. The accompanying index to financial statements on page 78 of this report is provided in response to this item.

(2) Financial Statement Schedules. All schedules are omitted because the required information is either not present, not present in material amounts or presented within the consolidated financial statements.

(3) Exhibits. The exhibits filed as part of this report are listed in the Exhibit Index which is located at the end of this report.

(b) Exhibits.
See Item 15(a)(3) of this report.

(c) Financial Statement Schedules.
See Item 15(a)(2) of this report.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

VANGUARD HEALTH SYSTEMS, INC. — Date

By: /s/ Charles N. Martin, Jr. — September 23, 2008
Charles N. Martin, Jr.
Chairman of the Board & Chief Executive Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/s/ Charles N. Martin, Jr. Charles N. Martin, Jr.	Chairman of the Board & Chief Executive Officer; Director (Principal Executive Officer)	September 23, 2008
/s/ Phillip W. Roe Phillip W. Roe	Executive Vice President, Chief Financial Officer & Treasurer (Principal Financial Officer)	September 23, 2008
/s/ Gary D. Willis Gary D. Willis	Senior Vice President, Controller & Chief Accounting Officer (Principal Accounting Officer)	September 23, 2008
/s/ Michael A. Dal Bello Michael A. Dal Bello	Director	September 23, 2008
/s/ M. Fazle Husain M. Fazle Husain	Director	September 23, 2008
/s/ Alan M. Muney, M.D. Alan M. Muney, M.D.	Director	September 23, 2008
/s/ Michael J. Parsons Michael J. Parsons	Director	September 23, 2008
/s/ James A. Quella James A. Quella	Director	September 23, 2008
/s/ Neil P. Simpkins Neil P. Simpkins	Director	September 23, 2008

Supplemental Information to be Furnished With Reports Filed Pursuant to Section 15(d) of the Act by Registrants Which Have Not Registered Securities Pursuant to Section 12 of the Act.

No annual report or proxy material has been sent to security holders.

EXHIBIT INDEX

Exhibit No.	Description
2.1	Agreement and Plan of Merger, dated as of July 23, 2004, among VHS Holdings LLC, Health Systems Acquisition Corp. and Vanguard Health Systems, Inc.(1)
2.2	First Amendment to the Agreement and Plan of Merger, dated as of September 23, 2004, among VHS Holdings LLC, Health Systems Acquisition Corp. and Vanguard Health Systems, Inc.(1)
2.3	Indemnification Agreement, dated as of July 23, 2004, among VHS Holdings LLC, Vanguard Health Systems, Inc., and the stockholders and holders of options set forth therein(1)(3)
3.1	Amended and Restated Certificate of Incorporation of Vanguard Health Systems, Inc.(1)
3.2	By-Laws of Vanguard Health Systems, Inc.(10)
4.1	Indenture, relating to the 9% Senior Subordinated Notes, dated as of September 23, 2004, among Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the Guarantors party thereto and the Trustee(1)
4.2	First Supplemental Indenture, dated as of November 5, 2004, among Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the Guarantors party thereto and the Trustee(1)
4.3	Indenture, relating to the 11 1/4% Senior Discount Notes, dated as of September 23, 2004, among Vanguard Health Holding Company I, LLC, Vanguard Holding Company I, Inc, Vanguard Health Systems, Inc. and the Trustee(1)
4.4	Registration Rights Agreement relating to the 9% Senior Subordinated Notes, dated as of September 23, 2004, among Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the Guarantors party thereto, Citigroup Global Markets Inc., Banc of America Securities LLC, Bear Stearns & Co., Inc., J.P. Morgan Securities Inc., Merrill Lynch, Pierce, Fenner & Smith Incorporated, Wachovia Capital Markets, LLC and ABN AMRO Incorporated(1)
4.5	Registration Rights Agreement, relating to the 11 1/4% Senior Discount Notes, dated as of September 23, 2004, among Vanguard Health Holding Company I, LLC, Vanguard Holding Company I, Inc., Vanguard Health Systems, Inc., Citigroup Global Markets Inc., Banc of America Securities LLC, Bear Stearns & Co., Inc., J.P. Morgan Securities Inc., Merrill Lynch, Pierce, Fenner & Smith Incorporated, Wachovia Capital Markets, LLC and ABN AMRO Incorporated(1)
4.6	Registration Rights Agreement, concerning Vanguard Health Systems, Inc., dated as of September 23, 2004(1)
4.7	Second Supplemental Indenture, dated as of March 28, 2005, among Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the Guarantors party thereto and the Trustee (8)
4.8	Third Supplemental Indenture, dated as of July 13, 2006, among Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the Guarantors party thereto and the Trustee (15)
4.9	Fourth Supplemental Indenture, dated as of June 25, 2007, among Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the Guarantors party thereto and the Trustee(19)

4.10	Fifth Supplemental Indenture, dated as of July 1, 2007, among Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the Guarantors party thereto and the Trustee(19)
4.11	Sixth Supplemental Indenture, dated as of October 2, 2007, among Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the Guarantors party thereto and the Trustee (20)
10.1	Credit Agreement, dated as of September 23, 2004, among Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., Vanguard Health Holding Company I, LLC, the lenders party thereto, Bank of America, N.A. as administrative agent, Citicorp North America, Inc., as syndication agent, the other agents named therein, and Banc of America Securities LLC and Citigroup Global Markets Inc., as joint lead arrangers and book runners(1)
10.2	Security Agreement, dated as of September 23, 2004, made by each assignor party thereto in favor of Bank of America, N.A., as collateral agent(1)
10.3	Vanguard Guaranty, dated as of September 23, 2004, made by and among Vanguard Health Systems, Inc. in favor of Bank of America, N.A., as administrative agent(1)
10.4	Subsidiaries Guaranty, dated as of September 23, 2004, made by and among each of the guarantors party thereto in favor of Bank of America, N.A., as administrative agent(1)
10.5	Pledge Agreement, dated as of September 23, 2004, among each of the pledgors party thereto and Bank of America, N.A., as collateral agent(1)
10.6	Transaction and Monitoring Fee Agreement, dated as of September 23, 2004, among Vanguard Health Systems, Inc., Blackstone Management Partners IV L.L.C., and Metalmark Management LLC(1)
10.7	Amended and Restated Limited Liability Company Operating Agreement of VHS Holdings LLC, dated as of September 23, 2004(1)
10.8	Vanguard Health Systems, Inc. 2004 Stock Incentive Plan(1)(3)
10.9	VHS Holdings LLC 2004 Unit Plan(1)(3)
10.10	Vanguard Health Systems, Inc. 2001 Annual Incentive Plan(2)(3)
10.11	Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Charles N. Martin, Jr., dated as of September 23, 2004(1)(3)
10.12	Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Joseph D. Moore, dated as of September 23, 2004(1)(3)
10.13	Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Ronald P. Soltman, dated as of September 23, 2004(1)(3)
10.14	Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Keith B. Pitts, dated as of September 23, 2004(1)(3)
10.15	Form of Amended and Restated Severance Protection Agreement of Vanguard Health Systems, Inc. dated as of September 23, 2004 for Vice Presidents and above (1)(3)
10.16	Arizona Health Care Cost Containment System Administration RFP re Contract No. YH04-0001-06 with VHS Phoenix Health Plan, awarded May 1, 2003(4)

10.17 Solicitation Amendments to RFP numbers One, Two, Three and Four and Contract Amendment No. 01 dated May 1, 2003, to Arizona Health Care Cost Containment System Administration Contract No. YH04-0001-06 with VHS Phoenix Health Plan(4)

10.18 Contract Amendments Numbered 02, 03, 04 and 05, each effective October 1, 2003, to the Arizona Health Care Cost Containment System Administration Contract No. YH04-0001-06 with VHS Phoenix Health Plan(5)

10.19 Contract Amendment Number 06, executed on November 10, 2003, but effective as of October 1, 2003, to the Arizona Health Care Cost Containment System Administration Contract No. YH04-0001-06 between VHS Phoenix Health Plan and the Arizona Health Care Cost Containment System(6)

10.20 Contract Amendment Number 07, executed on April 28, 2004, but effective as of April 1, 2004, to the Arizona Health Care Cost Containment System Administration Contract No. YH04-0001-06 between VHS Phoenix Health Plan and the Arizona Health Care Cost Containment System(1)

10.21 Contract Amendment Number 08, executed on September 16, 2004, but effective as of October 1, 2004, to the Arizona Health Care Cost Containment System Administration Contract No. YH04-0001-06 between VHS Phoenix Health Plan and the Arizona Health Care Cost Containment System(1)

10.22 Contract Amendment Number 09, executed on November 4, 2004, but effective as of October 1, 2004, to the Arizona Health Care Cost Containment System Administration Contract No. YH04-0001-06 between VHS Phoenix Health Plan and the Arizona Health Care Cost Containment System(1)

10.23 Amended and Restated Agreement Between the Shareholders of VHS Acquisition Subsidiary Number 5, Inc. executed on September 8, 2004, but effective as of September 1, 2004(1)

10.24 Certificate of Designations, Preferences and Rights of Series A Preferred Stock of VHS Acquisition Subsidiary Number 5, Inc., dated as of September 8, 2004(1)

10.25 License Agreement between Baptist Health System and VHS San Antonio Partners, L.P. dated as of January 1, 2003(7)

10.26 Form of Performance Option Under 2004 Stock Incentive Plan(1)(3)

10.27 Form of Time Option Under 2004 Stock Incentive Plan(1)(3)

10.28 Form of Liquidity Event Option Under 2004 Stock Incentive Plan(1)(3)

10.29 Stockholders Agreement Concerning Vanguard Health Systems, Inc., dated as of November 4, 2004, by and among Vanguard Health Systems, Inc., VHS Holdings LLC, Blackstone FCH Capital Partners IV L.P. and its affiliates identified on the signature pages thereto and the employees identified on the signature pages thereto(1)

10.30 Amendment No. 1 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Charles N. Martin, Jr., dated as of December 1, 2004(1)(3)

10.31 Amendment No. 1 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Joseph D. Moore, dated as of December 1, 2004(1)(3)

10.32 Amendment No. 1 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Ronald P. Soltman, dated as of December 1, 2004(1)(3)

10.33 Amendment No. 1 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Keith B. Pitts, dated as of December 1, 2004(1)(3)

10.34 Restatement dated October 22, 2004, but effective as of October 1, 2004, of Arizona Health Care Cost Containment System Administration ("AHCCCS") Contract No. YH04-0001-06 with VHS Phoenix Health Plan, to reflect Solicitation Amendments One through Four and Contract Amendments Numbers 01 through 09 (unofficial and never executed, but prepared by AHCCCS and distributed to VHS Phoenix Health Plan for ease of contract administration)(1)

10.35 First Amendment of VHS Holdings LLC 2004 Unit Plan(3)(10)

10.36 First Amendment to Credit Agreement, dated as of August 15, 2005, among Vanguard Health Holding Company I, LLC, Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the lenders party to the Credit Agreement referred to therein, and Bank of America, N.A. as administrative agent(9)

10.37 First Amendment to Credit Agreement, dated as of August 15, 2005, among Vanguard Health Holding Company I, LLC, Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the lenders party to the Credit Agreement referred to therein, and Bank of America, N.A. as administrative agent(11)

10.38 Contract Amendment Number 10, executed on September 7, 2005, but effective as of October 1, 2005, to the Arizona Health Care Cost Containment System Administration Contract No. YH04-0001-06 between VHS Phoenix Health Plan and the Arizona Health Care Cost Containment System(12)

10.39 Contract Amendment Number 11, executed on September 7, 2005, but effective as of September 1, 2005, to the Arizona Health Care Cost Containment System Administration Contract No. YH04-0001-06 between VHS Phoenix Health Plan and the Arizona Health Care Cost Containment System(12)

10.40 Amendment No. 2 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Charles N. Martin, Jr., dated as of December 1, 2005(3)(13)

10.41 Amendment No. 2 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Joseph D. Moore , dated as of December 1, 2005(3)(13)

10.42 Amendment No. 2 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Ronald P. Soltman, dated as of December 1, 2005(3)(13)

10.43 Amendment No. 2 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Keith B. Pitts, dated as of December 1, 2005(3)(13)

10.44 Amendment No. 1, dated as of November 3, 2005, to Amended and Restated Limited Liability Company Operating Agreement of VHS Holdings LLC(13)

10.45 Amendment Number 1 to the Vanguard Health Systems, Inc. 2004 Stock Incentive Plan, effective November 28, 2005(3)(13)

10.46 Contract Amendment Number 12, executed on December 21, 2005, but effective as of January 1, 2006, to the Arizona Health Care Cost Containment System Administration Contract No. YH04-0001-06 between VHS Phoenix Health Plan and the Arizona Health Care Cost Containment System(13)

10.47 Amendment Number 2 to the Vanguard Health Systems, Inc. 2004 Stock Incentive Plan, effective February 15, 2006(3)(14)

10.48 Amendment Number 3 to the Vanguard Health Systems, Inc. 2004 Stock Incentive Plan, effective April 15, 2006(3)(14)

10.49 Contract Amendment Number 13, executed on April 4, 2006, but effective as of October 1, 2005, to the Arizona Health Care Cost Containment System Administration Contract No. YH04-0001-06 between VHS Phoenix Health Plan and the Arizona Health Care Cost Containment System(14)

10.50 Contract Amendment Number 14, executed on April 26, 2006, but effective as of October 1, 2005, to the Arizona Health Care Cost Containment System Administration Contract No. YH04-0001-06 between VHS Phoenix Health Plan and the Arizona Health Care Cost Containment System(14)

10.51 Contract Amendment Number 15, executed on September 5, 2006, but effective as of October 1, 2006, to the Arizona Health Care Cost Containment System Administration Contract No. YH04-0001-06 between VHS Phoenix Health Plan and the Arizona Health Care Cost Containment System (16)

10.52 Amendment Number 4 to the Vanguard Health Systems, Inc. 2004 Stock Incentive Plan, effective November 13, 2006(3)(17)

10.53 Contract Amendment Number 16, executed on April 27, 2007, but effective as of October 1, 2006, to the Arizona Health Care Cost Containment System Administration Contract No. YH04-0001-06 between VHS Phoenix Health Plan and the Arizona Health Care Cost Containment System(18)

10.54 Contract Amendment Number 17, executed on September 6, 2006, but effective as of October 1, 2007, to the Arizona Health Care Cost Containment System Administration Contract No. YH04-0001-06 between VHS Phoenix Health Plan and the Arizona Health Care Cost Containment System(21)

10.55 Amendment No. 3 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Charles N. Martin, Jr., dated as of October 1, 2007(3)(22)

10.56 Amendment No. 3 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Keith B. Pitts, dated as of October 1, 2007(3)(22)

10.57 Amendment No. 3 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Joseph D. Moore, dated as of October 1, 2007(3)(22)

10.58 Amendment No. 4 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Joseph D. Moore, dated as of November 7, 2007(3)(22)

10.59 Amendment No. 3 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Ronald P. Soltman, dated as of October 1, 2007(3)(22)

10.60 Employment Agreement between Vanguard Health Systems, Inc. and Kent H. Wallace dated as of November 15, 2007(3)(22)

10.61 Employment Agreement between Vanguard Health Systems, Inc. and Phillip W. Roe dated as of November 15, 2007(3)(22)

10.62 Form of Amendment No. 1 to Severance Protection Agreement dated as of October 1, 2007, entered into between Vanguard Health Systems, Inc. and each of its executive officers (other than Messrs. Martin, Pitts, Moore, Soltman, Wallace and Roe who each have entered into employment agreements with the registrant)(3)(22)

10.63	Amendment Number 5 to the Vanguard Health Systems, Inc. 2004 Stock Incentive Plan, effective May 6, 2008(3)(23)
10.64	Letter dated May 13, 2008, from the Arizona Health Care Cost Containment System to VHS Phoenix Health Plan, LLC, countersigned by VHS Phoenix Health Plan, LLC on May 13, 2008 awarding Contract No. YH09-0001-07(24)
10.65	Waiver No. 1 dated as of May 22, 2008, to Amended and Restated Limited Liability Company Operating Agreement of VHS Holdings LLC, dated as of September 23, 2004, as amended by Amendment No. 1, dated as of November 3, 2005
10.66	Amendment No. 5 to Amended and Restated Employment Agreement between Vanguard Health Systems, Inc. and Joseph D. Moore, dated as of June 30, 2008(3)
10.67	Form of Severance Protection Agreement of Vanguard Health Systems, Inc. in current use for Vice Presidents and above(3)
10.68	Contract Amendment Number 18, executed on May 5, 2008, but effective as of April 1, 2008, to the Arizona Health Care Cost Containment System Administration Contract No. YH04-0001-06 between VHS Phoenix Health Plan and the Arizona Health Care Cost Containment System
10.69	Contract Amendment Number 19, executed on May 5, 2008, but effective as of June 1, 2008, to the Arizona Health Care Cost Containment System Administration Contract No. YH04-0001-06 between VHS Phoenix Health Plan and the Arizona Health Care Cost Containment System
10.70	Arizona Health Care Cost Containment System Administration RFP re Contract No. YH09-0001-07 with VHS Phoenix Health Plan, LLC awarded May 13, 2008
10.71	Solicitation Amendments to RFP numbers One, Two, Three, Four and Five dated February 29, 2008, March 14, 2008, March 26, 2008, March 28, 2008 and April 10, 2008, respectively, to Arizona Health Care Cost Containment System Administration Contract No. YH09-0001-07 with VHS Phoenix Health Plan, LLC
12.1	Computation of Ratio of Earnings to Fixed Charges
21.1	Subsidiaries of Vanguard Health Systems, Inc.
31.1	Certification of CEO pursuant to Rule 13a-14(a)/15d-14(a) as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
31.2	Certification of CFO pursuant to Rule 13a-14(a)/15d-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
32.1	Certification of CEO pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
32.2	Certification of CFO pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002

(1) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Registration Statement on Form S-4 first filed on November 12, 2004 (Registration No. 333-120436).

(2) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Registration Statement on Form S-1 first filed on October 19, 2001 (Registration No. 333-71934).

(3) Management compensatory plan or arrangement.

(4) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Annual Report on Form 10-K for the annual period ended June 30, 2003, File No. 333-71934.

(5) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended September 30, 2003, File No. 333-71934.

(6) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended December 31, 2003, File No. 333-71934.

(7) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Current Report on Form 8-K dated January 14, 2003, File No. 333-71934.

(8) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended March 31, 2005, File No. 333-71934.

(9) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Current Report on Form 8-K dated August 26, 2005, File No. 333-71934.

(10) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Annual Report on Form 10-K for the annual period ended June 30, 2005, File No. 333-71934.

(11) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Current Report on Form 8-K dated September 27, 2005, File No. 333-71934.

(12) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended September 30, 2005, File No. 333-71934.

(13) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended December 31, 2005, File No. 333-71934.

(14) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended March 31, 2006, File No. 333-71934.

(15) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Annual Report on Form 10-K for the annual period ended June 30, 2006, File No. 333-71934.

(16) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Current Report on Form 8-K dated September 8, 2006, File No. 333-71934.

(17) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended December 31, 2006, File No. 333-71934.

(18) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended March 31, 2007, File No. 333-71934.

(19) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Annual Report on Form 10-K for the annual period ended June 30, 2007, File No. 333-71934.

(20) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended September 30, 2007, File No. 333-71934.

(21) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Current Report on Form 8-K dated September 7, 2007, File No. 333-71934.

(22) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarterly period ended December 31, 2007, File No. 333-71934.

(23) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Current Report on Form 8-K dated May 9, 2008, File No. 333-71934.

(24) Incorporated by reference from exhibits to Vanguard Health Systems, Inc.'s Current Report on Form 8-K dated May 16, 2008, File No. 333-71934.