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HEALTH FACILITIES & SERVICES REVIEW BOARD

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	MetroSouth Medical Center				
Street Address:	12935 South Gregory Street				
City and Zip Code:	Blue Island, IL 60406				
County:	Cook	Health Service Area:	VII	Health Planning Area:	A-04

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

Exact Legal Name:	Blue Island Hospital Company, LLC
Address:	4000 Meridian Blvd. Franklin, TN 37067
Name of Registered Agent:	
Name of Chief Executive Officer:	Martin G. Schweinhart
CEO Address:	4000 Meridian Blvd. Franklin, TN 37067
Telephone Number:	615/465-7000

Type of Ownership of Applicant/Co-Applicant

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

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

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

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

Name:	Clare Connor Ranalli
Title:	Partner
Company Name:	Holland + Knight
Address:	131 S. Dearborn Street 30th Floor Chicago, IL 60603
Telephone Number:	312/578-6567
E-mail Address:	clare.ranalli@hklaw.com
Fax Number:	312/578-6666

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

Name:	Jacob M. Axel
Title:	President
Company Name:	Axel & Associates, Inc.
Address:	675 North Court Suite 210 Palatine, IL 60067
Telephone Number:	847/776-7101
E-mail Address:	jacobmaxel@msn.com
Fax Number:	847/776-7004

/

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

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Facility/Project Identification

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City and Zip Code:	Blue Island, IL 60406				
County:	Cook	Health Service Area:	VII	Health Planning Area:	A-04

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

Exact Legal Name:	Community Health Systems, Inc.
Address:	4000 Meridian Blvd. Franklin, TN 37067
Name of Registered Agent:	
Name of Chief Executive Officer:	Wayne Smith
CEO Address:	4000 Meridian Blvd. Franklin, TN 37067
Telephone Number:	615/465-7000

Type of Ownership of Applicant/Co-Applicant

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

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Title:	President
Company Name:	Axel & Associates, Inc.
Address:	675 North Court Suite 210 Palatine, IL 60067
Telephone Number:	847/776-7101
E-mail Address:	jacobmaxel@msn.com
Fax Number:	847/776-7004

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

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Street Address:	12935 South Gregory Street				
City and Zip Code:	Blue Island, IL 60406				
County:	Cook	Health Service Area:	VII	Health Planning Area:	A-04

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

Exact Legal Name:	MSMC Investors, LLC
Address:	500 Mamaroneck Avenue Harrison, NY 10528
Name of Registered Agent:	
Name of Chief Executive Officer:	David Reis
CEO Address:	500 Mamaroneck Avenue Harrison, NY 10528
Telephone Number:	212/662-5333

Type of Ownership of Applicant/Co-Applicant

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

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ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

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Street Address:	12935 South Gregory Street				
City and Zip Code:	Blue Island, IL 60406				
County:	Cook	Health Service Area:	VII	Health Planning Area:	A-04

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

Exact Legal Name:	Harrison Hospital Holdings, LLC
Address:	500 Mamaroneck Avenue Harrison, NY 10528
Name of Registered Agent:	
Name of Chief Executive Officer:	David Reis
CEO Address:	500 Mamaroneck Avenue Harrison, NY 10528
Telephone Number:	212/662-5333

Type of Ownership of Applicant/Co-Applicant

☐	Non-profit Corporation	☐	Partnership		
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Title:	President
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Applicant /Co-Applicant Identification
[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name:	MSMC Realty, LLC
Address:	500 Mamaroneck Avenue Harrison, NY 10528
Name of Registered Agent:	
Name of Chief Executive Officer:	David Reis
CEO Address:	500 Mamaroneck Avenue Harrison, NY 10528
Telephone Number:	212/662-5333

Type of Ownership of Applicant/Co-Applicant

☐	Non-profit Corporation	☐	Partnership		
	For-profit Corporation	☐	Governmental		
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Address:	675 North Court Suite 210 Palatine, IL 60067
Telephone Number:	847/776-7101
E-mail Address:	jacobmaxel@msn.com
Fax Number:	847/776-7004

Post Permit Contact

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

Name:	Enrique Beckmann, MD
Title:	CEO
Company Name:	MetroSouth Medical Center
Address:	12935 South Gregory Street Blue Island, IL 60406
Telephone Number:	708/597-2000
E-mail Address:	Enrique Beckmann@MetroSouthMedicalCenter.com
Fax Number:	

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	Blue Island Illinois Hospital Company, LLC (proposed)
Address of Site Owner:	4000 Meridian Blvd Franklin, TN 37067

Street Address or Legal Description of Site: 12935 South Gregory Street Blue Island, IL 60406

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

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

Operating Identity/Licensee

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

Exact Legal Name:	Blue Island Illinois Hospital Company, LLC (proposed)
Address:	4000 Meridian Blvd Franklin, TN 37067

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

- Corporations and limited liability companies must provide an Illinois Certificate of Good Standing.
- Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.
- **Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.**

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

Organizational Relationships

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

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

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	MSMC Investors, LLC (current)
Address of Site Owner:	500 Mamaroneck Avenue, Harrison, NY 10528
Street Address or Legal Description of Site:	12935 South Gregory Street Blue Island, IL 60406

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

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Operating Identity/Licensee

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

Exact Legal Name:	MSMC Investors, LLC (current)
Address:	500 Mamaroneck Avenue, Harrison, NY 10528

☐	Non-profit Corporation	☐	Partnership		
	For-profit Corporation	☐	Governmental		
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- Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.
- **Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.**

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

Flood Plain Requirements **Not Applicable**

[Refer to application instructions.]

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

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

Historic Resources Preservation Act Requirements **Not Applicable**

[Refer to application instructions.]

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

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

DESCRIPTION OF PROJECT

1. Project Classification

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

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

2. Narrative Description

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

The project addressed in this *Application for Permit* is limited to a "change of ownership" triggered by the ownership of MetroSouth Medical Center entering into an Asset Purchase Agreement "APA" with Blue Island Hospital Company, LLC,, effectuating the sale of the hospital, contingent among other things, receipt of a Certificate of Need Permit from the Illinois Health Facilities and Services Review Board to do so.

This is a "non-substantive" project, as it is limited to a change of ownership of a licensed health care facility.

Project Costs and Sources of Funds

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

Project Costs and Sources of Funds			
USE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Preplanning Costs			
Site Survey and Soil Investigation			
Site Preparation			
Off Site Work			
New Construction Contracts			
Modernization Contracts			
Contingencies			
Architectural/Engineering Fees			
Consulting and Other Fees			$3,500,000
Movable or Other Equipment (not in construction contracts)			
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment			
Other Costs To Be Capitalized			
Acquisition of Assets			$47,000,000
TOTAL USES OF FUNDS			**$50,500,000**
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities			$50,500,000
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS			**$50,500,000**

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

Related Project Costs

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

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

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

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

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

Project Status and Completion Schedules

Indicate the stage of the project's architectural drawings:

X None or not applicable ☐ Preliminary

☐ Schematics ☐ Final Working

Anticipated project completion date (refer to Part 1130.140): ____by July 31, 2012_____

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

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

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

State Agency Submittals

Are the following submittals up to date as applicable:

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

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

Cost Space Requirements not applicable

Provide in the following format, the department/area **DGSF** or the building/area **BGSF** and cost. The type of gross square footage either **DGSF** or **BGSF** must be identified. The sum of the department costs **MUST** equal the total estimated project costs. Indicate if any space is being reallocated for a different purpose. Include outside wall measurements plus the department's or area's portion of the surrounding circulation space. **Explain the use of any vacated space.**

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

APPEND DOCUMENTATION AS ATTACHMENT-9, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Facility Bed Capacity and Utilization

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

FACILITY NAME: MetroSouth Medical Center		**CITY: Blue Island**			
REPORTING PERIOD DATES:		**From: January 1, 2010**	**to: December 31, 2010**		
Category of Service	**Authorized Beds**	**Admissions**	**Patient Days**	**Bed Changes**	**Proposed Beds**
Medical/Surgical	272	7,305	30,760	None	272
Obstetrics	30	1,883	5,005	None	30
Pediatrics*					
Intensive Care	28	971	5,181	None	28
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness					
Neonatal Intensive Care					
General Long Term Care					
Specialized Long Term Care					
Long Term Acute Care					
Other ((identify)					
TOTALS:	330	10,159	40,946	None	330

*The pediatrics category of service was discontinued on March 2, 2010 by CON Permit 09-064, with no admissions to that service during 2010.

CERTIFICATION

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

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

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

SIGNATURE	SIGNATURE
David Rais	
PRINTED NAME	PRINTED NAME
manager	
PRINTED TITLE	PRINTED TITLE
Notarization:	Notarization:
Subscribed and sworn to before me this 5th day of December, 2011	Subscribed and sworn to before me this _____ day of _____
Signature of Notary	Signature of Notary
Seal	Seal

TERESA BERNARDI
Notary Public, State of New York
No. 01BE6187450
Qualified in Westchester County
Commission Expires May 19, 2012

*Insert EXACT legal name of the applicant

CERTIFICATION

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

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

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

SIGNATURE	SIGNATURE
David Ris	
PRINTED NAME	PRINTED NAME
manager	
PRINTED TITLE	PRINTED TITLE
Notarization: Subscribed and sworn to before me this 5th day of December, 2011	Notarization: Subscribed and sworn to before me this _____ day of _____
Signature of Notary	Signature of Notary
Seal TERESA BERNARDI Notary Public, State of New York No. 01BE6187450 Qualified in Westchester County Commission Expires May 19, 2012	Seal

*Insert EXACT legal name of the applicant

CERTIFICATION

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

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- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

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

SIGNATURE	SIGNATURE
David Ras	
PRINTED NAME	PRINTED NAME
Mngr	
PRINTED TITLE	PRINTED TITLE
Notarization: Subscribed and sworn to before me this 5th day of December, 2011	Notarization: Subscribed and sworn to before me this _____ day of _____
Signature of Notary	Signature of Notary
Seal	Seal

TERESA BERNARDI
Notary Public, State of New York
No. 01BE6187450
Qualified in Westchester County
Commission Expires May 19, 2012

*Insert EXACT legal name of the applicant

CERTIFICATION

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

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

SIGNATURE

RACHEL A. SEIFERT
EXECUTIVE VICE PRESIDENT
PRINTED NAME

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 9th day of December, 2011

Signature of Notary

Seal

MARY ANN ECKMAN
STATE OF TENNESSEE NOTARY PUBLIC
WILLIAMSON COUNTY, TN
My Comm. Expires September 27, 2015

SIGNATURE

Martin G. Schweinhart
PRINTED NAME

President
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 9th day of December, 2011

Signature of Notary

Seal

MARY ANN ECKMAN
STATE OF TENNESSEE NOTARY PUBLIC
WILLIAMSON COUNTY, TN
My Comm. Expires September 27, 2015

*Insert EXACT legal name of the applicant

CERTIFICATION

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

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

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

SIGNATURE

RACHEL A. SEIFERT
PRINTED NAME EXECUTIVE VICE PRESIDENT

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 9th day of December, 2011

Signature of Notary

Seal

MARY ANN ECKMAN
STATE OF TENNESSEE
NOTARY PUBLIC
WILLIAMSON COUNTY, TN
My Comm. Expires September 27, 2015

SIGNATURE

Martin G. Schweinhart
PRINTED NAME
President

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 9th day of December, 2011

Signature of Notary

Seal

MARY ANN ECKMAN
STATE OF TENNESSEE
NOTARY PUBLIC
WILLIAMSON COUNTY, TN
My Comm. Expires September 27, 2015

*Insert EXACT legal name of the applicant

SECTION III – BACKGROUND, PURPOSE OF THE PROJECT, AND ALTERNATIVES - INFORMATION REQUIREMENTS

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

Criterion 1110.230 – Background, Purpose of the Project, and Alternatives

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

1. A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.
2. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant during the three years prior to the filing of the application.
3. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to: official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**
4. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest the information has been previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.

APPEND DOCUMENTATION AS ATTACHMENT-11, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-4) MUST BE IDENTIFIED IN ATTACHMENT 11.

PURPOSE OF PROJECT

1. Document that the project will provide health services that improve the health care or well-being of the market area population to be served.
2. Define the planning area or market area, or other, per the applicant's definition.
3. Identify the existing problems or issues that need to be addressed, as applicable and appropriate for the project. [See 1110.230(b) for examples of documentation.]
4. Cite the sources of the information provided as documentation.
5. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.
6. Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals **as appropriate**.

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

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

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

ALTERNATIVES

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

Alternative options **must** include:

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

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

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

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

2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of total costs, patient access, quality and financial benefits in both the short term (within one to three years after project completion) and long term. This may vary by project or situation. **FOR EVERY ALTERNATIVE IDENTIFIED THE TOTAL PROJECT COST AND THE REASONS WHY THE ALTERNATIVE WAS REJECTED MUST BE PROVIDED.**

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

APPEND DOCUMENTATION AS ATTACHMENT-13, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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

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

VIII. - 1120.120 - Availability of Funds

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

$50,500,000_	a)	Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to: 1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and 2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion;
_____	b)	Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.
_____	c)	Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts;
_____	d)	Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including: 1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated; 2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate; 3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.; 4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment; 5) For any option to lease, a copy of the option, including all terms and conditions.
_____	e)	Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent;
_____	f)	Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt;
_____	g)	All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
$50,500,000	**TOTAL FUNDS AVAILABLE**	

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

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

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

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

A. Criterion 1110.240(b), Impact Statement

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

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

B. Criterion 1110.240(c), Access

Read the criterion and provide the following:

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

C. Criterion 1110.240(d), Health Care System

Read the criterion and address the following:

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

APPEND DOCUMENTATION AS ATTACHMENT-19, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

IX. 1120.130 - Financial Viability

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

not applicable, funded completely through internal sources

Financial Viability Waiver

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

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

See Section 1120.130 Financial Waiver for information to be provided

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

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

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

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

2. Variance

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

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

X. 1120.140 - Economic Feasibility

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

A. Reasonableness of Financing Arrangements

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

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

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

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

B) Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

B. Conditions of Debt Financing **not applicable, funded through internal sources**

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

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

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

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

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

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

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE

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

* Include the percentage (%) of space for circulation

D. Projected Operating Costs

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

E. Total Effect of the Project on Capital Costs

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

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

XII. Charity Care Information MetroSouth Medical Center

Charity Care information MUST be furnished for ALL projects.

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

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

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

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

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

CHARITY CARE			
	2008*	**2009**	**2010**
Net Patient Revenue	$165,208,867	$152,216,354	$153,867,657
Amount of Charity Care (charges)	$4,457,376	$10,578,202	$9,136,081
Cost of Charity Care	$3,919,502	$3,195,674	$2,738,997

*August-December

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

XII. Charity Care Information — Vista Medical Center-East*

Charity Care information MUST be furnished for ALL projects.

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

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

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

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

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

CHARITY CARE			
	2008	**2009**	**2010**
Net Patient Revenue	**$154,183,648**	**$160,090,957**	**$169,488,187**
Amount of Charity Care (charges)	$12,564,862	$17,763,211	$23,163,709
Cost of Charity Care	$2,534,154	$2,826,898	$3,660,091

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

* Waukegan Illinois Hospital Company, LLC also owns and operates Vista Medical Center-West

XII. Charity Care Information — Vista Medical Center-West*

Charity Care information MUST be furnished for ALL projects.

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

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

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

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

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

CHARITY CARE			
	2008	**2009**	**2010**
Net Patient Revenue	**$26,338,488**	**$25,448,500**	**$25,099,607**
Amount of Charity Care (charges)	$380,522	$2,770,726	$3,450,068
Cost of Charity Care	$152,135	$662,541	$819,253

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

* Waukegan Illinois Hospital Company, LLC also owns and operates Vista Medical Center-East

File Number 0373569-9

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

BLUE ISLAND HOSPITAL COMPANY, LLC, A DELAWARE LIMITED LIABILITY COMPANY HAVING OBTAINED ADMISSION TO TRANSACT BUSINESS IN ILLINOIS ON NOVEMBER 28, 2011, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A FOREIGN LIMITED LIABILITY COMPANY ADMITTED TO TRANSACT BUSINESS IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 5TH *day of* DECEMBER *A.D.* 2011 .

Jesse White

SECRETARY OF STATE

Authentication #: 1133900442

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

ATTACHMENT 1

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File Number 6483-188-7

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

COMMUNITY HEALTH SYSTEMS, INC., INCORPORATED IN DELAWARE AND LICENSED TO TRANSACT BUSINESS IN THIS STATE ON MARCH 31, 2006, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE BUSINESS CORPORATION ACT OF THIS STATE RELATING TO THE PAYMENT OF FRANCHISE TAXES, AND AS OF THIS DATE, IS A FOREIGN CORPORATION IN GOOD STANDING AND AUTHORIZED TO TRANSACT BUSINESS IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 16TH *day of* NOVEMBER *A.D.* 2011 .

Jesse White

SECRETARY OF STATE

Authentication #: 1132001716

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

ATTACHMENT 1

File Number 0251988-7

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

MSMC INVESTORS, LLC, A DELAWARE LIMITED LIABILITY COMPANY HAVING OBTAINED ADMISSION TO TRANSACT BUSINESS IN ILLINOIS ON MAY 27, 2008, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A FOREIGN LIMITED LIABILITY COMPANY ADMITTED TO TRANSACT BUSINESS IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 16TH *day of* NOVEMBER *A.D.* 2011 .

Jesse White

SECRETARY OF STATE

Authentication #: 1132001728

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

ATTACHMENT 1

File Number 0251987-9

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

MSMC REALTY, LLC, A DELAWARE LIMITED LIABILITY COMPANY HAVING OBTAINED ADMISSION TO TRANSACT BUSINESS IN ILLINOIS ON MAY 27, 2008, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A FOREIGN LIMITED LIABILITY COMPANY ADMITTED TO TRANSACT BUSINESS IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 16TH *day of* NOVEMBER *A.D.* 2011 .

Jesse White

SECRETARY OF STATE

Authentication #: 1132001762

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

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ATTACHMENT 1

File Number 0251985-2

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

HARRISON HOSPITAL HOLDINGS, LLC, A DELAWARE LIMITED LIABILITY COMPANY HAVING OBTAINED ADMISSION TO TRANSACT BUSINESS IN ILLINOIS ON MAY 27, 2008, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A FOREIGN LIMITED LIABILITY COMPANY ADMITTED TO TRANSACT BUSINESS IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 16TH *day of* NOVEMBER *A.D.* 2011 .

Jesse White

SECRETARY OF STATE

Authentication #: 1132001750

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

ATTACHMENT 1

ACORD® EVIDENCE OF COMMERCIAL PROPERTY INSURANCE

DATE (MM/DD/YYYY): 8/22/2011

THIS EVIDENCE OF COMMERCIAL PROPERTY INSURANCE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE ADDITIONAL INTEREST NAMED BELOW. THIS EVIDENCE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS EVIDENCE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE ADDITIONAL INTEREST.

PRODUCER NAME, CONTACT PERSON AND ADDRESS	PHONE (A/C, No, Ext): (815) 756-2906	COMPANY NAME AND ADDRESS	NAIC NO:
Crum - Halsted Agency Inc 2350 Bethany Road Sycamore IL 60178	FAX (A/C, No): (815) 756-2138 E-MAIL ADDRESS: bstankevitz@crumhalsted.com	CNA Insurance Co. 801 Warrenville Rd Suite 700 Lisle IL 60532 IF MULTIPLE COMPANIES, COMPLETE SEPARATE FORM FOR EACH	
CODE:	SUB CODE:	POLICY TYPE: Commercial Property	
AGENCY CUSTOMER ID #: 00038626			
NAMED INSURED AND ADDRESS MSMC Investors, LLC 500 Mamaroneck Harrison NY 10528		LOAN NUMBER	POLICY NUMBER: RMP4025816674
		EFFECTIVE DATE: 7/30/2011	EXPIRATION DATE: 12/31/2012
		☐ CONTINUED UNTIL TERMINATED IF CHECKED	
ADDITIONAL NAMED INSURED(S)		THIS REPLACES PRIOR EVIDENCE DATED:	

PROPERTY INFORMATION (Use REMARKS on page 2, if more space is required) ☒ BUILDING OR ☒ BUSINESS PERSONAL PROPERTY

LOCATION/DESCRIPTION
Blanket Building, Business Personal Property, Business Income

THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED.NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS EVIDENCE OF PROPERTY INSURANCE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

COVERAGE INFORMATION PERILS INSURED: ☐ BASIC ☐ BROAD ☒ SPECIAL ☐

COMMERCIAL PROPERTY COVERAGE AMOUNT OF INSURANCE: $ $420,157,407 DED: 25,000

	YES	NO	N/A	
☒ BUSINESS INCOME ☐ RENTAL VALUE	X			If YES, LIMIT: ☐ Actual Loss Sustained; # of months:
BLANKET COVERAGE	X			If YES, indicate value(s) reported on property identified above: $
TERRORISM COVERAGE				Attach Disclosure Notice / DEC
IS THERE A TERRORISM-SPECIFIC EXCLUSION?				
IS DOMESTIC TERRORISM EXCLUDED?				
LIMITED FUNGUS COVERAGE				If YES, LIMIT: DED:
FUNGUS EXCLUSION (If "YES", specify organization's form used)				
REPLACEMENT COST				
AGREED VALUE				
COINSURANCE				If YES, %
EQUIPMENT BREAKDOWN (If Applicable)				If YES, LIMIT: DED:
ORDINANCE OR LAW - Coverage for loss to undamaged portion of bldg				
- Demolition Costs				If YES, LIMIT: DED:
- Incr. Cost of Construction				If YES, LIMIT: DED:
EARTH MOVEMENT (If Applicable)				If YES, LIMIT: DED:
FLOOD (If Applicable)				If YES, LIMIT: DED:
WIND / HAIL (If Subject to Different Provisions)				If YES, LIMIT: DED:
PERMISSION TO WAIVE SUBROGATION IN FAVOR OF MORTGAGE HOLDER PRIOR TO LOSS				

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

ADDITIONAL INTEREST

☐	MORTGAGEE	☐	CONTRACT OF SALE
X	LENDERS LOSS PAYABLE	☐	

NAME AND ADDRESS

Gemino Healthcare Finance, LLC as Agent
1 International Plaza, Ste 220
Philadelphia, PA 19113

LENDER SERVICING AGENT NAME AND ADDRESS

AUTHORIZED REPRESENTATIVE

Bill Stankevitz/ERIN

ATTACHMENT 2

EVIDENCE OF COMMERCIAL PROPERTY INSURANCE REMARKS - Including Special Conditions (Use only if more space is required)

ACORD® EVIDENCE OF COMMERCIAL PROPERTY INSURANCE

DATE (MM/DD/YYYY): 8/22/2011

THIS EVIDENCE OF COMMERCIAL PROPERTY INSURANCE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE ADDITIONAL INTEREST NAMED BELOW. THIS EVIDENCE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS EVIDENCE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE ADDITIONAL INTEREST.

PRODUCER NAME, CONTACT PERSON AND ADDRESS	PHONE (A/C, No, Ext): (815) 756-2906	COMPANY NAME AND ADDRESS	NAIC NO:
Crum - Halsted Agency Inc 2350 Bethany Road Sycamore IL 60178	FAX (A/C, No): (815) 756-2138 E-MAIL ADDRESS: bstankevitz@crumhalsted.com	CNA Insurance Co. 801 Warrenville Rd Suite 700 Lisle IL 60532	IF MULTIPLE COMPANIES, COMPLETE SEPARATE FORM FOR EACH
CODE:	SUB CODE:	POLICY TYPE: Commercial Property	
AGENCY CUSTOMER ID #: 00038626			
NAMED INSURED AND ADDRESS MSMC Investors, LLC 500 Mamaroneck Harrison NY 10528		LOAN NUMBER	POLICY NUMBER: RMP4025816674
		EFFECTIVE DATE: 7/30/2011	EXPIRATION DATE: 12/31/2012
		☐ CONTINUED UNTIL TERMINATED IF CHECKED	
ADDITIONAL NAMED INSURED(S)		THIS REPLACES PRIOR EVIDENCE DATED:	

PROPERTY INFORMATION (Use REMARKS on page 2, if more space is required) ☒ BUILDING OR ☒ BUSINESS PERSONAL PROPERTY

LOCATION/DESCRIPTION: Blanket Building, Business Personal Property, Business Income

THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS EVIDENCE OF PROPERTY INSURANCE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

COVERAGE INFORMATION PERILS INSURED: ☐ BASIC ☐ BROAD ☒ SPECIAL ☐

COMMERCIAL PROPERTY COVERAGE AMOUNT OF INSURANCE: $ $420,157,407 DED: 25,000

	YES	NO	N/A	
☒ BUSINESS INCOME ☐ RENTAL VALUE	X			If YES, LIMIT: ☐ Actual Loss Sustained; # of months:
BLANKET COVERAGE	X			If YES, indicate value(s) reported on property identified above: $
TERRORISM COVERAGE				Attach Disclosure Notice / DEC
IS THERE A TERRORISM-SPECIFIC EXCLUSION?				
IS DOMESTIC TERRORISM EXCLUDED?				
LIMITED FUNGUS COVERAGE				If YES, LIMIT: DED:
FUNGUS EXCLUSION (If "YES", specify organization's form used)				
REPLACEMENT COST				
AGREED VALUE				
COINSURANCE				If YES, %
EQUIPMENT BREAKDOWN (If Applicable)				If YES, LIMIT: DED:
ORDINANCE OR LAW - Coverage for loss to undamaged portion of bldg				
- Demolition Costs				If YES, LIMIT: DED:
- Incr. Cost of Construction				If YES, LIMIT: DED:
EARTH MOVEMENT (If Applicable)				If YES, LIMIT: DED:
FLOOD (If Applicable)				If YES, LIMIT: DED:
WIND / HAIL (If Subject to Different Provisions)				If YES, LIMIT: DED:
PERMISSION TO WAIVE SUBROGATION IN FAVOR OF MORTGAGE HOLDER PRIOR TO LOSS				

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

ADDITIONAL INTEREST

☐	MORTGAGEE	☐	CONTRACT OF SALE
☐	LENDERS LOSS PAYABLE	X	Additional insured

NAME AND ADDRESS:

Gemino Healthcare Finance, LLC, as Agent
1 International Plaza, Ste 220
Philadelphia, PA 19113

LENDER SERVICING AGENT NAME AND ADDRESS:

AUTHORIZED REPRESENTATIVE: Bill Stankevitz/ERIN

ATTACHMENT 2

EVIDENCE OF COMMERCIAL PROPERTY INSURANCE REMARKS - Including Special Conditions (Use only if more space is required)

CNA PROPERTY POLICY

THIS ENDORSEMENT CHANGES YOUR POLICY - PLEASE READ IT CAREFULLY

In consideration with the premium charged at inception it is hereby agreed and understood that the following has been added as lender's loss payee and Additional Insured in respect to the below mentioned location:

GEMINO HEALTHCARE FINANCE, LLC, as AGENT

1 INTERNATIONAL PLAZA

SUITE 220

PHILADELPHIA, PA 19113

12935 South Gregory,

Blue Island, Il 60406

NO PREMIUM CHARGED

All other terms and conditions remain unchanged.

THIS ENDORSEMENT IS A PART OF YOUR POLICY AND TAKES EFFECT ON THE EFFECTIVE DATE OF YOUR POLICY UNLESS ANOTHER EFFECTIVE DATE IS SHOWN BELOW

ENDORSEMENT NUMBER	POLICY NUMBER
#6	RMP 4025816674
NAMED INSURED	EFFECTIVE DATE
Metro South Medical Center	6/15/2011

d. Any loss resulting from damage to, expense associated with, or cost to remanufacture or recall any ***Finished Stock***;

e. ***Time Element*** loss arising from property in transit away from ***Locations*** insured by this policy.

III. GENERAL CONDITIONS

1. ABANDONMENT

There can be no abandonment to the Company of any property.

2. ACCESS TO BOOKS AND RECORDS

It is agreed that the Company, or its authorized representatives, shall at all reasonable times, have access to and the right to review the books and records of the Insured for the purposes of conducting an audit or determining any facts relating to this insurance or a claim. With regard to any such review or access, the Insured shall provide, at the Insured's expense, adequate private working area and facilities and staff, adequate copying and telephone facilities.

3. ASSIGNMENT OF THE POLICY

This policy may be assigned or transferred only with the prior written consent of the Company.

4. CANCELLATION

This policy may be canceled at any time at the request of the Insured by mailing or delivering advance written notice of cancellation to the Company. If canceled at the Insured's request, the Company shall retain or collect the customary short rates for the time the policy has been in force. This policy may be canceled by the Company by mailing to the Insured written notice stating that not less than sixty (60) days after the mailing date such cancellation shall be effective. Upon cancellation by the Company, the Company shall return any pro-rata unearned premium to the Insured. Notwithstanding the above, this policy may be canceled by the Company for non-payment of premium by giving ten (10) days written notice of such cancellation.

The mailing of notice as aforesaid shall be sufficient proof of notice and the effective date and hour of cancellation stated in the notice shall become the end of the policy period. Delivery of such written notice either by the Insured or by the Company shall be equivalent to mailing.

File Number 0373569-9

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

BLUE ISLAND HOSPITAL COMPANY, LLC, A DELAWARE LIMITED LIABILITY COMPANY HAVING OBTAINED ADMISSION TO TRANSACT BUSINESS IN ILLINOIS ON NOVEMBER 28, 2011, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A FOREIGN LIMITED LIABILITY COMPANY ADMITTED TO TRANSACT BUSINESS IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 5TH *day of* DECEMBER *A.D.* 2011 .

Jesse White

SECRETARY OF STATE

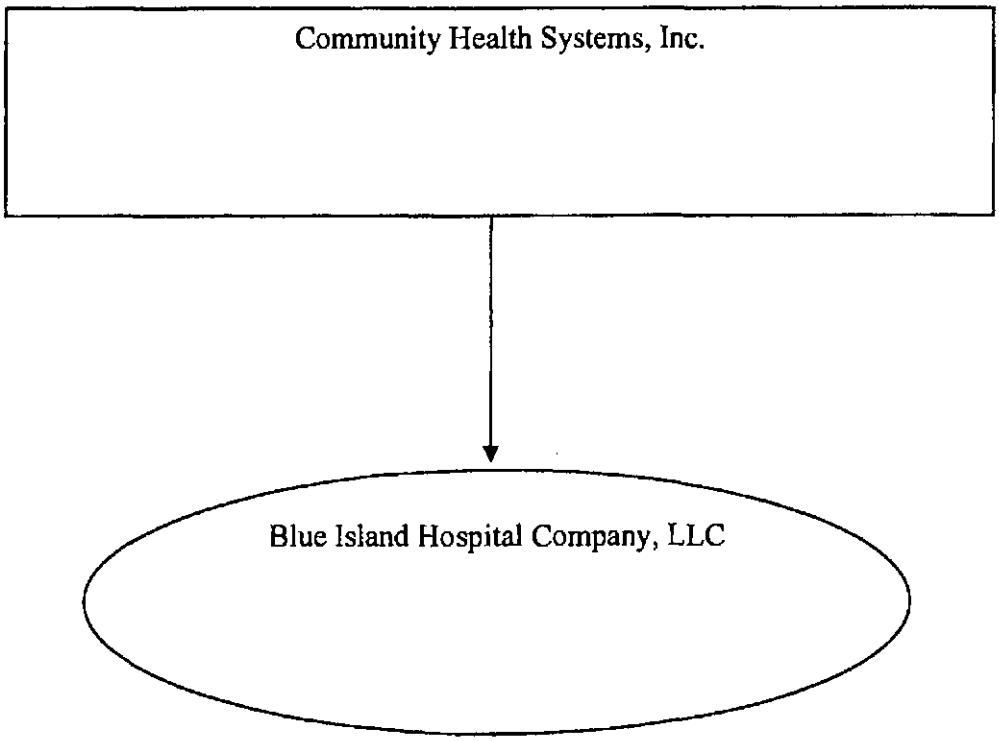
SEAL OF THE STATE OF ILLINOIS AUG. 26TH 1818

Authentication #: 1133900442

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

ATTACHMENT 3

40



Attachment 4

PROJECT COSTS

Acquisition of Assets ($47,000,000)

Negotiated acquisition cost to Community Health Systems, Inc. as identified in the Asset Purchase Agreement, to include the base acquisition cost plus a contingency for adjustments to be made at or following closing, per the Asset Purchase Agreement.

Consulting and Other Fees ($3,500,000)

Estimate of the transactional-related costs, including legal fees, consulting fees, Certificate of Need review fees, and other miscellaneous costs associated with the acquisition.

BACKGROUND

The table below identifies each of Community Health Systems, Inc.'s licensed health care facilities in Illinois.

Community Health Systems Illinois Hospitals

Facility Name	Location	IDPH License Number
Crossroads Community Hospital	Mt. Vernon	0003947
Galesburg Cottage Hospital	Galesburg	0005330
Gateway Regional Medical Center	Granite City	0005223
Heartland Regional Medical Center	Marion	0005298
Red Bud Regional Hospital	Red Bud	0005199
Union County Hospital	Anna	0005421
Vista Medical Center-East	Waukegan	0005397
Vista Medical Center-West	Waukegan	0005405

All of the above hospitals hold Joint Commission accreditation.

Attached are letters addressing the requirements of Section 1110.230.a.

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

To Whom It May Concern:

Please be advised that no adverse actions have been taken by IDPH or CMMS against provider entities related to MSMC Investors, LLC.

Further, the Illinois Health Facilities and Services Review Board, IDPH and their respective staffs are hereby granted authorization to access any records or documents necessary to verify the information submitted, including the records of MSMC Investors, LLC and related licensed health care facilities concerning those facilities' licensure and certification.

Sincerely,

David Reis
authorized representative of
MSMC Investors, LLC

Notarized:

OFFICIAL SEAL
ELIZABETH D. NEARY
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES JUN. 10, 2012

Elizabeth D. Neary 12/8/2011

ATTACHMENT 11

CHS

December 8, 2011

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

To Whom It May Concern:

Please be advised that two adverse actions have been taken by IDPH or CMS against provider entities related to Community Health Systems, Inc. as discussed in the attached.

Further, the Illinois Health Facilities and Services Review Board, IDPH and their respective staffs are hereby granted authorization to access any records or documents necessary to verify the information submitted, including the records of Community Health Systems, Inc. and related licensed health care facilities concerning those facilities' licensure and certification.

Sincerely,

Martin G. Schweinhart
Senior Vice President, Operations

Attachment

COMMUNITY
HEALTH
SYSTEMS

4000 Meridian Boulevard
Franklin, TN 37067
Tel: (615) 465-7000

P.O. Box 689020
Franklin, TN 37068-9020

4/5

Red Bud, IL - Red Bud Regional Hospital

Based on an Illinois Department of Public Health Survey that occurred in March 2009, the Centers for Medicare and Medicaid Services ("CMS") issued a notice in April 2009 that Red Bud Regional Hospital's Nursing facility was out of compliance with three certification requirements. As a result, CMS imposed a Civil Money Penalty of $400 per day for each day of non-compliance, which totaled $9,600. Although in the corrective action plan that was filed, the facility did not contest two of the allegations, it appealed the G level of the third allegation. Prior to hearing, the parties settled the matter for $8,160 in November 2009.

Marion, IL – Heartland Regional Medical Center

Based on an Illinois Department of Public Health Survey that occurred in September 2009, the Centers for Medicare and Medicaid Services ("CMS") issued a 23 day notice to terminate the facility's participating provider status. A Corrective Action Plan was submitted to CMS, which was subsequently accepted.

Pursuant to an IDPH resurvey in October 2009, CMS indicated that it was rescinding the 23 day notice of termination, however, it issued a 90 day notice of termination based on various life safety deficiencies. As a result, a Corrective Action Plan was filed. Through a series of subsequent communications and surveys by IDPH, the facility received notice from CMS in March 2010 that the facility was in compliance with the conditions of participation and therefore, CMS was rescinding the 90day notice of termination.

4/6

ATTACHMENT 11

State of Illinois 2040007
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

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

DAMON T. ARNOLD, M.D.
DIRECTOR

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

EXPIRATION DATE	CATEGORY	I.D. NUMBER
07/29/12	BGBD	0005546

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 07/30/11

BUSINESS ADDRESS

MSMC INVESTORS, LLC
D/B/A METROSOUTH MEDICAL CENTER
12935 S. GREGORY STREET

BLUE ISLAND IL 60406

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

← DISPLAY THIS PART IN A CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION

↓

State of Illinois 2040007
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

MSMC INVESTORS, LLC

EXPIRATION DATE	CATEGORY	I.D. NUMBER
07/29/12	BGBD	0005546

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 07/30/11

06/04/11

MSMC INVESTORS, LLC
D/B/A METROSOUTH MEDICAL CENTER
12935 S. GREGORY STREET
BLUE ISLAND IL 60406

FEE RECEIPT NO.

The Joint Commission

October 29, 2009

Joint Commission ID:# 7249
CCN: 140118
Program: Hospital
Accreditation Expiration Date: November 20, 2012

Enrique Beckmann
Chief Medical Officer
MetroSouth Medical Center
12935 South Gregory Street
Blue Island, Illinois 60406

Dear Dr. Beckmann:

This letter confirms that your August 17-19, 2009 unannounced full resurvey was conducted for the purposes of assessing compliance with the Medicare conditions for hospitals through The Joint Commission's deemed status survey process. Based upon the submission of your evidence of standards compliance on October 22, 2009, the area of deficiency listed below has been removed. The Joint Commission is granting your organization an accreditation decision of accredited with an effective date of August 20, 2009.

The Joint Commission is also recommending your organization for Medicare certification. Please note that the Centers for Medicare and Medicaid Services (CMS) Regional Office (RO) makes the final determination regarding your Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13.

482.23(c)/Medication Management
482.23(b)/Provision of Care, Treatment and Services
482.24(c)/Record or Care, Treatment and Services
482.41(a)/Environment of Care

We congratulate you on your effective resolution of these standard-level deficiencies.

This recommendation also applies to the following location(s):
MetroSouth Medical Center 12935 South Gregory Street, Blue Island, IL, 60406
MetroSouth Health Center at Blue Island2310 York Street Suite 4A, Blue Island, IL, 60406
MetroSouth Health Center at Monterey 1701 W Monterey Avenue Suite #4, Chicago, IL, 60643

We direct your attention to some important Joint Commission policies. First, your Medicare report is publicly accessible as required by the Joint Commission's agreement with the Centers for Medicare and Medicaid Services. Second, Joint Commission policy requires that you inform us of any changes in the name or ownership of your organization, or health care services you provide.

Sincerely,

Ann Scott Blouin RN, PhD

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

cc: CMS/Central Office/Survey & Certification Group/Division of Acute Care Services
CMS/Regional Office V/Survey and Certification Staff

ATTACHMENT 11

The Joint Commission

October 29, 2010

Barbara Coutain
Joint Commission LAB Survey Coordinator
MetroSouth Medical Center (# 7249)
12935 South Gregory Street
Blue Island IL 60406

Dear Ms. Coutain:

Congratulations on achieving Accredited status as a result of your Joint Commission Laboratory survey!

Enclosed you will find:

17. The Joint Commission's CLIA recognition certificates for your organization's moderate/high complexity services.

18. The Joint Commission Publicity Kit to assist your marketing efforts.

You should receive your complimentary accreditation certificate within 4-6 weeks. Additional certificates are available for purchase. Please submit the sample/order request form available on your organization's Joint Commission Connect extranet site; samples utilizing names and locations as recorded in the electronic application (EApp) will be promptly emailed or faxed for your review.

Please contact me with any questions regarding your certificate. Be sure to include your organization's ID#, the organization name-city-state, and the intended contact information (contact name, phone number, email address) in any communications sent to our direct fax (630-792-4004) or email address (certificates@jointcommission.org).

Thank you!

Jean Sponzilli

Jean Sponzilli
Certificate Coordinator
ACO/Management Support Unit
The Joint Commission
Phone (630) 792-5862
FAX (630) 792-4862
jsponzilli@jointcommission.org

ATTACHMENT 11

The Joint Commission

Dear Colleague:

Congratulations to you and your staff on achieving accreditation from The Joint Commission. Receiving the Joint Commission's Gold Seal of Approval™ for health care quality and safety says to your patients, staff and community that you are committed to providing the best care.

To help you publicize your organization's achievement, The Joint Commission provides an online publicity kit. The kit is available at www.jointcommission.org. Select "Accreditation Programs," then click on "Online Publicity Kit" under the Quick Links section.

The online publicity kit includes:

- Suggestions and guidelines for publicizing your accreditation
- Tips for communicating your survey results
- Background on The Joint Commission's Quality Reports
- Guidelines for publicizing compliance with the National Patient Safety Goals
- Guidelines for publicizing Hospital National Quality Improvement Goals
- Guidelines for using the Gold Seal of Approval™
- Downloadable images of the Gold Seal of Approval™
- Frequently Asked Questions
- Sample news releases
- Fact sheets on Joint Commission accreditation, the benefits of accreditation, and The Joint Commission's Public Information Policy

In addition, we have enclosed two Gold Seal of Approval™ decals, and information on the Speak Up™ campaign.

If you have questions or comments about promoting your accreditation, please contact Denise Tucker in The Joint Commission's Department of Communications at (630) 792-5633, fax to (630) 792-4633, or e-mail dtucker@jointcommission.org.

Sincerely,

Cathy Barry-Ipema
Chief Communications Officer

The Joint Commission

MetroSouth Medical Center
12935 South Gregory Street
Blue Island, IL 60406

Organization Identification Number: 7249

Measure of Success Submitted: 2/12/2010

Program(s)
Hospital Accreditation

Executive Summary

Hospital Accreditation : As a result of the accreditation activity conducted on the above date(s), there were no Requirements for Improvement identified.

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

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

ATTACHMENT 11

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The Joint Commission
Summary of Compliance

Program	Standard	Level of Compliance
HAP	EC.02.01.01	Compliant
HAP	MM.01.01.03	Compliant
HAP	NPSG.02.02.01	Compliant
HAP	RC.01.01.01	Compliant
HAP	RC.02.03.07	Compliant
OME	PC.01.03.01	Compliant

PURPOSE

The proposed project is of a very narrow scope, limited to the change of ownership of MetroSouth Medical Center.

No changes will be made in the types of services provided by MSMC or the patient population served by MSMC, and as noted in ATTACHMENT 19B, accessibility to the services offered at the hospital will not be diminished as a result of the proposed change of ownership.

Rather, the primary purpose of the project is provide the hospital, and in turn its patients, continued access to hospital services and access to the benefits of a multi-hospital system, including the ability to access clinical "best practice" models, improved access to the capital market to fund facility-related improvements, information technology systems, and proven management. As a result, the health care and well being of the area's residents that have come to rely on MSMC for care, will be enhanced. The benefits identified above will be immediately attainable, upon the closing of the transaction.

The table on the following page identifies MSMC's historical patient origin, and no appreciable changes are anticipated to result from the proposed change of ownership.

The data provided in the table suggests that MSMC attracts nearly 80% of its patients from a relatively-small area, consisting of nineteen ZIP Code areas in south suburban Cook County and the extreme southwestern part of the City of Chicago.

2010 MSMC Patient Origin

ZIP Code	Community	%	Cumulative %
60643	Calumet Park	12.9%	12.9%
60406	Blue Island	12.8%	25.8%
60628	Chicago	11.2%	36.9%
60827	Calumet Park	9.1%	46.0%
60445	Midlothian	5.0%	51.0%
60803	Alsip	4.1%	55.1%
60472	Robbins	3.6%	58.8%
60426	Harvey	3.5%	62.2%
60620	Chicago	2.0%	64.2%
60477	Tinley Park	1.8%	66.0%
60419	Dolton	1.8%	67.8%
60409	Calumet City	1.6%	69.4%
60655	Marionette Park	1.5%	71.0%
60452	Oak Forest	1.4%	72.4%
60617	Chicago	1.4%	73.8%
60619	Chicago	1.4%	75.2%
60473	South Holland	1.4%	76.6%
60469	Posen	1.2%	77.8%
60411	Chicago Heights	1.0%	78.8%
	< 1.0%	21.2%	100.0%

ATTACHMENT 12

ALTERNATIVES

Section 1110.230(c) requests that an applicant document that the proposed project is the most effective or least costly alternative for meeting the health care needs of the population to be served.

This project is limited to a change of ownership, and more specifically, the change of ownership of a 330-bed acute care hospital, providing a broad range of both inpatient and outpatient services.

In order to best respond to Section 1110.230(c), given the particular circumstances and limited nature of the project, when developing an *Application for Permit* for a similar project, the applicant's consultants conducted a technical assistance conference with State Agency Staff (July 12, 2010). That technical assistance conference was documented according to the agency's practice. Through the technical assistance process, the applicants were directed by State Agency staff to set forth the factual background in response to Section 1110.230(c): MSMC Investors, Inc. acquired MetroSouth Medical Center in July 2008, and has operated the hospital since. At the time of the acquisition, the hospital was scheduled for closure by its prior ownership, after years of financial losses. MSMC Investors, Inc. and its hospital management partner through, among other things, a rapid infusion of capital, restructuring expertise,

the re-kindling of relationships with local physicians, and strong management, the hospital has been returned to financial stability, 1,200 local jobs have been saved, and the hospital has continued to be a vital health care resource in the southwest suburbs.

While success had been achieved in the turnaround of MSMC, shifts in the U.S. economy and the health care environment changed the outlook of what could be accomplished in the future under the current private ownership model. In mid-2010, and in response to the identified need to raise capital to continue to fund facility improvements, equipment acquisition and other demands, ownership began the process of evaluating the alternatives available to them, including continuing to operate the hospital as they had been doing, a "sale-leaseback" of MSMC's real estate, improvements, furnishings and equipment as vehicle to provide access to capital, as well as the sale of the hospital to a larger hospital operator. The alternative of continuing to operate in the current fashion was dismissed because of the demands for additional capital. A "sale-leaseback" was viewed by ownership as a viable alternative, however an agreement suitable to current ownership could not be reached. The alternative of selling the hospital to a larger hospital operator was identified as the most viable alternative, and a number of potential acquisition candidates were evaluated. In the Fall of 2011, MSMC Investors, Inc. entered into exclusive negotiations with Community Health Systems, Inc. to acquire MetroSouth. Those negotiations culminated in the signing of the Asset Purchase Agreement included in this *Application for Permit.*

IMPACT STATEMENT

The proposed change of ownership will not result in any negative impact to the MetroSouth Medical Center's traditional patient population, the communities served by MSMC, the physicians practicing at MetroSouth, or its employees. Neither the number of beds provided at MetroSouth Medical Center (330), nor the complement of services provided at or through the medical center are anticipated to change; and Community Health Systems, Inc. attests that it does not intend to reduce MSMC's bed complement or eliminate any IDPH-designated "categories of service" for a minimum of two years following the Closing Date. In addition, the applicants expect that for a period of at least two (2) years after the Closing Date, there will be no material reductions in the levels of clinical and non-administrative operational staff employed by the hospital, other than those typically associated with the ongoing operations of hospitals.

As identified in Section I, the owner/operator/licensee will be Blue Island Hospital Company, LLC.

The proposed change of ownership will bring MSMC into a multi-hospital system, and bring the benefits of such system membership, such as the ability to share clinical "best-practices", improved IT capabilities, greater access to the capital markets to

fund facility improvements, experienced management, improved purchasing power and the ability to share certain administrative costs.

The costs associated with the change of ownership are generally those identified in ATTACHMENT 7.

ACCESS

Attached are the admissions policies currently in use at MetroSouth Medical Center. Also attached are the admissions policies used at Vista Health System's two Waukegan hospitals. CHS's Illinois hospitals operate with common admissions policies, and as such; the Vista Health System policies will be used at MSMC.

Neither MSMC nor CHS hospitals discriminate in the admitting of patients, based on sex, race, creed, sexual orientation, religion, or any other factor. Both accept Medicare and Medicaid recipients, and both provide charity care as outlined in the attached policies. As a result, and as attested to in the attached letter, the admissions policies under which MSMC will operate following the proposed change of ownership will not result in diminished access.

ATTACHMENT 19B

CHS

December 12, 2011

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

To Whom It May Concern:

Please be advised that the proposed change of ownership of MetroSouth Medical Center will not result in diminished accessibility to services, nor will the admissions/registration policies of the facility become more restrictive than Vista Medical Center in Waukegan Illinois as a result of the proposed change of ownership.

Sincerely,

Martin G. Schweinhart
Senior Vice President, Operations

COMMUNITY
HEALTH
SYSTEMS

4000 Meridian Boulevard
Franklin, TN 37067
Tel: (615) 465-7000

P.O. Box 689020
Franklin, TN 37068-9020

ATTACHMENT 11

MetroSouth
MEDICAL CENTER

CHARITY
FINANCE POLICY MANUAL

PURPOSE

To provide guidelines on how the Charity Care program will be administered for hospital services. To assist patients in timely paying for the cost of care received at the hospital by providing financial assistance based on the criteria set forth MetroSouth Medical Center.

POLICY

1. MetroSouth Medical Center will review requests made prior to receiving services for hospital charity and make a determination of eligibility within 14 days of receipt of requested documentation required to process the Financial Assistance application. Charity requests received after the date of service(s) or during the collection process will receive determination within 30 days of the receipt of the required documentation.

2. Charity care within the available resources of MetroSouth Medical Center will be granted to those patients, regardless of sex, race, color, creed, sexual orientation, or religion, who:
   a) fail to be approved for financial assistance through any other hospital approved program (e.g., Medical Assistance Non Grant (MANG); and
   b) meet the eligibility criteria outlined below

3. Patients are required to willingly cooperate with the Financial Assessment and MANG (Medical Assistance Non Grant) process to be eligible for charity care consideration.

4. The eligibility criteria to be used by MetroSouth Medical Center in granting charity care are predicated on the published federal poverty guidelines for adjusted gross income in relation to the size of the family unit.

5. The Charity care write-off is based on 200% up to 400% of the federal poverty guidelines, based on income and size of family. See addendum #1 for the schedule and scale criteria. Addendum #1 will be updated annually based on changes to the federal poverty guidelines.

6. Patients who have been determined eligible to receive General Assistance by the State and those who have qualified for the State's Healthy Women, DHS Social Services, HFS Social Services and Crime Victims programs will be eligible for charity care with or without the receipt of a completed Financial Assistance Application and the supporting documents. Based on the guidelines of the State for this group of individuals, they meet the charity care eligibility requirements of the MetroSouth Charity policy.

7. Patients that are homeless or deceased with no estate may be presumed to be eligible for financial assistance without the completion of a formal application.

8. Charity care applications that have been approved are valid for six (6) months from the determination date.

PROCEDURE

1. Admitting or Patient Financial Services representatives receiving a request for hospital financial assistance/charity care and/or determines potential charity care at point of admission, during admission or via the collection follow-up process with the patient or guarantor may offer information about and provide an application for Financial Assistance.

2. Patients receiving a statement or calling to inquire about a hospital bill may request Financial Assistance when speaking with a representative from Patient Financial Services.

3. Patients who express an inability to pay for hospital services will be notified of the hospital's policy on charity care and offered assistance with the process.

4. A representative of Patient Financial Services mails or hand delivers an application for hospital financial assistance / charity care to patient / guarantor along with a letter requesting specific financial documentation necessary to determine eligibility.

5. Patients requesting Financial Assistance will be required to complete a Financial Assistance Application and sign the application attesting that the information is accurate and true.

6. Upon return of the application and all requested documentation, the Collection Manager processes the application in accordance with the hospital's charity policy and criteria for granting charity care, following the schedule in addendum #1.

7. Collection Manager obtains appropriate signatures for write-off in accordance with the established approval schedule as stated below:
   a. < $ 5,000.00.....Credit/Collection Manager
   b. >$ 5,000.00 to 10,000.00.....Director, PFS
   c. >$ 10,000.00 to 20,000.00.....Controller
   d. >$ 20,000.00.....Chief Financial Officer

8. The Collection Manager or their designee mails the Hospital Financial Assistance Determination letter to patient / guarantor for their records and files a copy with the Financial Assistance application.

DEFINITIONS

Adjusted Gross Income is defined in accordance with the most recent IRS definition.
Charity care is defined as the forgiveness of patient financial responsibility remaining after all third party payments have been made to the hospital.

ADDENDA

Charity Care Sliding Fee Schedule
Financial Assistance Application
Room and Board Letter
Financial Assistance Documents Checklist

ADDENDA 1
CHARITY CARE SLIDING FEE SCHEDULE

2011 Charity Sliding Fee Schedule

Effective 1.20.2011

Family Size	U.S. Poverty Guideline	Percent of Discount						
		100%	95%	90%	85%	80%	75%	70%
1	$10,890 less than	$10,890 $21,780	$21,780 $25,410	$25,410 $29,040	$29,040 $32,670	$32,670 $36,300	$36,300 $39,930	$39,930 $43,560
2	$14,710 less than	$14,710 $29,420	$29,420 $34,323	$34,323 $39,226	$39,226 $44,130	$44,130 $49,033	$49,033 $53,936	$53,936 $58,840
3	$18,530 less than	$18,530 $37,060	$37,060 $43,237	$43,237 $49,413	$49,413 $55,590	$55,590 $61,767	$61,767 $67,943	$67,943 $74,120
4	$22,350 less than	$22,350 $44,700	$44,700 $52,150	$52,150 $59,599	$59599 $67,050	$67,050 $74,500	$74,500 $81,949	$81,949 $89,400
5	$26,170 less than	$26,170 $52,340	$52,340 $61,063	$61,063 $69,785	$69,785 $78,510	$78,510 $87,233	$87,233 $95,955	$95,955 $104,680
6	$29,990 less than	$29,990 $59,980	$59,980 $69,976	$69,976 $79,972	$79,972 $89,970	$89,970 $99,966	$99,966 $109,962	$109,962 $119,960
7	$33,810 less than	$33,810 $67,620	$67,620 $78,889	$78,889 $90,158	$90,158 $101,430	$101,430 $112,699	$112,699 $123,968	$123,968 $135,240
8	$37,630 less than	$37,630 $75,260	$75,260 $87,803	$87,803 $100,345	$100,345 $112,890	$112,890 $125,433	$125,433 $137,975	$137,975 $150,520
9	$41,450 less than	$41,450 $82,900	$82,900 $96,716	$96,716 $110,531	$110,531 $124,350	$124,350 $138,166	$138,166 $151,981	$151,981 $165,800
10	$45,270 less than	$45,270 $90,540	$90,540 $105,629	$105,629 $120,717	$120,717 $135,810	$135,810 $150,899	$150,899 $165,987	$165,987 $181,080

ADDENDA 2
FINANCIAL ASSISTANCE APPLICATION
SAMPLE

Date: _____

I request that MetroSouth Medical Center make a determination of my eligibility for financial assistance. I understand that the information, which I submit concerning my annual income and family size, is subject to verification. I also understand that if the information, which I submit, is determined false, this will result in a denial of financial assistance. Also, any failure on my part to cooperate with this process will also result in denial.

Name
(First)_____(Last)_____

Address_____

Telephone Number _____

Employer_____(Occupation)_____

Income (Last 12 Months) _____ (Expenses) _____

Family Size (Number) _____

Names and Relationship of Family Members (Include self):

_____ _____

_____ _____

_____ _____

I affirm that the above information is true and correct.

_____
Signature (Person making request)

ADDENDA 3
ROOM AND BOARD LETER
SAMPLE

RE:_____

DATE: _____

NAME: _____

STREET ADDRESS: _____

CITY: _____

STATE & ZIP CODE:_____

RELATIONSHIP TO PATIENT: _____

PHONE NUMBER: _____

TO WHOM IT MAY CONCERN:

I have provided room and board to _____for

the past _____ .

I can continue to provide room and board, but I am unable to contribute toward any outstanding hospital bills.

_____
Signature & Date

_____
Witness Date

ADDENDA 4
FINANCIAL ASSISTANCE DOCUMENTS CHECKLIST
SAMPLE

Date: _____

Account Number: _____

Patient Name: _____

Dear

In order for MetroSouth Medical Center to determine your eligibility for financial assistance, the documents checked below must be submitted to us within five days of receipt of this letter along with the enclosed application.

_____ Tax Return /W2 Forms

_____ Proof of income (copies of last three pay stubs)

_____ Employer letter verifying gross income year to date

_____ Verification of unemployment benefits

_____ Verification of pension benefits

_____ Other

Eligibility is determined based on family size, gross income, and potential future earnings. Upon receipt of your application and accompanying documents, written notification will be sent to you concerning your eligibility. Should you have any questions concerning this process, please feel free to contact us at (708) 824-4606.

Sincerely,

MetroSouth Medical Center
Patient Financial Services Department

Enclosure

MetroSouth
MEDICAL CENTER

ADMISSION OF THE PATIENT
PATIENT ACCESS (REGISTRATION) DEPARTMENT MANUAL

PURPOSE

- To provide a commitment to appropriate treatment of and interaction with MetroSouth Medical Center's patients during the intake and admissions process.
- Assure all demographic and personal information be obtained through professional communication, verification of identification as standard practice.
- Protect patient's identity and minimize duplicate files and prevention of error/rejected claims.
- Assure that all State and Federal regulations and laws that govern conduct for hospitals in the admission of patients, and all other applicable laws and regulations governing patient care delivery, be followed by MetroSouth Medical Center's support and clinical staff at all times.

POLICY

1. No patient is to be denied medical care due to race, color, religion, ancestry, financial class or national origin.

2. Patients will be admitted promptly upon verification of the medical need for non-elective admissions. MetroSouth Medical Center shall follow EMTALA laws. In no event will a patient be denied treatment in the Emergency Department or as an emergency transfer because of ability and or inability to make payment.

3. Patients must be admitted to MetroSouth Medical Center by members of the Medical Staff with admitting privileges. The patient's physician shall establish the patient's admitting diagnosis during notification of direct admission order.

4. Acceptance of non-emergent admissions and transfers to MetroSouth Medical Center shall be made contingent upon verification of available resources.

5. All patients admitted to the hospital shall receive appropriate laboratory tests as determined by the medical staff. The required list or lists of tests shall be in written form and shall be available to all members of the medical staff.

6. Except for an emergency situation, no patient shall be admitted to MetroSouth Medical Center until after a provisional diagnosis has been stated. In the cases of an emergency, the provisional diagnosis shall be stated during care and treatment by the emergency Physician, or as soon after admission as possible.

7. All patients are required to present with a picture identification as a precaution to prevent identity theft. A copy of the picture identification will be obtained and become part of the medical record. For elective admissions, all registration areas shall confirm and verify eligibility of insurance coverage. Admissions may be delayed for patients whose insurance coverage requires pre-certification. For those patients that are uninsured or underinsured, the staff shall communicate the possibility of assistance through

governmental programs and/or MetroSouth Medical Center internal financial assistance programs.

8. MetroSouth Medical Center registration staff will inform Patients of insurance benefits during admitting process. Staff will instruct the patients of required payment options for co-pays, deductibles, co-insurance, non-covered services and out of pocket responsibilities.

9. All protected health information shall be maintained in a manner that complies with HIPAA and follows MetroSouth Medical Center's code of conduct for security private health information.

10. Patients' protected health information shall be entered hospital's system for record generation.

11. Prior to scheduling inpatient admissions, Physician's offices shall be contacted for referrals, treatment authorizations and admitting orders.

12. MetroSouth Medical Center will manage room and bed assignment through bed control and communication with nursing for discharges. The hospital will monitor open and available beds during peak Physician call times.

13. MetroSouth Medical Center will ensure that Patients fill out and sign all consent forms and documentation required by Federal and State guidelines and regulations Complies with all guidelines and regulations of signature prior to the receipt of treatment and care. This includes but is not limited to: MSP questionnaires; Consent for Treatments; ABN; and living wills.

14. MetroSouth Medical Center will assist Patients with completion of applications for government assistance programs, Crime Victims, State of Illinois Sexual Assault, Illinois Medicaid MANG, Kid Care, and Veterans Administration.

MetroSouth
MEDICAL CENTER

HOSPICE PATIENT – ADMISSION OF INPATIENT & RESPITE CARE PATIENT CARE POLICY

PURPOSE

To describe the Standard of Care for the admission of a Hospice patient.

POLICY

MetroSouth Medical Center provides inpatient care for medical necessity and to provide respite care. Short-term inpatient care may be indicated when the patient's condition or progress of the disease must be closely monitored in order that pain, symptoms, physical or psychological crisis can be managed. Inpatient Hospice services are available around the clock by Hospice nurses. All Hospice inpatient admissions must be approved by attending physician, Hospice Medical Director and Hospice Supervisor.

PROCEDURE

1. The Hospice RN will notify the Admitting Department of Hospice inpatient status after approvals are obtained and Hospice assessment is completed. The Electronic Medical Record (EMR) will be assigned to Hospice. The chart will be identified with a sticker and a divider will be placed to accommodate the Hospice notes.

2. All inpatient Hospice patients will be admitted to designated Hospice rooms. Admitting will notify Environmental Services (Ext. 5092) of a Hospice inpatient admission to convert room to a homelike environment. (Example: Private room with single bed, provide sleeper chair, round table with 2 chairs, rug, pictures for walls and plants.)

3. No acute care and Hospice patients will be treated in the same room.

4. Hospice RN to complete Hospice admission assessment.

5. Hospice RN to notify attending physician for admission orders as indicated.

6. Orientate family to use of Hospice family room. Hospice inpatient has unlimited visiting hours with children of any age accompanied by a responsible adult. Security is notified of a Hospice patient admission.

7. Dietary is notified of Hospice inpatient for specific dietary needs.

8. All other special requests should be directed through the Hospice RN.

MetroSouth
MEDICAL CENTER

REFERRALS / ADMISSION PROCEDURE
PROVISION OF CARE, TREATMENT AND SERVICES
HOME CARE/HOSPICE

POLICY

Provision of Care, Treatment and Services-Referrals/Admission Procedure

PURPOSE

To coordinate patient care and services

PROCEDURE

HOME HEALTH

1. Home Health referrals may be accepted by licensed profession staff by phone, mail, in person or by means of computer/fax printout.
2. Referrals may be received from physician's offices, hospitals, nursing homes, home care agencies, social service agencies, case managers, coordinators or other representative of insurance companies or other alternative health care settings. They may also be received from patients or their families.
3. All referrals received for skilled intermittent services will be confirmed as physician ordered prior to initiating service.
4. Telephone or direct contact will be made with each client within 24 hours of receipt of the referral as appropriate for the purposes of verifying patient information, notifying the patient/family that a referral for service has been received and establishing a time frame for the initial visit.
5. Private insurance/medical coverage will be verified prior to initiating care. An insurance verification form will be completed by the Document Control Clerk.
6. Medicare Insurance will be verified prior to or at the time of the initial visit using the Medicare Admission Screening Tool.
7. See Scope of Service.

Admission Procedure for Home Health:

a. An initial assessment is made by Skilled Nursing, Physical Therapy or Speech Therapy to ensure that admission is appropriate (see scope).
b. At or before the time of admission the patient/family will:

- Sign the Consent for Treatment and receive a copy of the consent.
- Be informed of policies/procedures pertinent to care
- Be provided with information related to patient rights and responsibilities,

advance directives, resuscitation/DNR policy, office hours, charges for services and terms of payment, telephone numbers for the physician, home health hotline, office and the after hours number

- Be provided with home health folder containing pertinent information related to home health services.

c. Organization staff will verify advance directives, if any, and request a copy for the medical records.

d. Admitting staff will notify organization staffing coordinator of need for additional services (i.e. Home Health Aide, Medical Social Worker, Skilled Nursing, Physical Therapy, Occupational Therapy, Speech Therapy)

HOSPICE

1. Hospice referrals may be accepted by licensed professional staff, by phone, mail, in person or by means or computer/fax printout.
2. Referrals may be received from physician's offices, hospitals, nursing homes, home care agencies, social service agencies, case managers, case coordinators or other representatives of insurance companies or other alternative health care settings. They may also be received from patients or their families.
3. All referrals received for skilled intermittent services will be confirmed as physician ordered prior to initiating service.
4. Telephone or direct contact will be made with each patient within 24 hours of receipt of the referral as appropriate for the purposes of verifying patient information, notifying the patient/family that a referral for service has been received and establishing a time frame for the initial visit.
5. Private insurance/medical coverage as applicable will be verified prior to initiating care. An insurance verification form will be completed by appropriate personnel.
6. Medicare insurance will be verified prior to or at the time of the initial visit using the Medicare Admission Screening Tool
7. **Admission Procedure for Hospice:**

   An appropriately qualified professional staff member will make the initial visit and assessment for the purpose of admitting the patient who meets eligibility requirements. Each discipline is responsible for completing their own discipline specific initial assessment.

   a. Have patient/representative sign the following forms:

      - Hospice Informed Consent
      - Hospice Plan of Care
      - Important Information about Benefits
      - Outpatient Admission Release (Section I, II, III as appropriate)
      - Medicare Benefits Election (for Medicare patients)
      - Hospice Election Statement and Hospice Nursing Home Resident Status Report when applicable.

b. Verify advance directives, if any, and obtain copy for the medical record.
c. Complete medical record forms for hospice
d. Have physician sign and date the following forms:

- Physician Authorization
- Medical Assessment
- Hospice Plan of Care

e. Notify Home Information Services (Medical Records) of patient admission.
f. For Medicaid patients, notify the state Medicaid office of new admission including:

- Medicaid Hospice Election Statement (within 5 days of admission)
- Physician Certification Statement (within 8 days of admission)
- Plan of Care (within 10 days of admission)
- Medicaid Hospice Nursing Home Resident Status if patient is a nursing home resident (within 5 days of admission).

g. Make chart log on which to record all charges billable to the patient.
h. Make volunteer assignment if appropriate. Provide the following information to the volunteer(s) involved:

- Copy of face sheet
- Supply of volunteer home visit report forms
- Volunteer activity records
- Postage paid envelopes

i. The agency may choose to complete an admission checklist to be placed in the medical record to ensure that all admission information is obtained.
j. The agency may choose to complete an admission checklist to be placed in the medical record to ensure that all admission information is obtained.

VISTA HEALTH SYSTEM

Policy/Procedure Title	Admission of Patients	Manual Location	Patient Rights
Policy/Procedure #		Effective	5/1989
Department Generating Policy	Administration	Page 1 of 1	
Affected Departments	All		
Prepared By	Administration	Dept/Title	
Dept / Committee Approval (If Applicable)		Date/Title	
Administrative Approval (If Applicable)		Date/Title	

POLICY:

Persons presenting themselves for treatment shall receive care consistent with the Mission, Vision and Values of Vista Health System.

Nor person will be denied access to care because of sex, race, nationality, creed, financial status, medical condition, disability or age.

All patients are given a copy of patient rights upon admission.

All inpatients are given a patient information guide that includes, but is not limited to: Patient Rights & Responsibilities, Addressing HIPAA, Speak Up, Medication Safety, Pain Control and Information about Discharge Rights.

VISTA MISSION STATEMENT:

We strive to be Lake County's choice for health care services. We will collaborate with patients, physicians, the community, and others to deliver quality care. We will be known for excellent service and responsible stewardship as we strengthen our heritage of treating each person with dignity, respect and compassion. Our mission is to:

*Strive for excellence in treatment and service;
*Respond to the needs of those we serve and one another;
*Improve the health of the communities we serve; and
*Use our resources wisely

Reviews/Revisions:	1st	2nd	3rd	4th	5th
Date:	4/26/2010	8/2011			
By:	K. Needham	K. Needham			

ATTACHMENT 19B

Vista Health System

Policy/Procedure Title	ILLINOIS UNINSURED/SELF PAY DISCOUNT POLICY	Manual Location			
Policy/Procedure #		Effective Revised	5/1/2010	Page	1 of 10
Department Generating Policy	Patient Financial Services				
Affected Departments	Business Office				
Prepared By	Lisa Machado	Dept/Title	Business Office Director		
Chief Executive Officer	Barbara Martin	Date/Title			
Chief Financial Officer	Edwin Bode	Date/Title			
Business Office Director		Date/Title			

POLICY STATEMENT:

As a condition of participation in the Medicaid disproportionate share program (if applicable) and to comply with Illinois Public Act 95-0965, and to serve the health care needs of our community, Vista Health System will provide discount care to uninsured patients, who do not otherwise qualify for third party coverage, local, state and/or government assistance with their health care bills.

Discount care will be provided to all uninsured patients without regard to race, creed, color, religious beliefs or national origin.

Patients may apply for the discount within 60 days of service.

All Illinois CHS hospitals will charge Illinois residents no more than 135% of cost based on their most recently filed Medicare cost report(25%PCR/75%Discount as of 5/1/10). Where a prior agreement such as an Asset Purchase Agreement requires the hospital to apply an existing policy, hospital will charge the patient the lesser of the APA agreement or 135% of Medicare cost. Non Illinois residents will receive the minimum uninsured discount without proof of income and/or residency.

PURPOSE:

To properly identify those patients who do not have insurance and do not qualify for third party coverage, state and/or government assistance, and to provide assistance with their medical expenses under the guidelines for the Uninsured/Self Pay Discount Policy.

ELIGIBILITY FOR DISCOUNT CARE

ATTACHMENT 19B

1. To be eligible for a reduction in the patient balance through the Discount Policy, the patient must be uninsured and the hospital services are not covered in whole or part, by any other third party source.

2. For the purposes of Illinois Public Act 95-0965, the services provided must be on or after 4/1/09, otherwise, the minimum uninsured discount will apply.

3. The household income must be 300% of the Federal Poverty Income, or less at Critical Access or Rural Area Hospitals or 600% of the Federal Poverty Income or less at Urban Area Hospitals. Galesburg Cottage Hospital is classified as a Rural Area Hospital.

4. Patients who do not apply for Charity Care and/or does not provide the documents required to make a determination for Charity or a determination of income for the purpose of Illinois Public Act 95-0965, will only be eligible for the minimum discount of 25% and have 60 days from discharge/service date to provide the documents required in order to receive an additional discount.

5. The services the patient receives must be medically necessary based on Medicare Medical Necessity criteria.

6. Must be an Illinois Resident and provide acceptable family income verification. Acceptable forms of verification of Illinois residency includes one of the following:

   -Any document listed on acceptable family income verification
   -A valid state issued identification card
   -A recent residential utility bill
   -A lease agreement
   -A vehicle registration card
   -A voter registration card
   -Mail addressed to the uninsured patient at an Illinois address from a government or other credible source
   -A statement from a family member of the uninsured patient who resides at the same address and presents verification of residency
   -A letter from a homeless shelter, transitional house or other similar facility verifying that the uninsured patient resides at the facility

THE AMOUNT OF THE DISCOUNT PROVIDED

Patients who do not provide proof of income; who are not eligible for the self pay discount or whose charges for an inpatient or outpatient encounter is less than $300.00: these patients are eligible for a minimum discount of 25% off billed charges.

Patients who provide proof of Illinois Residency, who are eligible for a self pay discount and whose charges for an inpatient or outpatient encounter is more than $300.00: a discount of 74% will be provided. The discount is based on 135% of the hospital cost based on the most recently filed Medicare Cost Report.

However, the maximum amount collected in a 12-month period from eligible patients is 25% of the family's annual gross income, excluding patients with substantial assets as described in Appendix 1.

- A 12 month period begins as of the first date of service determined to be eligible for a discount.
- The patient must inform the hospital that he/she has received prior services from the hospital which were eligible for the discount
- Substantial assets do not include primary residence, personal property and amounts held in a pension or retirement plan

EXCLUDED FROM COVERAGE

1. Patient's covered by any insurance, local, state or government health care coverage or other third party coverage. This includes any portion of a hospital bill where the patient's insurance has denied or excluded certain services from coverage.

2. Patient's who qualify and receive a hospital Charity Care Discount.

3. Patient's requesting cosmetic procedures or services not considered medically necessary based on Medicare medical necessity criteria. In the case of elective procedures such as cosmetic procedures or weight reduction procedures, package pricing often applies and a discount is automatically provided within the package pricing. These services should not be provided until the patient has paid for the service in advance. Non-medical services such as social and vocational services are excluded from coverage.

4. Any other patient/account already receiving a discount, such as (but not limited to) Industrial Accounts or Client Accounts.

5. Hospital based physician charges.

THE PROCESS

1. **Identification of Patients Eligible for Discount Policy:**

   A. The hospital will include a statement on each hospital bill or summary of charges of the availability of an Uninsured Discount and how to make application. The statement will include information regarding income requirements.
   B. All patients with no insurance who do not qualify for Charity Care or who do not apply for Charity Care will be eligible for a discount off billed charges (subject to charges exceeding $300 of charges in any one Inpatient and Outpatient encounters). Excluding encounters where charges are $300 or less. No discount will be provided when the total charges for that encounter is $300 or less.

The maximum amount collected in a 12-month period from eligible patients is 25% of the family's annual gross income excluding substantial assets. The 12-month period beings from the date of service in which the patient is eligible for the discount.

   C. During the screening process for the Charity Care and the Discount Programs, the financial counselor or self pay screening vendor will screen for potential Medicaid eligibility as well as coverage by other sources, including governmental programs. During this screening process a

"FA" will be completed. (Exhibit A) While it is not necessary that a FA be completed in order to receive a discount, when a FA is completed during the screening process, it will be used for the purpose of this policy as well. Patients will be required to cooperate and apply for Medicare, Medicaid, AllKids, SCHIP, or any other public program providing there is reason to believe they would qualify. Proof of denial will be required for the patient to be eligible for the discount above the minimum uninsured discount.

D. All uninsured patients will be screened for existing Medicaid coverage by using the hospital's insurance eligibility software. A copy of the response will be retained as verification that the patient did not have Medicaid coverage.

E. The hospital will view prior accounts for the patient as well as the guarantor to determine if insurance coverage existed on prior hospital records. If so, the hospital will 'verify insurance coverage' and document the call and response.

F. The hospital reserves the right to pull a copy of the patient's credit report for verification of information provided.

G. When it is determined the patient does not qualify for Medicare, Medicaid or any other third party coverage and the patient does not qualify for Charity Care, the patient will immediately qualify for a discount off billed charges.

H. Patients who are not screened for Medicare, Medicaid and other third party coverage, due to the patient not returning calls or providing the necessary information to make a determination of coverage and who do not provide the necessary information to make a Charity Care or Illinois State discount determination will only be eligible for the minimum uninsured discount off billed charges.

I. Proof of Income and/or residency must be provided within 30 days of request.

Acceptable forms of documentation of family income shall include one of the following:

- A copy of the most recent tax return
- A copy of the most recent W-2 and 1099 forms
- Copies of the 2 most recent pay stubs
- Written income verification from an employer, if paid in cash
- One other reasonable form of third party income verification deemed acceptable to the hospital

Acceptable forms of documentation of residency shall include one of the following:

- Any document listed on acceptable family income verification
- A valid state issued identification card
- A recent residential utility bill
- A lease agreement
- A vehicle registration card
- A voter registration card
- Mail addressed to the uninsured patient at an Illinois address from a government or other credible source
- A statement from a family member of the uninsured patient who resides at the same address and presents verification of residency

- A letter from a homeless shelter, transitional house or other similar facility verifying that the uninsured patient resides at the facility

2. FAILURE TO PROVIDE ACCURATE INFORMATION

If it is later determined that the patient qualified for coverage by Medicare, Medicaid or any other third party coverage or met the criteria for the hospital
Charity Care Discount program, any discount provided for under this policy shall be reversed.

If any information provided by the patient/guarantor is later found to be untrue, any discount provided may be forfeited.

3. DOCUMENTATION OF ELIGIBILITY DETERMINATION AND APPROVAL OF WRITE-OFF

A. For those patients screened by the hospital financial counselor or self pay screening vendor, once the eligibility determination has been made, the results will be documented in the comments section on the patient's account.

B. The discount will be set in the system and will not require hospital authorization.

C. The transaction code used will reflect 'Self Pay Discount' and will not be considered Charity.

D. The 25% discount applied to all self pay accounts will be adjusted with transaction codes **556** for Inpatient, and **557** for Outpatient.

E. If the patient qualifies for the additional discount; the 25% discount shall be reversed and a new 75% discount will be applied using the following codes:

Inpatient Discount – Transaction code **558**

Outpatient Discount – Transaction code **559**

Bad Debt Inpatient Discount – Transaction Code **794**

Bad Debt Outpatient Discount – Transaction Code **795**

4. REPORTING OF DISCOUNT CARE

Information regarding the amount of discount care provided by the hospital, based on the hospital's fiscal year, shall be aggregated and included in the annual report filed with the Bureau of State Health Data and Process Analysis at the State Department of Health. These reports also will include information concerning the provision of government sponsored indigent health care and other county benefits. (Only for those states that require).

Illinois hospitals must annually file a copy of Worksheet C Part I of their Medicare Cost Report with the Attorney General's office. The first filing is due 2/20/09.

5. POLICY REVIEW AND APPROVAL

The below individuals have read and approved this policy:

Hospital CEO	Date
Hospital CFO	Date
Corporate VP, Patient Financial Services	Date
Group VP Operations	Date

Financial Assistance Program Application

Patient Account Number:_____ Date of Application_____

Due Date if Application is for Illinois Public Act_____

PATIENT INFORMATION	PARENT/GUARANTOR/SPOUSE
Name_____	Name_____
Address_____	Address_____
City_____	City_____
State/Zip_____	State/Zip_____
SS#_____	SS#_____
Employer_____	Employer_____
Address_____	Address_____
City_____	City_____
State/Zip_____	State/Zip_____
Work Phone_____	Work Phone_____
Length of Employment_____	Length of Employment_____
Supervisor_____	Supervisor_____

RESOURCES

Checking: yes___ no___
Savings: yes___ no___

Cash on hand: $_____

Vehicle 1: Yr_____ Make_____ Model_____
Vehicle 2: Yr_____ Make_____ Model_____
Vehicle 3: Yr_____ Make_____ Model_____

ATTACHMENT 19B

Exhibit A (continued)
Financial Assistance Program Application

INCOME

Patient/Guarantor:
Wages(monthly): _____

Spouse/Second Parent:
Wages(monthly): _____

Other Income: Child Support: $_____

VA Benefits: $_____

Workers' Comp: $_____

SSI: $_____

Other: $_____

Other Income: Child Support: $_____

VA Benefits: $_____

Workers' Comp: $_____

SSI: $_____

Other: $_____

LIVING ARRANGEMENTS

Rent_____ Own_____ Other (explain)_____

Landlord/Mortgage Holder: _____

Phone Number_____ Monthly payment $_____

REQUIRED DOCUMENTS

The following documents must be attached to process your application for **Charity Care/Financial Assistance:**

Proof of Income: Prior year income tax return, last 4 pay check stubs, letter from employer, Social Security, etc. Last 3 months bank statements. Other documents as requested.

Proof of Expenses: Copy of mortgage payment or rental agreement, copies of all monthly bills including credit cards, bank loans, car loans, insurance payments, utilities, cable and cell phones. Other documents as requested.

The information provided in this application is subject to verification by the hospital and has been provided to determine my ability to pay my debt. I understand that any false information provided by me will result in denial of any financial assistance by the hospital.

The Hospital reserves the right to pull a copy of your credit report.

Signature of Applicant_____

Hospital Representative Completing Application: _____

Approval/Authorization of Charity Care Write-Off **Amount Approved $**_____

BOM_____ **CEO**_____

CFO_____

ATTACHMENT 19B

Appendix 1

Under Section 10 of the Hospital Uninsured Patient Discount Act, certain personal property is exempt from the determination of assets owned by an eligible uninsured patient as it relates to the maximum collectible amount in a 12 month period (25% of annual income.) Those assets are listed in the Code of Civil Procedure, 735 ILCS 5/12-1001, with reference to a "debtor's" assets. They include the following:

(a) The necessary wearing apparel, bible, school books, and family pictures of the debtor and the debtor's dependents;

(b) The debtor's equity interest, not to exceed $4,000 in value, in any other property;

(c) The debtor's interest, not to exceed $2,400 in value, in any one motor vehicle;

(d) The debtor's equity interest, not to exceed $1,500 in value, in any implements, professional books, or tools of the trade of the debtor;

(e) Professionally prescribed health aids for the debtor or a dependent of the debtor;

(f) All proceeds payable because of the death of the insured and the aggregate net cash value of any or all life insurance and endowment policies and annuity contracts payable to a wife or husband of the insured, or to a child, parent, or other person dependent upon the insured, whether the power to change the beneficiary is reserved to the insured or not and whether the insured or the insured's estate is a contingent beneficiary or not;

(g) The debtor's right to receive:

(1) a social security benefit, unemployment compensation, or public assistance benefit;
(2) a veteran's benefit;
(3) a disability, illness, or unemployment benefit; and
(4) alimony, support, or separate maintenance, to the extent reasonably necessary for the support of the debtor and any dependent of the debtor.

(h) The debtor's right to receive, or property that is traceable to:

(1) an award under a crime victim's reparation law;
(2) a payment on account of the wrongful death of an individual of whom the debtor was a dependent, to the extent reasonably necessary for the support of the debtor;
(3) a payment under a life insurance contract that insured the life of an individual of whom the debtor was a dependent, to the extent reasonably necessary for the support of the debtor or a dependent of the debtor;
(4) a payment, not to exceed $15,000 in value, on account of personal bodily injury of the debtor or an individual of whom the debtor was a dependent; and
(5) any restitution payments made to persons pursuant to the federal Civil Liberties Act of 1988 and the Aleutian and Pribilof Island Restitution Act,

For purposes of this subsection (h), a debtor's right to receive an award or payment shall be exempt for a maximum of 2 years after the debtor's right to receive the award or payment accrues; property traceable to an award or payment shall be exempt for a maximum of 5 years after the award or payment accrues; and an award or payment and property traceable to an award or payment shall be exempt only to the extent of the amount of the award or payment, without interest or appreciation from the date of the award or payment.

(i) The debtor's right to receive an award under Part 20 of Article II of this Code relating to crime victims' awards.

(j) Moneys held in an account invested in the Illinois College Savings Pool of which the debtor is a participant or donor, except the following non-exempt contributions:

(1) any contribution to such account by the debtor as participant or donor that is made with the actual intent to hinder, delay, or defraud any creditor of the debtor;
(2) any contributions to such account by the debtor as participant during the 365 day period prior to the date of filing of the debtor's petition for bankruptcy that, in the aggregate during such period, exceed the amount of the annual gift tax exclusion under Section 2503(b) of the Internal Revenue code of 1986,as amended, in effect at the time of contribution; or
(3) any contributions to such account by the debtor as participant during the period commencing 730 days prior to and ending 366 days prior to the date of filing of the debtor's petition for bankruptcy that, in the aggregate during such period, exceed the amount of the annual gift tax exclusion under Section 2503(b) of the Internal Revenue code of 1986, as amended, in effect at the time of contribution.

For purposes of this subsection (j), "account" includes all accounts for a particular designated beneficiary, of which the debtor is a participant or donor. Money due the debtor from the sale of any personal property that was exempt from judgment, attachment, or distress for rent at the time of the sale is exempt from attachment and garnishment to the same extent that the property would be exempt had the same not been sold by the debtor. If a debtor owns property exempt under this Section and he or she purchased that property with the intent of converting nonexempt property into exempt property or in fraud of his or her creditors, that property shall not be exempt from judgment, attachment, or distress for rent. Property acquired within 6 months of the filing of the petition for bankruptcy shall be presumed to have been acquired in contemplation of bankruptcy. The personal property exemptions set forth in this Section shall apply only to individuals and only to personal property that is used for personal rather than business purposes. The personal property exemptions set forth in this Section shall not apply to or be allowed against any money, salary, or wages due or to become due to the debtor that are required to be withheld in a wage deduction proceeding under Part 8 of this Article XII.

Revisions	1st	2nd	3rd	4th	5th
Date:	05/01/2010				
By:	Edwin Bode				

HEALTH CARE SYSTEM

The applicants do not anticipate that the proposed change of ownership will have any impact on other area providers, and there are no plans as of the filing of this application to change the clinical programs offered by the hospital, in any way that would impact other area providers.

Copies of the 2010 IDPH *Hospital Profiles* for each of the eight hospitals owned by Community Health Systems in Illinois are attached in response to the requirement to identify services provided by other hospitals within the health care system, and the historical utilization of those services. It should be noted, however, that the closest CHS hospital to Blue Island is located in Waukegan, approximately sixty miles away. As a result, there will be little, if any, relationship between MSMC and any of CHS' other hospitals in terms of direct patient care, or the transfer of patients.

Copies of MSMC's current transfer agreements are attached. It is anticipated that these agreements will remain in place during CHS' initial six months of control, during which time the hospital's complement of transfer agreements will be evaluated and modified, as appropriate. MSMC operates as an independent hospital, and is not a member of a "health care system". In addition, none of the facilities or programs with which MSMC maintains transfer agreements are members of the health care system that

will be in place following the change of ownership. Therefore, and consistent with Section 1110.240.d, issues related to proximity relationships and the duplication of services within the health care system are not germane to this application.

CHS will not provide any direction related to the usage of health care system member facilities over other facilities. Rather, the transfer of patients will be at the choice of the patient, the patient's family and the patient's physician.

MetroSouth Medical Center is active in its community, providing a broad range of community programs and services, such as:

- health fairs
- diabetes screening
- free health care screenings
- blood drives
- fitness programs
- Latino outreach program
- Asian outreach program
- speakers bureau
- prostate and testicular cancer prevention

Like MetroSouth, CHS had a strong commitment to community-based programming, and following the change of ownership, both existing programs and the needs of the communities served by MSMC will be evaluated, with the addition of new programs as needed.

Ownership, Management and General Information

ADMINISTRATOR NAME:	Ed Cunningham
ADMINSTRATOR PHONE	618-241-8505
OWNERSHIP:	National Healthcare of Mt. Vernon, Inc.
OPERATOR:	National Healthcare of Mt. Vernon, Inc.
MANAGEMENT:	For Profit Corporation
CERTIFICATION:	
FACILITY DESIGNATION:	General Hospital
ADDRESS	8 Doctors Park Road

CITY: Mount Vernon COUNTY: Jefferson County

Patients by Race

White	88.4%
Black	6.3%
American Indian	0.0%
Asian	0.1%
Hawaiian/ Pacific	0.0%
Unknown:	5.2%

Patients by Ethnicity

Hispanic or Latino:	0.3%
Not Hispanic or Latino:	94.5%
Unknown:	5.2%

IDPH Number:	3947
HPA	F-04
HSA	5

Facility Utilization Data by Category of Service

Clinical Service	Authorized CON Beds 12/31/2010	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy 12/31/2010	Staff Bed Occupancy Rate %
Medical/Surgical	50	46	33	1,694	4,957	305	3.1	14.4	28.8	31.3
0-14 Years				*14*	*24*					
15-44 Years				*332*	*593*					
45-64 Years				*453*	*1,197*					
65-74 Years				*335*	*1,002*					
75 Years +				*560*	*2,141*					
Pediatric	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Intensive Care	7	7	7	151	496	0	3.3	1.4	19.4	19.4
Direct Admission				*40*	*283*					
Transfers				*111*	*213*					
Obstetric/Gynecology	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Maternity				*0*	*0*					
Clean Gynecology				*0*	*0*					
Neonatal	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long Term Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Swing Beds				0	0		0.0	0.0		
Acute Mental Illness	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Rehabilitation	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long-Term Acute Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Dedcated Observation	*0*					*0*				
Facility Utilization	**57**			**1,734**	**5,453**	**305**	**3.3**	**15.8**	**27.676**	

(Includes ICU Direct Admissions Only)

Inpatients and Outpatients Served by Payor Source

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Totals
	59.7%	**13.5%**	**0.0%**	**21.2%**	**3.7%**	**1.8%**	
Inpatients	1036	234	0	368	64	32	1,734
	52.0%	**20.1%**	**0.0%**	**24.2%**	**3.6%**	**0.2%**	
Outpatients	17851	6896	0	8314	1227	69	34,357

Financial Year Reported: 1/1/2010 *to* 12/31/2010

Inpatient and Outpatient Net Revenue by Payor Source

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Totals	Charity Care Expense
Inpatient Revenue ($)	**46.4%**	**18.4%**	**0.0%**	**30.3%**	**4.9%**	**100.0%**	
	7,453,218	2,954,367	0	4,858,935	785,552	16,052,072	599,042
Outpatient Revenue ($)	**14.4%**	**1.2%**	**0.0%**	**79.1%**	**5.4%**	**100.0%**	
	3,168,173	259,062	0	17,439,684	1,183,686	22,050,605	186,060

Total Charity Care Expense 785,102

Totals: Charity Care as % of Net Revenue 2.1%

Birthing Data

Number of Total Births:	0
Number of Live Births:	0
Birthing Rooms:	0
Labor Rooms:	0
Delivery Rooms:	0
Labor-Delivery-Recovery Rooms:	0
Labor-Delivery-Recovery-Postpartum Rooms:	0
C-Section Rooms:	0
CSections Performed:	0

Newborn Nursery Utilization

Level 1 Patient Days	0
Level 2 Patient Days	0
Level 2+ Patient Days	0
Total Nursery Patientdays	0

Laboratory Studies

Inpatient Studies	46,336
Outpatient Studies	109,124
Studies Performed Under Contract	0

Organ Transplantation

Kidney:	0
Heart:	0
Lung:	0
Heart/Lung:	0
Pancreas:	0
Liver:	0
Total:	0

ATTACHMENT 19C

8L

Surgery and Operating Room Utilization

Surgical Specialty	Operating Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Cardiovascular	0	0	0	0	0	0	0	0	0	0.0	0.0
Dermatology	0	0	0	0	0	0	0	0	0	0.0	0.0
General	0	0	5	5	122	241	463	773	1236	3.8	3.2
Gastroenterology	0	0	0	0	0	0	0	0	0	0.0	0.0
Neurology	0	0	0	0	0	3	0	8	8	0.0	2.7
OB/Gynecology	0	0	0	0	84	206	334	628	962	4.0	3.0
Oral/Maxillofacial	0	0	0	0	0	0	0	0	0	0.0	0.0
Ophthalmology	0	0	0	0	0	360	0	704	704	0.0	2.0
Orthopedic	0	0	0	0	177	340	758	1113	1871	4.3	3.3
Otolaryngology	0	0	0	0	1	131	3	354	357	3.0	2.7
Plastic Surgery	0	0	0	0	0	0	0	0	0	0.0	0.0
Podiatry	0	0	0	0	1	13	4	43	47	4.0	3.3
Thoracic	0	0	0	0	0	0	0	0	0	0.0	0.0
Urology	0	0	0	0	69	300	217	860	1077	3.1	2.9
Totals	**0**	**0**	**5**	**5**	**454**	**1594**	**1779**	**4483**	**6262**	**3.9**	**2.8**

SURGICAL RECOVERY STATIONS Stage 1 Recovery Stations 8 Stage 2 Recovery Stations 12

Dedicated and Non-Dedicated Procedure Room Utilization

Procedure Type	Procedure Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Gastrointestinal	0	0	1	1	40	472	110	1179	1289	2.8	2.5
Laser Eye Procedures	0	0	0	0	0	0	0	0	0	0.0	0.0
Pain Management	0	0	0	0	0	0	0	0	0	0.0	0.0
Cystoscopy	0	0	1	1	14	176	38	438	476	2.7	2.5
Multipurpose Non-Dedicated Rooms											
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0

Cardiac Catheterization Labs

Total Cath Labs (Dedicated+Nondedicated labs):	**0**
Cath Labs used for Angiography procedures	0
Dedicated Diagnostic Catheterization Labs	0
Dedicated Interventional Catheterization Labs	0
Dedicated EP Catheterization Labs	0

Emergency/Trauma Care

Certified Trauma Center		No
Level of Trauma Service	**Level 1**	**Level 2**
	Not Applicable	Not Applicable
Operating Rooms Dedicated for Trauma Care		0
Number of Trauma Visits:		0
Patients Admitted from Trauma		0
Emergency Service Type:		Comprehensive
Number of Emergency Room Stations		0
Persons Treated by Emergency Services:		8,875
Patients Admitted from Emergency:		1,250
Total ED Visits (Emergency+Trauma):		**8,875**

Cardiac Catheterization Utilization

Total Cardiac Cath Procedures:	0
Diagnostic Catheterizations (0-14)	0
Diagnostic Catheterizations (15+)	0
Interventional Catheterizations (0-14):	0
Interventional Catheterization (15+)	0
EP Catheterizations (15+)	0

Cardiac Surgery Data

Total Cardiac Surgery Cases:	**0**
Pediatric (0 - 14 Years):	0
Adult (15 Years and Older):	0
Coronary Artery Bypass Grafts (CABGs) performed of total Cardiac Cases :	0

Outpatient Service Data

Total Outpatient Visits	**34,288**
Outpatient Visits at the Hospital/ Campus:	**34,288**
Outpatient Visits Offsite/off campus	0

Diagnostic/Interventional Equipment

	Own	Contract	Examinations Inpatient	Examinations Outpt	Examinations Contract
General Radiography/Fluoroscopy	8	0	2,674	7,422	0
Nuclear Medicine	0	1	91	281	0
Mammography	1	0	0	1,915	0
Ultrasound	2	0	737	1,814	0
Angiography	0	0			
Diagnostic Angiography			0	0	0
Interventional Angiography			0	0	0
Positron Emission Tomography (PET)	0	0	0	0	0
Computerized Axial Tomography (CAT)	1	0	1,752	3,100	0
Magnetic Resonance Imaging	0	1	6	260	0

Radiation Equipment

	Owned	Contract	Therapies Treatments
Lithotripsy	0	0	0
Linear Accelerator	0	0	0
Image Guided Rad Therapy	0	0	0
Intensity Modulated Rad Thrpy	0	0	0
High Dose Brachytherapy	0	0	0
Proton Beam Therapy	0	0	0
Gamma Knife	0	0	0
Cyber knife	0	0	0

ATTACHMENT 19C

Source: 2010 Annual Hospital Questionnaire, Illinois Department of Public Health, Health Systems Development.

Ownership, Management and General Information

ADMINISTRATOR NAME:	Earl Tamar
ADMINSTRATOR PHONE	(309) 345-4567
OWNERSHIP:	Galesburg Hospital Corporation
OPERATOR:	Galesburg Cottage Hospital
MANAGEMENT:	For Profit Corporation
CERTIFICATION:	
FACILITY DESIGNATION:	General Hospital
ADDRESS	695 North Kellogg Street CITY: Galesburg COUNTY: Knox County

Patients by Race

White	92.0%
Black	5.5%
American Indian	0.0%
Asian	0.1%
Hawaiian/ Pacific	0.0%
Unknown:	2.4%

Patients by Ethnicity

Hispanic or Latino:	1.6%
Not Hispanic or Latino:	98.1%
Unknown:	0.2%

IDPH Number:	0794
HPA	C-03
HSA	2

Facility Utilization Data by Category of Service

Clinical Service	Authorized CON Beds 12/31/2010	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy 12/31/2010	Staff Bed Occupancy Rate %
Medical/Surgical	87	85	54	2,519	12,130	0	4.8	33.2	38.2	39.1
0-14 Years				*0*	*0*					
15-44 Years				*249*	*985*					
45-64 Years				*645*	*3,197*					
65-74 Years				*518*	*2,397*					
75 Years +				*1,107*	*5,551*					
Pediatric	18	18	5	86	192	0	2.2	0.5	2.9	2.9
Intensive Care	12	12	12	661	2,398	0	3.6	6.6	54.7	54.7
Direct Admission				*661*	*2,398*					
Transfers				*0*	*0*					
Obstetric/Gynecology	10	10	8	410	987	0	2.4	2.7	27.0	27.0
Maternity				*396*	*945*					
Clean Gynecology				*14*	*42*					
Neonatal	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long Term Care	34	34	33	670	8,344	0	12.5	22.9	67.2	67.2
Swing Beds				0	0		0.0	0.0		
Acute Mental Illness	12	12	12	263	2,945	0	11.2	8.1	67.2	67.2
Rehabilitation	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long-Term Acute Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Dedcated Observation	*0*					*0*				
Facility Utilization	173			4,609	26,996	0	5.9	74.0	42.752	

(Includes ICU Direct Admissions Only)

Inpatients and Outpatients Served by Payor Source

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Totals
	64.8%	12.8%	0.7%	18.6%	2.4%	0.6%	
Inpatients	2987	591	31	859	112	29	4,609
	40.1%	23.0%	1.8%	29.3%	5.7%	0.2%	
Outpatients	27554	15779	1232	20151	3917	108	66,741

Financial Year Reported: 1/1/2010 *to* 12/31/2010

Inpatient and Outpatient Net Revenue by Payor Source

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Totals	Charity Care Expense
Inpatient Revenue ($)	46.7%	20.7%	1.8%	26.5%	4.3%	100.0%	
	17,744,592	7,877,193	667,214	10,051,645	1,622,689	37,963,333	156,080
Outpatient Revenue ($)	25.4%	1.0%	3.5%	56.0%	14.1%	100.0%	
	9,345,852	359,721	1,287,598	20,638,120	5,191,501	36,822,792	63,020

Total Charity Care Expense 219,100

Totals: Charity Care as % of Net Revenue 0.3%

Birthing Data

Number of Total Births:	393
Number of Live Births:	391
Birthing Rooms:	0
Labor Rooms:	0
Delivery Rooms:	0
Labor-Delivery-Recovery Rooms:	0
Labor-Delivery-Recovery-Postpartum Rooms:	10
C-Section Rooms:	1
CSections Performed:	86

Newborn Nursery Utilization

Level 1 Patient Days	723
Level 2 Patient Days	35
Level 2+ Patient Days	8
Total Nursery Patientdays	766

Laboratory Studies

Inpatient Studies	123,664
Outpatient Studies	170,902
Studies Performed Under Contract	23,602

Organ Transplantation

Kidney:	0
Heart:	0
Lung:	0
Heart/Lung:	0
Pancreas:	0
Liver:	0
Total:	0

ATTACHMENT 19C

Surgery and Operating Room Utilization

Surgical Specialty	Operating Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Cardiovascular	0	0	0	0	12	0	36	0	36	3.0	0.0
Dermatology	0	0	0	0	0	0	0	0	0	0.0	0.0
General	0	0	5	5	1191	4718	2084	8257	10341	1.7	1.8
Gastroenterology	0	0	1	1	362	1087	400	1150	1550	1.1	1.1
Neurology	0	0	0	0	0	0	0	0	0	0.0	0.0
OB/Gynecology	0	0	0	0	140	337	280	674	954	2.0	2.0
Oral/Maxillofacial	0	0	0	0	3	4	6	8	14	2.0	2.0
Ophthalmology	0	0	0	0	0	465	0	465	465	0.0	1.0
Orthopedic	0	0	0	0	137	639	345	977	1322	2.5	1.5
Otolaryngology	0	0	0	0	0	243	0	243	243	0.0	1.0
Plastic Surgery	0	0	0	0	0	0	0	0	0	0.0	0.0
Podiatry	0	0	0	0	0	21	0	37	37	0.0	1.8
Thoracic	0	0	0	0	13	3	26	6	32	2.0	2.0
Urology	0	0	1	1	72	215	144	430	574	2.0	2.0
Totals	**0**	**0**	**7**	**7**	**1930**	**7732**	**3321**	**12247**	**15568**	**1.7**	**1.6**

SURGICAL RECOVERY STATIONS Stage 1 Recovery Stations 5 Stage 2 Recovery Stations 12

Dedicated and Non-Dedicated Procedure Room Utilization

Procedure Type	Procedure Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Gastrointestinal	0	0	1	1	362	1087	400	1150	1550	1.1	1.1
Laser Eye Procedures	0	0	0	0	0	0	0	0	0	0.0	0.0
Pain Management	0	0	1	1	0	1025	0	1025	1025	0.0	1.0
Cystoscopy	0	0	1	1	72	215	144	430	574	2.0	2.0
Multipurpose Non-Dedicated Rooms											
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0

Cardiac Catheterization Labs

Total Cath Labs (Dedicated+Nondedicated labs):	**0**
Cath Labs used for Angiography procedures	0
Dedicated Diagnostic Catheterization Labs	0
Dedicated Interventional Catheterization Labs	0
Dedicated EP Catheterization Labs	0

Emergency/Trauma Care

Certified Trauma Center		Yes
Level of Trauma Service	**Level 1** Not Applicable	**Level 2** Adult
Operating Rooms Dedicated for Trauma Care		1
Number of Trauma Visits:		46
Patients Admitted from Trauma		12
Emergency Service Type:		Comprehensive
Number of Emergency Room Stations		12
Persons Treated by Emergency Services:		13,695
Patients Admitted from Emergency:		2,287
Total ED Visits (Emergency+Trauma):		**13,741**

Cardiac Catheterization Utilization

Total Cardiac Cath Procedures:	**0**
Diagnostic Catheterizations (0-14)	0
Diagnostic Catheterizations (15+)	0
Interventional Catheterizations (0-14):	0
Interventional Catheterization (15+)	0
EP Catheterizations (15+)	0

Cardiac Surgery Data

Total Cardiac Surgery Cases:	**0**
Pediatric (0 - 14 Years):	0
Adult (15 Years and Older):	0
Coronary Artery Bypass Grafts (CABGs) performed of total Cardiac Cases :	0

Outpatient Service Data

Total Outpatient Visits	**68,633**
Outpatient Visits at the Hospital/ Campus:	68,633
Outpatient Visits Offsite/off campus	0

Diagnostic/Interventional Equipment

	Own	Contract	Examinations Inpatient	Examinations Outpt	Examinations Contract
General Radiography/Fluoroscopy	4	0	7,401	13,747	0
Nuclear Medicine	1	0	143	644	0
Mammography	1	0	0	2,671	0
Ultrasound	2	0	289	1,713	0
Angiography	1	0			
Diagnostic Angiography			5	15	0
Interventional Angiography			5	135	0
Positron Emission Tomography (PET)	0	1	0	0	83
Computerized Axial Tomography (CAT)	1	0	1,997	4,009	0
Magnetic Resonance Imaging	1	0	98	1,292	0

Radiation Equipment

	Owned	Contract	Therapies Treatments
Lithotripsy	0	1	30
Linear Accelerator	0	0	0
Image Guided Rad Therapy	0	0	0
Intensity Modulated Rad Thrpy	0	0	0
High Dose Brachytherapy	0	0	0
Proton Beam Therapy	0	0	0
Gamma Knife	0	0	0
Cyber knife	0	0	0

ATTACHMENT 19C

Source: 2010 Annual Hospital Questionnaire, Illinois Department of Public Health, Health Systems Development.

GG

Ownership, Management and General Information

ADMINISTRATOR NAME:	Mark Bethell
ADMINSTRATOR PHONE	618-798-3175
OWNERSHIP:	Granite city Illinois Hospital Co.
OPERATOR:	Granite City Illinois Hospital Co.
MANAGEMENT:	For Profit Corporation
CERTIFICATION:	
FACILITY DESIGNATION:	General Hospital
ADDRESS	2100 Madison Avenue

CITY: Granite City COUNTY: Madison County

Patients by Race

White	80.2%
Black	17.5%
American Indian	0.1%
Asian	0.2%
Hawaiian/ Pacific	0.3%
Unknown:	1.7%

Patients by Ethnicity

Hispanic or Latino:	1.2%
Not Hispanic or Latino:	98.3%
Unknown:	0.5%

IDPH Number:	5223
HPA	F-01
HSA	11

Facility Utilization Data by Category of Service

Clinical Service	Authorized CON Beds 12/31/2010	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy 12/31/2010	Staff Bed Occupancy Rate %
Medical/Surgical	167	165	66	3,920	15,310	887	4.1	44.4	26.6	26.9
0-14 Years				*15*	*104*					
15-44 Years				*652*	*1,789*					
45-64 Years				*1,348*	*4,796*					
65-74 Years				*637*	*2,515*					
75 Years +				*1,268*	*6,106*					
Pediatric	28	0	0	0	0	0	0.0	0.0	0.0	0.0
Intensive Care	12	11	10	403	1,587	11	4.0	4.4	36.5	39.8
Direct Admission				*180*	*802*					
Transfers				*223*	*785*					
Obstetric/Gynecology	27	27	11	358	918	83	2.8	2.7	10.2	10.2
Maternity				*255*	*703*					
Clean Gynecology				*103*	*215*					
Neonatal	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long Term Care	19	19	18	285	3,441	0	12.1	9.4	49.6	49.6
Swing Beds				0	0		0.0	0.0		
Acute Mental Illness	100	100	100	3,282	20,487	0	6.2	56.1	56.1	56.1
Rehabilitation	14	14	8	95	1,154	0	12.1	3.2	22.6	22.6
Long-Term Acute Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Dedcated Observation	*0*					*0*				
Facility Utilization	367			8,120	42,897	981	5.4	120.2	32.756	

(Includes ICU Direct Admissions Only)

Inpatients and Outpatients Served by Payor Source

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Totals
	34.9%	28.3%	12.6%	15.3%	0.0%	8.9%	
Inpatients	2832	2302	1024	1242	0	720	8,120
	20.9%	35.9%	9.9%	31.7%	0.0%	1.6%	
Outpatients	12361	21259	5838	18772	0	955	59,185

Financial Year Reported: 1/1/2010 *to* 12/31/2010

Inpatient and Outpatient Net Revenue by Payor Source

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Totals	Charity Care Expense
Inpatient Revenue ($)	27.0%	38.6%	6.6%	19.1%	8.7%	100.0%	
	19,770,670	28,249,060	4,803,164	14,018,518	6,363,754	73,205,166	2,856,611
Outpatient Revenue ($)	17.0%	8.6%	2.5%	46.1%	25.8%	100.0%	
	4,532,903	2,302,799	655,152	12,316,786	6,898,870	26,706,510	808,527

Total Charity Care Expense
3,665,138

Totals: Charity Care as % of Net Revenue
3.7%

Birthing Data

Number of Total Births:	270
Number of Live Births:	270
Birthing Rooms:	0
Labor Rooms:	0
Delivery Rooms:	0
Labor-Delivery-Recovery Rooms:	0
Labor-Delivery-Recovery-Postpartum Rooms:	4
C-Section Rooms:	0
CSections Performed:	128

Newborn Nursery Utilization

Level 1 Patient Days	588
Level 2 Patient Days	0
Level 2+ Patient Days	0
Total Nursery Patientdays	588

Laboratory Studies

Inpatient Studies	210,286
Outpatient Studies	124,665
Studies Performed Under Contract	5,534

Organ Transplantation

Kidney:	0
Heart:	0
Lung:	0
Heart/Lung:	0
Pancreas:	0
Liver:	0
Total:	0

* Note: According to Board action approved on 10/26/10, Board reduced voluntarily 14 M/S and 1 OB bed.

ATTACHMENT 19C

Surgery and Operating Room Utilization

Surgical Specialty	Operating Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Cardiovascular	0	0	0	0	11	41	14	49	63	1.3	1.2
Dermatology	0	0	0	0	0	0	0	0	0	0.0	0.0
General	0	0	9	9	222	311	427	412	839	1.9	1.3
Gastroenterology	0	0	0	0	0	0	0	0	0	0.0	0.0
Neurology	0	0	0	0	1	4	2	7	9	2.0	1.8
OB/Gynecology	0	0	0	0	73	426	124	390	514	1.7	0.9
Oral/Maxillofacial	0	0	0	0	0	0	0	0	0	0.0	0.0
Ophthalmology	0	0	0	0	0	0	0	0	0	0.0	0.0
Orthopedic	0	0	0	0	265	210	680	318	998	2.6	1.5
Otolaryngology	0	0	0	0	1	392	1	195	196	1.0	0.5
Plastic Surgery	0	0	0	0	7	1	9	2	11	1.3	2.0
Podiatry	0	0	0	0	0	1	0	1	1	0.0	1.0
Thoracic	0	0	0	0	33	7	111	12	123	3.4	1.7
Urology	0	0	0	0	44	94	42	81	123	1.0	0.9
Totals	**0**	**0**	**9**	**9**	**657**	**1487**	**1410**	**1467**	**2877**	**2.1**	**1.0**

SURGICAL RECOVERY STATIONS Stage 1 Recovery Stations 11 Stage 2 Recovery Stations 24

Dedicated and Non-Dedicated Procedure Room Utilization

Procedure Type	Procedure Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Gastrointestinal	0	0	3	3	464	1256	497	1355	1852	1.1	1.1
Laser Eye Procedures	0	0	0	0	0	0	0	0	0	0.0	0.0
Pain Management	0	0	1	1	5	169	1	55	56	0.2	0.3
Cystoscopy	0	0	0	**0**	0	0	0	0	0	0.0	0.0
Multipurpose Non-Dedicated Rooms											
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0

Cardiac Catheterization Labs

Total Cath Labs (Dedicated+Nondedicated labs):	**1**
Cath Labs used for Angiography procedures	0
Dedicated Diagnostic Catheterization Labs	0
Dedicated Interventional Catheterization Labs	0
Dedicated EP Catheterization Labs	0

Emergency/Trauma Care

Certified Trauma Center		No
Level of Trauma Service	**Level 1**	**Level 2**
	Not Applicable	Not Applicable
Operating Rooms Dedicated for Trauma Care		0
Number of Trauma Visits:		0
Patients Admitted from Trauma		0
Emergency Service Type:		Comprehensive
Number of Emergency Room Stations		17
Persons Treated by Emergency Services:		20,516
Patients Admitted from Emergency:		4,742
Total ED Visits (Emergency+Trauma):		**20,516**

Cardiac Catheterization Utilization

Total Cardiac Cath Procedures:	**412**
Diagnostic Catheterizations (0-14)	0
Diagnostic Catheterizations (15+)	398
Interventional Catheterizations (0-14):	0
Interventional Catheterization (15+)	14
EP Catheterizations (15+)	0

Cardiac Surgery Data

Total Cardiac Surgery Cases:	**0**
Pediatric (0 - 14 Years):	0
Adult (15 Years and Older):	0
Coronary Artery Bypass Grafts (CABGs) performed of total Cardiac Cases :	0

Outpatient Service Data

Total Outpatient Visits	**59,185**
Outpatient Visits at the Hospital/ Campus:	59,185
Outpatient Visits Offsite/off campus	0

Diagnostic/Interventional Equipment

	Own	Contract	Examinations Inpatient	Examinations Outpt	Examinations Contract
General Radiography/Fluoroscopy	1	0	7,367	14,250	0
Nuclear Medicine	1	0	344	474	0
Mammography	2	0	1	2,208	0
Ultrasound	3	0	690	2,366	0
Angiography	1	0			
Diagnostic Angiography			19	67	0
Interventional Angiography			0	0	0
Positron Emission Tomography (PET)	0	0	0	0	0
Computerized Axial Tomography (CAT)	3	0	3,052	6,203	0
Magnetic Resonance Imaging	2	0	244	1,378	0

Radiation Equipment

	Owned	Contract	Therapeutic Treatments
Lithotripsy	0	1	10
Linear Accelerator	0	0	0
Image Guided Rad Therapy	0	0	0
Intensity Modulated Rad Thrpy	0	0	0
High Dose Brachytherapy	0	0	0
Proton Beam Therapy	0	0	0
Gamma Knife	0	0	0
Cyber knife	0	0	0

ATTACHMENT 19C

Source: 2010 Annual Hospital Questionnaire, Illinois Department of Public Health, Health Systems Development.

Ownership, Management and General Information

ADMINISTRATOR NAME:	Phil Dionne
ADMINSTRATOR PHONE	618-998-7021
OWNERSHIP:	Marion Hospital Corporation
OPERATOR:	Marion Hospital Corporation
MANAGEMENT:	For Profit Corporation
CERTIFICATION:	LongTerm Acute Care Hospital (LTACH)
FACILITY DESIGNATION:	General Hospital
ADDRESS	3333 West Deyoung
CITY:	Marion
COUNTY:	Williamson County

Patients by Race

White	93.0%
Black	4.7%
American Indian	0.1%
Asian	0.2%
Hawaiian/ Pacific	0.0%
Unknown:	1.9%

Patients by Ethnicity

Hispanic or Latino:	0.7%
Not Hispanic or Latino:	98.9%
Unknown:	0.5%

IDPH Number:	4739
HPA	F-06
HSA	5

Facility Utilization Data by Category of Service

Clinical Service	Authorized CON Beds 12/31/2010	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy 12/31/2010	Staff Bed Occupancy Rate %
Medical/Surgical	68	68	68	4,817	13,984	381	3.0	39.4	57.9	57.9
0-14 Years				*170*	*256*					
15-44 Years				*1,526*	*2,720*					
45-64 Years				*1,171*	*3,740*					
65-74 Years				*725*	*2,484*					
75 Years +				*1,225*	*4,784*					
Pediatric	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Intensive Care	12	12	12	1,091	4,152	0	3.8	11.4	94.8	94.8
Direct Admission				*257*	*1,984*					
Transfers				*834*	*2,168*					
Obstetric/Gynecology	12	12	12	1,028	2,422	40	2.4	6.7	56.2	56.2
Maternity				*1,028*	*2,422*					
Clean Gynecology				*0*	*0*					
Neonatal	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long Term Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Swing Beds				40	217		5.4	0.6		
Acute Mental Illness	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Rehabilitation	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long-Term Acute Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Dedcated Observation	*0*					*0*				
Facility Utilization	**92**			**6,142**	**20,775**	**421**	**3.5**	**58.1**	**63.121**	

(Includes ICU Direct Admissions Only)

Inpatients and Outpatients Served by Payor Source

	Medicare	*Medicaid*	*Other Public*	*Private Insurance*	*Private Pay*	*Charity Care*	*Totals*
	42.2%	**25.2%**	**6.1%**	**18.3%**	**7.3%**	**0.9%**	
Inpatients	2589	1547	377	1123	448	58	6,142
	41.0%	**22.9%**	**1.9%**	**28.9%**	**5.1%**	**0.1%**	
Outpatients	24182	13524	1127	17062	3021	49	58,965

Financial Year Reported: 1/1/2010 *to* 12/31/2010

Inpatient and Outpatient Net Revenue by Payor Source

	Medicare	*Medicaid*	*Other Public*	*Private Insurance*	*Private Pay*	*Totals*	*Charity Care Expense*
Inpatient Revenue ($)	**30.8%**	**15.8%**	**15.7%**	**24.8%**	**13.0%**	**100.0%**	
	18,424,739	9,451,809	9,377,179	14,875,576	7,781,077	59,910,380	325,413
Outpatient Revenue ($)	**13.5%**	**0.1%**	**10.5%**	**65.6%**	**10.3%**	**100.0%**	
	5,868,646	39,565	4,593,824	28,610,388	4,492,484	43,604,907	57,170

Total Charity Care Expense
382,583
Totals: Charity Care as % of Net Revenue
0.4%

Birthing Data

Number of Total Births:	948
Number of Live Births:	946
Birthing Rooms:	0
Labor Rooms:	0
Delivery Rooms:	0
Labor-Delivery-Recovery Rooms:	5
Labor-Delivery-Recovery-Postpartum Rooms:	0
C-Section Rooms:	1
CSections Performed:	272

Newborn Nursery Utilization

Level 1 Patient Days	1,383
Level 2 Patient Days	431
Level 2+ Patient Days	40
Total Nursery Patientdays	**1,854**

Laboratory Studies

Inpatient Studies	188,127
Outpatient Studies	165,467
Studies Performed Under Contract	8,589

Organ Transplantation

Kidney:	0
Heart:	0
Lung:	0
Heart/Lung:	0
Pancreas:	0
Liver:	0
Total:	0

ATTACHMENT 19C

Surgery and Operating Room Utilization

Surgical Specialty	Operating Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Cardiovascular	0	0	1	1	158	27	453	52	505	2.9	1.9
Dermatology	0	0	0	0	0	0	0	0	0	0.0	0.0
General	0	0	4	4	341	240	555	296	851	1.6	1.2
Gastroenterology	0	0	0	0	0	0	0	0	0	0.0	0.0
Neurology	0	0	0	0	0	0	0	0	0	0.0	0.0
OB/Gynecology	0	0	0	0	547	252	1000	295	1295	1.8	1.2
Oral/Maxillofacial	0	0	0	0	0	11	0	18	18	0.0	1.6
Ophthalmology	0	0	0	0	0	3	0	4	4	0.0	1.3
Orthopedic	0	0	0	0	395	168	941	309	1250	2.4	1.8
Otolaryngology	0	0	0	0	8	525	11	256	267	1.4	0.5
Plastic Surgery	0	0	0	0	11	91	35	156	191	3.2	1.7
Podiatry	0	0	0	0	32	33	62	87	149	1.9	2.6
Thoracic	0	0	0	0	53	13	142	19	161	2.7	1.5
Urology	0	0	0	0	142	336	110	395	505	0.8	1.2
Totals	**0**	**0**	**5**	**5**	**1687**	**1699**	**3309**	**1887**	**5196**	**2.0**	**1.1**

SURGICAL RECOVERY STATIONS Stage 1 Recovery Stations 10 Stage 2 Recovery Stations 26

Dedicated and Non-Dedicated Procedure Room Utilization

Procedure Type	Procedure Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
GastroIntestinal	0	0	2	2	240	255	133	130	263	0.6	0.5
Laser Eye Procedures	0	0	0	0	0	0	0	0	0	0.0	0.0
Pain Management	0	0	1	1	0	195	0	87	87	0.0	0.4
Cystoscopy	0	0	1	1	6	2	1	1	2	0.2	0.5
Multipurpose Non-Dedicated Rooms											
Minor Procedures	0	0	1	1	104	36	58	18	76	0.6	0.5
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0

Cardiac Catheterization Labs

Total Cath Labs (Dedicated+Nondedicated labs):	**2**
Cath Labs used for Angiography procedures	0
Dedicated Diagnostic Catheterization Labs	0
Dedicated Interventional Catheterization Labs	0
Dedicated EP Catheterization Labs	0

Emergency/Trauma Care

Certified Trauma Center		No
Level of Trauma Service	**Level 1**	**Level 2**
	Not Applicable	Not Applicable
Operating Rooms Dedicated for Trauma Care		0
Number of Trauma Visits:		0
Patients Admitted from Trauma		0
Emergency Service Type:		Comprehensive
Number of Emergency Room Stations		12
Persons Treated by Emergency Services:		16,546
Patients Admitted from Emergency:		3,225
Total ED Visits (Emergency+Trauma):		**16,546**

Cardiac Catheterization Utilization

Total Cardiac Cath Procedures:	**426**
Diagnostic Catheterizations (0-14)	0
Diagnostic Catheterizations (15+)	304
Interventional Catheterizations (0-14):	0
Interventional Catheterization (15+)	122
EP Catheterizations (15+)	0

Cardiac Surgery Data

Total Cardiac Surgery Cases:	**29**
Pediatric (0 - 14 Years):	0
Adult (15 Years and Older):	29
Coronary Artery Bypass Grafts (CABGs) performed of total Cardiac Cases :	24

Outpatient Service Data

Total Outpatient Visits	**58,965**
Outpatient Visits at the Hospital/ Campus:	58,965
Outpatient Visits Offsite/off campus	0

Diagnostic/Interventional Equipment

	Own	Contract	Examinations Inpatient	Examinations Outpt	Examinations Contract
General Radiography/Fluoroscopy	3	0	8,162	15,251	0
Nuclear Medicine	2	0	674	921	0
Mammography	1	0	0	2,390	0
Ultrasound	2	0	1,280	2,529	0
Angiography	0	0			
Diagnostic Angiography			0	0	0
Interventional Angiography			0	0	0
Positron Emission Tomography (PET)	0	0	0	0	0
Computerized Axial Tomography (CAT)	2	0	3,214	4,774	0
Magnetic Resonance Imaging	1	0	165	1,085	0

Radiation Equipment

	Owned	Contract	Therapies Treatments
Lithotripsy	0	1	77
Linear Accelerator	0	0	0
Image Guided Rad Therapy	0	0	0
Intensity Modulated Rad Thrpy	0	0	0
High Dose Brachytherapy	0	0	0
Proton Beam Therapy	0	0	0
Gamma Knife	0	0	0
Cyber knife	0	0	0

ATTACHMENT 19C

Source: 2010 Annual Hospital Questionnaire, Illinois Department of Public Health, Health Systems Development.

Ownership, Management and General Information

ADMINISTRATOR NAME:	Shane Watson
ADMINSTRATOR PHONE	618-282-5107
OWNERSHIP:	Community Health Systems
OPERATOR:	Red Bud Illinois Hospital Company, LLC
MANAGEMENT:	Limited Liability Company
CERTIFICATION:	Critical Access Hospital
FACILITY DESIGNATION:	
ADDRESS	325 Spring Street

CITY: Red Bud COUNTY: Randolph County

Patients by Race

White	99.8%
Black	0.2%
American Indian	0.0%
Asian	0.0%
Hawaiian/ Pacific	0.0%
Unknown:	0.0%

Patients by Ethnicity

Hispanic or Latino:	0.2%
Not Hispanic or Latino:	99.8%
Unknown:	0.0%

IDPH Number:	5199
HPA	F-07
HSA	5

Facility Utilization Data by Category of Service

Clinical Service	Authorized CON Beds 12/31/2010	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy 12/31/2010	Staff Bed Occupancy Rate %
Medical/Surgical	25	25	25	891	3,025	105	3.5	8.6	34.3	34.3
0-14 Years				*6*	*9*					
15-44 Years				*118*	*234*					
45-64 Years				*158*	*472*					
65-74 Years				*128*	*368*					
75 Years +				*481*	*1,942*					
Pediatric	2	0	0	0	0	0	0.0	0.0	0.0	0.0
Intensive Care	3	0	0	0	0	0	0.0	0.0	0.0	0.0
Direct Admission				*0*	*0*					
Transfers				*0*	*0*					
Obstetric/Gynecology	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Maternity				*0*	*0*					
Clean Gynecology				*0*	*0*					
Neonatal	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long Term Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Swing Beds				297	3,327		11.2	9.1		
Acute Mental Illness	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Rehabilitation	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long-Term Acute Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Dedcated Observation	*0*					*0*				
Facility Utilization	30			1,188	6,352	105	5.4	17.7	58.988	

(Includes ICU Direct Admissions Only)

Inpatients and Outpatients Served by Payor Source

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Totals
	76.1%	6.5%	0.4%	15.5%	1.1%	0.4%	
Inpatients	904	77	5	184	13	5	1,188
	47.6%	11.0%	0.8%	38.2%	2.3%	0.2%	
Outpatients	8201	1898	130	6591	390	28	17,238

Financial Year Reported: 1/1/2010 *to* 12/31/2010

Inpatient and Outpatient Net Revenue by Payor Source

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Totals	Charity Care Expense
Inpatient Revenue ($)	66.1%	11.4%	2.4%	18.5%	1.6%	100.0%	
	5,284,228	910,885	190,198	1,479,665	126,476	7,991,452	143,626
Outpatient Revenue ($)	23.1%	1.9%	6.7%	65.7%	2.6%	100.0%	
	2,924,730	240,116	849,998	8,327,718	331,301	12,673,863	133,065

Total Charity Care Expense
276,691
Totals: Charity Care as % of Net Revenue
1.3%

Birthing Data

Number of Total Births:	0
Number of Live Births:	0
Birthing Rooms:	0
Labor Rooms:	0
Delivery Rooms:	0
Labor-Delivery-Recovery Rooms:	0
Labor-Delivery-Recovery-Postpartum Rooms:	0
C-Section Rooms:	0
CSections Performed:	0

Newborn Nursery Utilization

Level 1 Patient Days	0
Level 2 Patient Days	0
Level 2+ Patient Days	0
Total Nursery Patientdays	0

Laboratory Studies

Inpatient Studies	21,990
Outpatient Studies	54,365
Studies Performed Under Contract	6,382

Organ Transplantation

Kidney:	0
Heart:	0
Lung:	0
Heart/Lung:	0
Pancreas:	0
Liver:	0
Total:	0

ATTACHMENT 19C

Surgery and Operating Room Utilization

Surgical Specialty	Operating Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Cardiovascular	0	0	0	0	0	0	0	0	0	0.0	0.0
Dermatology	0	0	0	0	0	0	0	0	0	0.0	0.0
General	0	0	2	2	58	164	115	193	308	2.0	1.2
Gastroenterology	0	0	0	0	0	0	0	0	0	0.0	0.0
Neurology	0	0	0	0	0	0	0	0	0	0.0	0.0
OB/Gynecology	0	0	0	0	44	140	126	251	377	2.9	1.8
Oral/Maxillofacial	0	0	0	0	0	0	0	0	0	0.0	0.0
Ophthalmology	0	0	0	0	0	0	0	0	0	0.0	0.0
Orthopedic	0	0	0	0	1	2	2	4	6	2.0	2.0
Otolaryngology	0	0	0	0	0	71	0	70	70	0.0	1.0
Plastic Surgery	0	0	0	0	0	38	0	48	48	0.0	1.3
Podiatry	0	0	0	0	2	7	4	10	14	2.0	1.4
Thoracic	0	0	0	0	0	0	0	0	0	0.0	0.0
Urology	0	0	0	0	0	0	0	0	0	0.0	0.0
Totals	**0**	**0**	**2**	**2**	**105**	**422**	**247**	**576**	**823**	**2.4**	**1.4**

SURGICAL RECOVERY STATIONS Stage 1 Recovery Stations 3 Stage 2 Recovery Stations 3

Dedicated and Non-Dedicated Procedure Room Utilization

Procedure Type	Procedure Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Gastrointestinal	0	0	1	1	41	779	23	433	456	0.6	0.6
Laser Eye Procedures	0	0	0	0	0	0	0	0	0	0.0	0.0
Pain Management	0	0	1	1	0	237	0	107	107	0.0	0.5
Cystoscopy	0	0	0	0	0	0	0	0	0	0.0	0.0
Multipurpose Non-Dedicated Rooms											
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0

Cardiac Catheterization Labs

Total Cath Labs (Dedicated+Nondedicated labs):	0
Cath Labs used for Angiography procedures	0
Dedicated Diagnostic Catheterization Labs	0
Dedicated Interventional Catheterization Labs	0
Dedicated EP Catheterization Labs	0

Emergency/Trauma Care

Certified Trauma Center		No
Level of Trauma Service	**Level 1**	**Level 2**
	Not Applicable	Not Applicable
Operating Rooms Dedicated for Trauma Care		0
Number of Trauma Visits:		0
Patients Admitted from Trauma		0
Emergency Service Type:		Basic
Number of Emergency Room Stations		5
Persons Treated by Emergency Services:		4,603
Patients Admitted from Emergency:		691
Total ED Visits (Emergency+Trauma):		**4,603**

Cardiac Catheterization Utilization

Total Cardiac Cath Procedures:	0
Diagnostic Catheterizations (0-14)	0
Diagnostic Catheterizations (15+)	0
Interventional Catheterizations (0-14):	0
Interventional Catheterization (15+)	0
EP Catheterizations (15+)	0

Cardiac Surgery Data

Total Cardiac Surgery Cases:	0
Pediatric (0 - 14 Years):	0
Adult (15 Years and Older):	0
Coronary Artery Bypass Grafts (CABGs) performed of total Cardiac Cases :	0

Outpatient Service Data

Total Outpatient Visits	**26,075**
Outpatient Visits at the Hospital/ Campus:	26,075
Outpatient Visits Offsite/off campus	0

Diagnostic/Interventional Equipment

	Own	Contract	Examinations Inpatient	Examinations Outpt	Examinations Contract
General Radiography/Fluoroscopy	2	0	962	7,040	0
Nuclear Medicine	0	1	0	0	331
Mammography	1	0	0	1,538	0
Ultrasound	2	0	249	1,743	0
Angiography	0	0			
Diagnostic Angiography			0	0	0
Interventional Angiography			0	0	0
Positron Emission Tomography (PET)	0	0	0	0	0
Computerized Axial Tomography (CAT)	1	0	366	2,119	0
Magnetic Resonance Imaging	0	1	0	0	370

Radiation Equipment

	Owned	Contract	Therapies Treatments
Lithotripsy	0	0	0
Linear Accelerator	0	0	0
Image Guided Rad Therapy	0	0	0
Intensity Modulated Rad Thrpy	0	0	0
High Dose Brachytherapy	0	0	0
Proton Beam Therapy	0	0	0
Gamma Knife	0	0	0
Cyber knife	0	0	0

ATTACHMENT 19C

Source: 2010 Annual Hospital Questionnaire, Illinois Department of Public Health, Health Systems Development.

Ownership, Management and General Information

ADMINISTRATOR NAME:	Jim Farris
ADMINSTRATOR PHONE	618-833-4511
OWNERSHIP:	Union County Hospital District
OPERATOR:	Community Health Systems, Inc.
MANAGEMENT:	For Profit Corporation
CERTIFICATION:	
FACILITY DESIGNATION:	
ADDRESS	517 North Main Street

CITY: Anna COUNTY: Union County

Patients by Race

White	94.9%
Black	4.8%
American Indian	0.1%
Asian	0.0%
Hawaiian/ Pacific	0.0%
Unknown:	0.2%

Patients by Ethnicity

Hispanic or Latino:	0.1%
Not Hispanic or Latino:	99.8%
Unknown:	0.1%

IDPH Number:	2824
HPA	F-07
HSA	5

Facility Utilization Data by Category of Service

Clinical Service	Authorized CON Beds 12/31/2010	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy 12/31/2010	Staff Bed Occupancy Rate %
Medical/Surgical	25	25	19	893	3,636	101	4.2	10.2	41.0	41.0
0-14 Years				*0*	*0*					
15-44 Years				*70*	*267*					
45-64 Years				*293*	*565*					
65-74 Years				*113*	*747*					
75 Years +				*417*	*2,057*					
Pediatric	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Intensive Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Direct Admission				*0*	*0*					
Transfers				*0*	*0*					
Obstetric/Gynecology	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Meternity				*0*	*0*					
Clean Gynecology				*0*	*0*					
Neonatal	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long Term Care	22	22	20	4	7,112	0	########	19.5	88.6	88.6
Swing Beds				0	0		0.0	0.0		
Acute Mental Illness	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Rehabilitation	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long-Term Acute Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Dedcated Observation	*0*					*0*				
Facility Utilization	**47**			**897**	**10,748**	**101**	**12.1**	**29.7**	**63.241**	

(Includes ICU Direct Admissions Only)

Inpatients and Outpatients Served by Payor Source

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Totals
	73.5%	**11.4%**	**1.8%**	**8.0%**	**4.6%**	**0.8%**	
Inpatients	659	102	16	72	41	7	897
	32.4%	**31.1%**	**1.0%**	**29.3%**	**6.3%**	**0.0%**	
Outpatients	10765	10344	319	9742	2081	16	33,267

Financial Year Reported: 1/1/2010 *to* 12/31/2010

Inpatient and Outpatient Net Revenue by Payor Source

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Totals	Charity Care Expense
Inpatient Revenue ($)	**42.3%** 3,471,470	**39.5%** 3,239,391	**1.1%** 90,291	**5.5%** 452,233	**11.6%** 951,075	**100.0%** 8,204,460	12,385
Outpatient Revenue ($)	**22.5%** 2,784,578	**7.2%** 886,155	**11.7%** 1,450,197	**42.3%** 5,224,593	**16.2%** 2,003,275	**100.0%** 12,348,798	16,996

Total Charity Care Expense **29,381**

Totals: Charity Care as % of Net Revenue **0.1%**

Birthing Data

Number of Total Births:	0
Number of Live Births:	0
Birthing Rooms:	0
Labor Rooms:	0
Delivery Rooms:	0
Labor-Delivery-Recovery Rooms:	0
Labor-Delivery-Recovery-Postpartum Rooms:	0
C-Section Rooms:	0
CSections Performed:	0

Newborn Nursery Utilization

Level 1 Patient Days	0
Level 2 Patient Days	0
Level 2+ Patient Days	0
Total Nursery Patientdays	0

Laboratory Studies

Inpatient Studies	16,641
Outpatient Studies	45,485
Studies Performed Under Contract	8,101

Organ Transplantation

Kidney:	0
Heart:	0
Lung:	0
Heart/Lung:	0
Pancreas:	0
Liver:	0
Total:	0

ATTACHMENT 19C

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Surgery and Operating Room Utilization

Surgical Specialty	Operating Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Cardiovascular	0	0	0	0	0	0	0	0	0	0.0	0.0
Dermatology	0	0	0	0	0	0	0	0	0	0.0	0.0
General	0	0	2	2	76	392	61	250	311	0.8	0.6
Gastroenterology	0	0	0	0	0	0	0	0	0	0.0	0.0
Neurology	0	0	0	0	0	0	0	0	0	0.0	0.0
OB/Gynecology	0	0	0	0	0	0	0	0	0	0.0	0.0
Oral/Maxillofacial	0	0	0	0	0	0	0	0	0	0.0	0.0
Ophthalmology	0	0	0	0	0	0	0	0	0	0.0	0.0
Orthopedic	0	0	0	0	0	0	0	0	0	0.0	0.0
Otolaryngology	0	0	0	0	0	0	0	0	0	0.0	0.0
Plastic Surgery	0	0	0	0	0	0	0	0	0	0.0	0.0
Podiatry	0	0	0	0	0	0	0	0	0	0.0	0.0
Thoracic	0	0	0	0	0	0	0	0	0	0.0	0.0
Urology	0	0	0	0	0	0	0	0	0	0.0	0.0
Totals	**0**	**0**	**2**	**2**	**76**	**392**	**61**	**250**	**311**	**0.8**	**0.6**

SURGICAL RECOVERY STATIONS Stage 1 Recovery Stations 4 Stage 2 Recovery Stations 0

Dedicated and Non-Dedicated Procedure Room Utilization

Procedure Type	Procedure Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
GastroIntestinal	0	0	0	0	0	0	0	0	0	0.0	0.0
Laser Eye Procedures	0	0	0	0	0	0	0	0	0	0.0	0.0
Pain Management	0	0	0	0	0	0	0	0	0	0.0	0.0
Cystoscopy	0	0	0	0	0	0	0	0	0	0.0	0.0
Multipurpose Non-Dedicated Rooms											
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0

Cardiac Catheterization Labs

Total Cath Labs (Dedicated+Nondedicated labs):	**0**
Cath Labs used for Angiography procedures	0
Dedicated Diagnostic Catheterization Labs	0
Dedicated Interventional Catheterization Labs	0
Dedicated EP Catheterization Labs	0

Emergency/Trauma Care

Certified Trauma Center		No
Level of Trauma Service	**Level 1**	**Level 2**
	Not Applicable	Not Applicable
Operating Rooms Dedicated for Trauma Care		0
Number of Trauma Visits:		0
Patients Admitted from Trauma		0
Emergency Service Type:		Comprehensive
Number of Emergency Room Stations		0
Persons Treated by Emergency Services:		8,707
Patients Admitted from Emergency:		838
Total ED Visits (Emergency+Trauma):		**8,707**

Cardiac Catheterization Utilization

Total Cardiac Cath Procedures:	0
Diagnostic Catheterizations (0-14)	0
Diagnostic Catheterizations (15+)	0
Interventional Catheterizations (0-14):	0
Interventional Catheterization (15+)	0
EP Catheterizations (15+)	0

Cardiac Surgery Data

Total Cardiac Surgery Cases:	**0**
Pediatric (0 - 14 Years):	0
Adult (15 Years and Older):	0
Coronary Artery Bypass Grafts (CABGs) performed of total Cardiac Cases :	0

Outpatient Service Data

Total Outpatient Visits	**33,267**
Outpatient Visits at the Hospital/ Campus:	33,267
Outpatient Visits Offsite/off campus	0

Diagnostic/Interventional Equipment

	Own	Contract	Examinations Inpatient	Examinations Outpt	Examinations Contract
General Radiography/Fluoroscopy	4	0	470	7,509	0
Nuclear Medicine	0	1	0	0	79
Mammography	1	0	3	905	0
Ultrasound	1	0	206	918	0
Angiography	0	0			
Diagnostic Angiography			0	0	0
Interventional Angiography			0	0	0
Positron Emission Tomography (PET)	0	0	0	0	0
Computerized Axial Tomography (CAT)	1	0	391	3,178	0
Magnetic Resonance Imaging	0	1	0	0	322

Radiation Equipment

	Owned	Contract	Therapeutic Treatments
Lithotripsy	0	0	0
Linear Accelerator	0	0	0
Image Guided Rad Therapy	0	0	0
Intensity Modulated Rad Thrpy	0	0	0
High Dose Brachytherapy	0	0	0
Proton Beam Therapy	0	0	0
Gamma Knife	0	0	0
Cyber knife	0	0	0

ATTACHMENT 19C

Source: 2010 Annual Hospital Questionnaire, Illinois Department of Public Health, Health Systems Development.

Ownership, Management and General Information

ADMINISTRATOR NAME:	Barbara Martin
ADMINSTRATOR PHONE	847-360-4001
OWNERSHIP:	Community Health Systems
OPERATOR:	Community Health Systems
MANAGEMENT:	For Profit Corporation
CERTIFICATION:	
FACILITY DESIGNATION:	General Hospital
ADDRESS	1324 North Sheridan Road

CITY: Waukegan COUNTY: Lake County

Patients by Race

White	70.3%
Black	27.0%
American Indian	0.2%
Asian	1.3%
Hawaiian/ Pacific	0.0%
Unknown:	1.1%

Patients by Ethnicity

Hispanic or Latino:	22.8%
Not Hispanic or Latino:	76.0%
Unknown:	1.1%

IDPH Number:	2857
HPA	A-09
HSA	8

Facility Utilization Data by Category of Service

Clinical Service	Authorized CON Beds 12/31/2010	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy 12/31/2010	Staff Bed Occupancy Rate %
Medical/Surgical	256	158	131	8,490	34,902	544	4.2	97.1	37.9	61.5
0-14 Years				*399*	*798*					
15-44 Years				*1,723*	*5,399*					
45-64 Years				*2,888*	*11,438*					
65-74 Years				*1,339*	*6,550*					
75 Years +				*2,141*	*10,717*					
Pediatric	35	0	0	0	0	0	0.0	0.0	0.0	0.0
Intensive Care	16	16	16	1,717	5,807	0	3.4	15.9	99.4	99.4
Direct Admission				*1,534*	*5,188*					
Transfers				*183*	*619*					
Obstetric/Gynecology	29	29	29	1,595	3,512	94	2.3	9.9	34.1	34.1
Maternity				*1,590*	*3,501*					
Clean Gynecology				*5*	*11*					
Neonatal	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long Term Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Swing Beds				0	0		0.0	0.0		
Acute Mental Illness	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Rehabilitation	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long-Term Acute Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Dedcated Observation	*0*					*0*				
Facility Utilization	**336**			11,619	44,221	**638**	**3.9**	**122.9**	**36.578**	

(Includes ICU Direct Admissions Only)

Inpatients and Outpatients Served by Payor Source

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Totals
	40.3%	**26.5%**	**0.0%**	**23.8%**	**6.8%**	**2.6%**	
Inpatients	4680	3084	0	2769	789	297	11,619
	26.6%	**29.7%**	**0.0%**	**37.6%**	**4.7%**	**1.5%**	
Outpatients	28933	32309	0	40890	5158	1589	108,679

Financial Year Reported: 1/1/2010 *to* 12/31/2010

Inpatient and Outpatient Net Revenue by Payor Source

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Totals	Charity Care Expense
Inpatient Revenue ($)	**37.4%** 40,645,026	**26.0%** 28,247,544	**0.0%** 0	**28.2%** 30,671,985	**8.4%** 9,185,532	**100.0%** 108,750,087	2,511,567
Outpatient Revenue ($)	**25.2%** 12,777,278	**12.5%** 6,357,375	**0.0%** 0	**48.6%** 24,673,552	**13.7%** 6,929,895	**100.0%** 50,738,100	1,148,524

Total Charity Care Expense 3,660,091

Totals: Charity Care as % of Net Revenue **2.3%**

Birthing Data

Number of Total Births:	1,537
Number of Live Births:	1,527
Birthing Rooms:	0
Labor Rooms:	7
Delivery Rooms:	1
Labor-Delivery-Recovery Rooms:	5
Labor-Delivery-Recovery-Postpartum Rooms:	0
C-Section Rooms:	2
CSections Performed:	495

Newborn Nursery Utilization

Level 1 Patient Days	2,767
Level 2 Patient Days	801
Level 2+ Patient Days	105
Total Nursery Patientdays	**3,673**

Laboratory Studies

Inpatient Studies	311,832
Outpatient Studies	144,765
Studies Performed Under Contract	0

Organ Transplantation

Kidney:	0
Heart:	0
Lung:	0
Heart/Lung:	0
Pancreas:	0
Liver:	0
Total:	**0**

ATTACHMENT 19C

Surgery and Operating Room Utilization

Surgical Specialty	Operating Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Cardiovascular	0	0	1	1	62	17	269	10	279	4.3	0.6
Dermatology	0	0	0	0	0	0	0	0	0	0.0	0.0
General	0	0	8	8	404	889	468	1052	1520	1.2	1.2
Gastroenterology	0	0	2	2	716	1579	349	790	1139	0.5	0.5
Neurology	0	0	0	0	51	181	90	383	473	1.8	2.1
OB/Gynecology	0	0	2	2	151	866	126	834	960	0.8	1.0
Oral/Maxillofacial	0	0	0	0	18	139	22	207	229	1.2	1.5
Ophthalmology	0	0	0	0	4	189	3	388	391	0.8	2.1
Orthopedic	0	0	0	0	208	1038	273	1459	1732	1.3	1.4
Otolaryngology	0	0	0	0	13	317	17	283	300	1.3	0.9
Plastic Surgery	0	0	0	0	2	4	3	4	7	1.5	1.0
Podiatry	0	0	0	0	15	56	15	81	96	1.0	1.4
Thoracic	0	0	0	0	248	55	294	51	345	1.2	0.9
Urology	0	0	1	1	132	318	101	296	397	0.8	0.9
Totals	**0**	**0**	**14**	**14**	**2024**	**5648**	**2030**	**5838**	**7868**	**1.0**	**1.0**

SURGICAL RECOVERY STATIONS Stage 1 Recovery Stations 15 Stage 2 Recovery Stations 16

Dedicated and Non-Dedicated Procedure Room Utilization

Procedure Type	Procedure Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Gastrointestinal	0	0	0	0	0	0	0	0	0	0.0	0.0
Laser Eye Procedures	0	0	0	0	0	0	0	0	0	0.0	0.0
Pain Management	0	0	0	0	0	0	0	0	0	0.0	0.0
Cystoscopy	0	0	0	0	0	0	0	0	0	0.0	0.0
Multipurpose Non-Dedicated Rooms											
Pain Mgmt	0	0	1	1	44	104	31	83	114	0.7	0.8
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0

Cardiac Catheterization Labs

Total Cath Labs (Dedicated+Nondedicated labs):	**3**
Cath Labs used for Angiography procedures	1
Dedicated Diagnostic Catheterization Labs	0
Dedicated Interventional Catheterization Labs	1
Dedicated EP Catheterization Labs	1

Emergency/Trauma Care

Certified Trauma Center		Yes
Level of Trauma Service	**Level 1**	**Level 2**
	Not Applicable	Adult
Operating Rooms Dedicated for Trauma Care		1
Number of Trauma Visits:		0
Patients Admitted from Trauma		0
Emergency Service Type:		Comprehensive
Number of Emergency Room Stations		31
Persons Treated by Emergency Services:		38,102
Patients Admitted from Emergency:		7,525
Total ED Visits (Emergency+Trauma):		**38,102**

Cardiac Catheterization Utilization

Total Cardiac Cath Procedures:	**1,022**
Diagnostic Catheterizations (0-14)	0
Diagnostic Catheterizations (15+)	685
Interventional Catheterizations (0-14):	0
Interventional Catheterization (15+)	164
EP Catheterizations (15+)	173

Cardiac Surgery Data

Total Cardiac Surgery Cases:	**61**
Pediatric (0 - 14 Years):	0
Adult (15 Years and Older):	61
Coronary Artery Bypass Grafts (CABGs) performed of total Cardiac Cases :	0

Outpatient Service Data

Total Outpatient Visits	**108,879**
Outpatient Visits at the Hospital/ Campus:	74,783
Outpatient Visits Offsite/off campus	34,096

Diagnostic/Interventional Equipment

	Own	Contract	Examinations Inpatient	Examinations Outpt	Examinations Contract
General Radiography/Fluoroscopy	19	0	16,211	25,319	0
Nuclear Medicine	8	0	1,152	1,055	0
Mammography	6	0	7	16,009	0
Ultrasound	11	0	2,299	10,468	0
Angiography	1	0			
Diagnostic Angiography			1	0	0
Interventional Angiography			861	643	0
Positron Emission Tomography (PET)	0	1	0	136	0
Computerized Axial Tomography (CAT)	5	0	7,329	13,466	0
Magnetic Resonance Imaging	5	0	1,065	4,203	0

Radiation Equipment

	Owned	Contract	Therapies Treatments
Lithotripsy	0	0	0
Linear Accelerator	0	0	0
Image Guided Rad Therapy	0	0	0
Intensity Modulated Rad Thrpy	0	0	0
High Dose Brachytherapy	0	0	0
Proton Beam Therapy	0	0	0
Gamma Knife	0	0	0
Cyber knife	0	0	0

ATTACHMENT 19C

Source: 2010 Annual Hospital Questionnaire, Illinois Department of Public Health, Health Systems Development.

Ownership, Management and General Information

ADMINISTRATOR NAME:	Barbara Martin
ADMINSTRATOR PHONE	(847) 360-4001
OWNERSHIP:	Community Health Systems
OPERATOR:	Community Health Systems
MANAGEMENT:	For Profit Corporation
CERTIFICATION:	
FACILITY DESIGNATION:	Psychiatric Hospital
ADDRESS	2615 West Washington CITY: Waukegan COUNTY: Lake County

Patients by Race

White	72.5%
Black	23.9%
American Indian	0.2%
Asian	0.9%
Hawaiian/ Pacific	0.0%
Unknown:	2.5%

Patients by Ethnicity

Hispanic or Latino:	13.8%
Not Hispanic or Latino:	86.2%
Unknown:	0.0%

IDPH Number:	4895
HPA	A-09
HSA	8

Facility Utilization Data by Category of Service

Clinical Service	Authorized CON Beds 12/31/2010	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy 12/31/2010	Staff Bed Occupancy Rate %
Medical/Surgical	0	0	0	0	0	0	0.0	0.0	0.0	0.0
0-14 Years				*0*	*0*					
15-44 Years				*0*	*0*					
45-64 Years				*0*	*0*					
65-74 Years				*0*	*0*					
75 Years +				*0*	*0*					
Pediatric	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Intensive Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Direct Admission				*0*	*0*					
Transfers				*0*	*0*					
Obstetric/Gynecology	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Maternity				*0*	*0*					
Clean Gynecology				*0*	*0*					
Neonatal	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long Term Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Swing Beds				0	0		0.0	0.0		
Acute Mental Illness	46	42	41	1,542	10,141	0	6.6	27.8	60.4	66.2
Rehabilitation	25	25	25	381	5,428	0	14.2	14.9	59.5	59.5
Long-Term Acute Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Dedcated Observation	*0*					*0*				
Facility Utilization	71			1,923	15,569	0	8.1	42.7	60.077	

(Includes ICU Direct Admissions Only)

Inpatients and Outpatients Served by Payor Source

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Totals
	31.1%	33.0%	0.0%	28.1%	4.5%	3.3%	
Inpatients	599	634	0	540	86	64	1,923
	8.3%	51.4%	0.0%	20.0%	16.0%	4.3%	
Outpatients	1015	6323	0	2460	1967	527	12,292

Inpatient and Outpatient Net Revenue by Payor Source

Financial Year Reported: 1/1/2010 *to* 12/31/2010

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Totals	Charity Care Expense
Inpatient Revenue ($)	41.9%	23.2%	0.0%	29.1%	5.8%	100.0%	
	6,138,033	3,407,200	0	4,267,823	849,151	14,662,207	169,215
Outpatient Revenue ($)	7.6%	18.8%	0.0%	35.9%	37.7%	100.0%	
	797,429	1,964,362	0	3,742,198	3,933,411	10,437,400	650,038

Total Charity Care Expense 819,253

Totals: Charity Care as % of Net Revenue 3.3%

Birthing Data

Number of Total Births:	0
Number of Live Births:	0
Birthing Rooms:	0
Labor Rooms:	0
Delivery Rooms:	0
Labor-Delivery-Recovery Rooms:	0
Labor-Delivery-Recovery-Postpartum Rooms:	0
C-Section Rooms:	0
CSections Performed:	0

Newborn Nursery Utilization

Level 1 Patient Days	0
Level 2 Patient Days	0
Level 2+ Patient Days	0
Total Nursery Patientdays	0

Laboratory Studies

Inpatient Studies	27,503
Outpatient Studies	37,352
Studies Performed Under Contract	0

Organ Transplantation

Kidney:	0
Heart:	0
Lung:	0
Heart/Lung:	0
Pancreas:	0
Liver:	0
Total:	0

ATTACHMENT 19C

METROSOUTH MEDICAL CENTER

TRANSFER AGREEMENT

THIS TRANSFER AGREEMENT ("**Agreement**") is entered into as of the30th day of June 2009 ("**Effective Date**") by and between MSMC Investors, a Delaware Corporation, d/b/a MetroSouth Medical Center ("**Transferring Facility**"), and Pediatric Services of Rush University Medical Center, an Illinois non-profit corporation ("**Receiving Hospital**") (each a "**Party**" and collectively the "**Parties**").

RECITALS

WHEREAS, Transferring Facility operates a general acute care hospital in Blue Island, Illinois; and

WHEREAS, Transferring Facility receives from time to time patients ("**Patient**" or "**Patients**") who are in need of pediatric services ("**Specialty**") not available at Transferring Facility, but available at Receiving Hospital; and

WHEREAS, Receiving Hospital operates a general acute care hospital in Chicago, Illinois, and is willing to receive Patients from Transferring Facility in order to provide Specialty services; and

WHEREAS, the Parties wish to establish transfer arrangements in order to assure continuity of care and accessibility of services to Patients.

NOW, THEREFORE, for and in consideration of the terms, conditions, covenants, agreements and obligations contained herein, it is hereby mutually agreed by the Parties as follows:

ARTICLE I.

Patient Transfers

1.1. Acceptance of Patients. The need for transfer of a Patient to the Receiving Hospital shall be determined by the Patient's attending physician. When the attending physician determines that transfer is medically appropriate, the Transferring Facility shall contact the Receiving Hospital regarding the need for transfer. The Receiving Hospital shall confirm to the Transferring Facility that it can accept the patient after the Receiving Hospital has determined it has the appropriate space, equipment and personnel; after a member of the Receiving Hospital's medical staff agrees to accept responsibility for the care of the patient; and provided that customary admission requirements are met, and State and Federal laws and regulations are met. Notice of the transfer shall be given by Transferring Facility as far in advance as possible. Receiving Hospital shall give prompt confirmation of whether it can provide health care appropriate to the Patient's medical needs. Receiving Hospital agrees to exercise its best efforts to provide for prompt admission of transferred Patients.

1.2. Appropriate Transfer. It shall be the Transferring Facility's responsibility to arrange for, at no cost to Receiving Hospital, appropriate care and safe transportation of the Patient during a transfer. The Transferring Facility shall ensure that the transfer is an "appropriate transfer" under the Emergency Medical Treatment and Active Labor Act, as may be amended from time to time ("**EMTALA**"), and carried out in accordance with all applicable laws and regulations. Usually the transportation will be arranged by the Receiving Hospital.

(a) Prior to any Patient transfer to the Receiving Hospital, Transferring Facility shall provide sufficient information as far in advance as possible, and in any event prior to the Patient leaving Transferring Facility for transport, to allow the Receiving Hospital to determine whether it can provide the necessary Patient care. Transferring Facility shall remain responsible for determining whether the anticipated transport time to Receiving Hospital is reasonable considering the Patient's medical needs, medical condition and proximity of other hospitals to Transferring Facility and the services offered by such alternative facilities.

(b) The Patient's medical record shall contain a physician's order to transfer, and the attending physician recommending the transfer shall communicate directly with Receiving Hospital's patient admissions, or, in the case of an emergency services patient who has been screened and stabilized for transfer, with the Receiving Hospital's Pediatric Services.

(c) In addition to a Patient's medical records and the physician's order to transfer, Transferring Facility shall provide Receiving Hospital with all information regarding a Patient's medications, and clear direction as to who may make medical decisions on behalf of the Patient, with copies of any power of attorney for medical decision making or, in the absence of such document, a list of next of kin, if feasible, to assist the Receiving Hospital in determining appropriate medical decision makers in the event a Patient is or becomes unable to do so on his or her own behalf.

1.3. Transfer Log. The Transferring Facility shall keep an accurate and current log of all Patients transferred to the Receiving Hospital and the disposition of such Patient transfers.

1.4. Admission to the Receiving Hospital from Transferring Facility. When a Patient's need for admission is determined by his/her attending physician, Receiving Hospital shall admit the Patient in accordance with the provisions of this Agreement as follows:

(a) Patients determined to be emergent by the attending physician shall be admitted, subject to bed, space, qualified personnel and equipment availability, provided that all usual conditions of admission to Receiving Hospital are met.

(b) All other Patients shall be admitted according to the established routine of Receiving Hospital.

1.5. Standard of Performance. Each Party shall, in performing its obligations under this Agreement, provide Patient care services in accordance with the same standards as services provided under similar circumstances to all other Patients of such Party, and as required by federal and state laws and Medicare/Medicaid certification standards. Each Party shall maintain

all legally required certifications and licenses from all applicable governmental and accrediting bodies, and shall maintain full eligibility for participation in Medicare and Medicaid.

1.6. Billing and Collections. Each Party shall be entitled to bill Patients, payors, managed care plans and any other third party responsible for paying a Patient's bill for services rendered to Patients by such Party and its employees, agents and representatives under this Agreement, and neither Party will have any liability to the other Party for such charges. Each Party shall be solely responsible for all matters pertaining to the billing and collection of such charges. The Parties shall reasonably cooperate with each other in the preparation and completion of all necessary forms and documentation and the determination of insurance coverage and managed care requirements for each transferred Patient. Each Party shall have the sole final responsibility for all forms, documentation, and insurance verification.

1.7. Personal Effects. Personal effects of any transferred Patient shall be delivered to the transfer team or admissions department of the Receiving Hospital. Personal effects include money, jewelry, personal papers and articles for personal hygiene.

ARTICLE II.

Medical Records

Subject to applicable confidentiality requirements, the Parties shall exchange all information which may be necessary or useful in the care and treatment of the transferred Patient or which may be relevant in determining whether such Patient can be adequately cared for by the other Party. All such information shall be provided by the Transferring Facility in advance, where possible, and in any event, no later than at the time of the transfer. The Transferring Facility shall send a copy of all Patient medical records that are available at the time of transfer to the Receiving Hospital. Other records shall be sent as soon as practicable after the transfer. The Patient's medical record shall contain evidence that the Patient was transferred promptly, safely and in accordance with all applicable laws and regulations. Each Party shall, and shall cause its employees and agents to protect the confidentiality of all Patient information (including, but not limited to, medical records, electronic data, radiology films, laboratory blocks, slides and billing information), and comply with all applicable state and federal laws and regulations protecting the confidentiality of Patients' records, including the Health Insurance Portability and Accountability Act of 1996 and the corresponding Standards for Privacy of Individually Identifiable Health Information regulations, each as amended from time to time (collectively, "**HIPAA**").

ARTICLE III.

Term and Termination

3.1. Term. The initial term of this Agreement shall begin on the Effective Date and continue for a period of one (1) year. **Thereafter, this Agreement shall automatically renew for successive one (1) year terms unless terminated pursuant to this Article.** The initial term and all renewal terms shall collectively be the "Term" of this Agreement.

3.2. Termination. This Agreement may be terminated as follows:

(a) Termination Without Cause. Either Party may terminate this Agreement, at any time without cause, upon ninety (90) days prior written notice to the other Party.

(b) Termination for Cause. The Parties shall have the right to immediately terminate this Agreement for cause upon the happening of any of the following:

(i) If either Party determines that the continuation of this Agreement would endanger Patient care.

(ii) Violation by the other Party of any material provision of this Agreement, provided such violation continues for a period of thirty (30) days after receipt of written notice by the other Party specifying the violation.

(iii) A general assignment by the other Party for the benefit of creditors; the institution by or against the other Party, as debtor, of proceedings of any nature under any law of the United States or any state, whether now existing or currently enacted or amended, for the relief of debtors, provided that in the event such proceedings are instituted against the other Party remain unstayed or undismissed for thirty (30) days; the liquidation of the other Party for any reason; or the appointment of a receiver to take charge of the other Party's affairs, provided such appointment remains undischarged for thirty (30) days. Such termination of the provisions of this Agreement shall not affect obligations which accrued prior to the effective date of such termination.

(iv) Exclusion of either Party from participation in the Medicare or Medicaid programs or conviction of either Party of a felony related to the provision of health care services.

(v) Except with respect to a change from one accrediting body to another, either Party's loss or suspension of any certification, license, accreditation (including JCAHO accreditation or other applicable accreditation), or other approval necessary to render Patient care services.

(vi) In the event of insufficient coverage as defined in **Article V** herein, or lapse of coverage.

ARTICLE IV.

Non-Exclusive Relationship

This Agreement shall be non-exclusive. Either Party shall be free to enter into any other similar arrangement at any time, and nothing in this Agreement shall be construed as limiting the

right of either Party to affiliate or contract with any other hospital, nursing home, home health agency, school or other entity on either a limited or general basis while this Agreement is in effect. Neither Party shall use the other Party's name or marks in any promotional or advertising material without first obtaining the written consent of the other Party. In entering into this Agreement, neither Party is acting to endorse or promote the services of the other Party.

ARTICLE V.

Certification and Insurance

5.1 Licenses, Permits, and Certification. Each Party represents to the other that it and all of its employees, agents and representatives possess and shall maintain in valid and current status during the term of this Agreement all required licenses, permits and certifications enabling each Party to provide the services set forth in this Agreement.

5.2 Insurance. Each Party shall maintain during the term of this Agreement, at its sole cost and expense, general liability and professional liability insurance in such amounts as are reasonable and customary in the industry to guard against those risks which are customarily insured against in connection with the operation of activities of comparable scope and size. A written certificate of such coverage shall be provided to each Party together with a certification that such coverage may not be canceled without at least thirty (30) days notice to the other Party. Each Party shall notify the other Party within ten (10) days of any material change or cancellation in any policy of insurance required to be secured or maintained by such Party. In the event the form of insurance held by a party is claims made, such Party warrants and represents that it will purchase appropriate tail coverage for claims, demands, or actions reported in future years for acts of omissions during the Term of this Agreement. In the event of insufficient coverage as defined in this Article, or lapse of coverage, the non-breaching Party reserves the right to immediately and unilaterally terminate this Agreement.

5.3 Notification of Claims. Each Party shall notify the other in writing, by certified mail, of any action or suit filed and shall give prompt notice of any claim made against either by any person or entity which may result in litigation related in any way to this Agreement.

ARTICLE VI.

Liability

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

ARTICLE VII.

Compliance With Laws

At all times, both Parties shall comply with all federal, state and local laws, rules and regulations now in effect or later adopted relating to the services to be provided hereunder and that may be applicable to the Parties including, but not limited to, laws, rules and regulations regarding confidentiality, disclosure and retention of Patient records, such as the regulations promulgated under HIPAA. A Party shall promptly notify the other Party if it receives notice of any actual or alleged infraction, violation, default or breach of the same. Neither Transferring Facility nor Receiving Hospital, nor any employee, officer, director or agent thereof, is an "excluded person" under the Medicare rules and regulations.

Transferring Facility represents, warrants and covenants to Receiving Hospital that Transferring Hospital, prior to the first Patient transfer made under this Agreement and at all times thereafter during the term of the Agreement, will be licensed to operate a hospital in Illinois and will be a participating facility in Medicare and Medicaid. Receiving Hospital represents, warrants and covenants to Transferring Facility that Receiving Hospital is, and will be at all times during the term of this Agreement, licensed to operate a general acute hospital, be an approved provider of services required by the Specialty, and participate in Medicare and Medicaid.

ARTICLE VIII.

Miscellaneous

8.1. Non-Referral of Patients. Neither Party is under any obligation to refer or transfer Patients to the other Party, and neither Party will receive any payment for any Patient referred or transferred to the other Party. A Party may refer or transfer Patients to any facility based on its professional judgment and the individual needs and wishes of the Patients.

8.2. Relationship of the Parties. The Parties expressly acknowledge that in performing their respective obligations under this Agreement, they are acting as independent contractors. Transferring Facility and Receiving Hospital are not and shall not be considered joint venturers or partners, and nothing herein shall be construed to authorize either Party to act as general agent for the other. Neither Party, by virtue of this Agreement, assumes any liability for any debts or obligations of either a financial or legal nature incurred by the other Party. Each Party shall disclose in its respective dealings that they are separate entities.

8.3. No Third Party Rights. This Agreement shall not be construed under any circumstance to confer any rights or privileges on any third parties, and neither Party shall be under any obligation to any third party by reason of this Agreement or any term thereof.

8.4. Notices. All notices that may be given under this Agreement shall be in writing, addressed to the receiving Party's address as set forth below or otherwise designated in writing from time to time, and shall be delivered by hand, traceable courier service, or sent by certified or registered mail, return receipt requested:

To Transferring Facility: MetroSouth Medical Center
12935 South Gregory Street
Blue Island, IL 60406
Attn: Executive Vice President of Finance
Fax No.: 708-389-9480

To Receiving Hospital: Rush University Medical Center
Legal Affairs
1700 West Van Buren, Suite 301
Chicago, IL 60612
Attn: _____
Fax No.: _____

All notices shall be deemed to have been given, if by hand or traceable courier service, at the time of the delivery to the receiving Party at the address set forth above or to such other address as the receiving Party may designate by notice hereunder, or if sent by certified or registered mail, on the 2nd business day after such mailing.

8.5. Assignment. Neither Party may assign its rights or delegate its obligations under this Agreement without the prior written consent of the other, except that either Party may assign all or part of its rights and delegate all or part of its obligations under this Agreement to any entity controlled by or under common control with such Party.

8.6. Entire Agreement; Amendment. This Agreement contains the entire agreement of the Parties with respect to the subject matter hereof and may not be amended or modified except in a writing signed by both Parties. All continuing covenants, duties, and obligations contained herein shall survive the expiration or termination of this Agreement.

8.7. Governing Law. This Agreement shall be governed by and construed according to the laws of the State of Illinois without regard to the conflict of laws provisions thereunder.

8.8. Headings. The headings of articles and sections contained in this Agreement are for reference purposes only and will not affect in any way the meaning or interpretation of this Agreement.

8.9. Non-discrimination. Neither Party shall discriminate against any individuals on the basis of race, color, sex, age, religion, national origin, or disability in providing services under this Agreement.

8.10. Severability. If any provision of this Agreement, or the application thereof to any person or circumstance, shall be held to be invalid, illegal or unenforceable in any respect by any court or other entity having the authority to do so, the remainder of this Agreement, or the application of such affected provision to persons or circumstances other than those to which it is held invalid or unenforceable, shall be in no way affected, prejudiced or disturbed, and each provision of this Agreement shall be valid and shall be enforced to the fullest extent permitted by law.

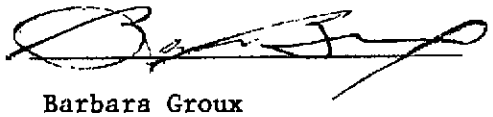
8.11. Successors and Assigns. This Agreement shall be binding upon, and shall inure to the benefit of the Parties hereto, their respective successors and permitted assigns.

8.12. Waiver. No covenant or condition of this Agreement can be waived, except to the extent set forth in writing by the waving Party.

8.13. Counterparts. This Agreement may be executed in two (2) counterparts, each of which shall be deemed an original, but all of which, when taken together, shall constitute one and the same Agreement.

IN WITNESS WHEREOF, the Parties have caused this Agreement to be executed and delivered as of the day and year written above.

TRANSFERRING FACILITY

Signature: 

Name: Barbara Groux

Title: Executive Vice President

RECEIVING HOSPITAL

Signature: William R Hayden MD

Name: William R Hayden. MD

Title: Section Head, Pediatric Critical Care

30 June 2009

Rush University Medical Center

Name: William Hayden, MD

Title: Section Head, ~~Department~~ Section of Pediatric Critical Care

Signature: William R Hayden

Date: 30 June 2009

Name: Kenneth Boyer, MD

Title: Chairman, Department of Pediatrics

Signature:

Date: 6/30/09

Name: Robert Clapp, Jr.

Title: Senior Vice President for Hospital Affairs

Signature:

Date: 6/30/09

BUSINESS ASSOCIATE AGREEMENT ("BA Agreement")

To the extent that MSMC Investors, LLC, a Delaware limited liability company d/b/a MetroSouth Medical Center ("Covered Entity") discloses Protected Health Information to Pediatric Services of Rush University Medical Center ("BUSINESS ASSOCIATE") in connection with services or products provided to Covered Entity, or as otherwise required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Covered Entity and BUSINESS ASSOCIATE agree to the following terms and conditions, which are intended to comply with HIPAA and its implementing regulations:

1. General Terms and Conditions

(a) "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. part 160 and part 164.

(b) "Security Rule" shall mean the Standards for Security of Individually Identifiable Health Information at 45 C.F.R. part 160 and part 164.

(c) Capitalized terms used but not otherwise defined in this BA Agreement shall have the same meaning as those terms in the Privacy Rule and Security Rule, including 45 CFR §160.103 and 164.501.

2. Obligations and Activities of BUSINESS ASSOCIATE

(a) BUSINESS ASSOCIATE agrees to not use or disclose Protected Health Information other than as permitted or required by this BA Agreement or as Required By Law.

(b) BUSINESS ASSOCIATE agrees to use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this BA Agreement.

(d) BUSINESS ASSOCIATE agrees to report to Covered Entity's Privacy Official any use or disclosure of the Protected Health Information not provided for by this BA Agreement.

(e) BUSINESS ASSOCIATE agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by BUSINESS ASSOCIATE on behalf of Covered Entity, agrees to the same restrictions and conditions that apply through this BA Agreement to BUSINESS ASSOCIATE with respect to such information.

(f) To the extent BUSINESS ASSOCIATE has Protected Health Information in a Designated Record Set, and only to the extent required by HIPAA, BUSINESS ASSOCIATE agrees to provide access, at the request of Covered Entity to Protected Health Information in a Designated Record Set, to Covered Entity in order to meet the requirements under 45 C.F.R. § 164.524.

(g) BUSINESS ASSOCIATE agrees to make any amendment(s) to Protected Health Information in its possession contained in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 C.F.R. § 164.526 at the request of Covered Entity.

(h) BUSINESS ASSOCIATE agrees to make internal practices, books, and records relating to the use and disclosure of Protected Health Information received from, or created or received by BUSINESS ASSOCIATE on behalf of Covered Entity, available to the Secretary, in a time and manner designated by the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.

(i) BUSINESS ASSOCIATE agrees to document such disclosures of Protected Health Information in its possession and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. § 164.528.

(j) BUSINESS ASSOCIATE agrees to provide to Covered Entity information collected in accordance with Section 2(i) of this BA Agreement, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. § 164.528.

(k) BUSINESS ASSOCIATE agrees to, subject to subsection 5.3(2) below, return to the Covered Entity or destroy, within fifteen (15) days of the termination of this Agreement, the Protected Health Information in its possession and retains no copies.

(l) BUSINESS ASSOCIATE agrees to mitigate, to the extent practicable, any harmful effect that is known to either party, of a use or disclosure of Protected Health Information in violation of this BA Agreement.

3. Permitted Uses and Disclosures of Protected Health Information by Business Associate

3.1 General Use and Disclosure Provisions

Except as otherwise limited in this BA Agreement, BUSINESS ASSOCIATE may use or disclose Protected Health Information obtained from or on behalf of Covered Entity to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in this BA Agreement, provided that such use or disclosure complies with HIPAA. BUSINESS ASSOCIATE acknowledges and agrees that it acquires no title or rights to the Protected Health Information, including any de-identified information, as a result of this BA Agreement.

3.2 Specific Use and Disclosure Provisions

(a) BUSINESS ASSOCIATE may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, Covered Entity and fulfill its obligations under any underlying agreement with Covered Entity, provided that such use or disclosure would not violate the Privacy Rule or Security Rule if done by the Covered Entity.

(b) BUSINESS ASSOCIATE may use and disclose Protected Health Information for the proper and necessary management and administration of BUSINESS ASSOCIATE or to carry out the legal responsibilities of BUSINESS ASSOCIATE, provided that, as to any such disclosure, the following requirements are met:

(i) the disclosure is Required By Law; or

(ii) BUSINESS ASSOCIATE obtains reasonable assurances from the person or entity to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies BUSINESS ASSOCIATE of any instances of which it is aware in which the confidentiality of the information has been breached.

(c) Except as otherwise limited in this BA Agreement, BUSINESS ASSOCIATE may use Protected Health Information to provide Data Aggregation services to Covered Entity.

4. Security of Electronic Protected Health Information

In addition to its overall obligations with respect to Protected Health Information, to the extent required by the Security Rule, BUSINESS ASSOCIATE will:

4.1 Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of Covered Entity as required by HIPAA;

4.2 Ensure that any agent, including a subcontractor, to whom it provides such electronic Protected Health Information agrees to implement reasonable and appropriate safeguards to protect it; and

4.3 Except for Security Incidents required to be reported under Section 2 of this BA Agreement, Provide aggregate reports to Covered Entity regarding any security incident of which it becomes aware in a frequency mutually agreeable to the parties.

5. Survival and Termination

5.1 Survival

BUSINESS ASSOCIATE's obligations under this BA Agreement shall survive the termination of this BA Agreement and shall end when all of the Protected Health Information provided by Covered Entity to BUSINESS ASSOCIATE, or created or received by BUSINESS ASSOCIATE on behalf of Covered Entity, is destroyed or returned to Covered Entity. If it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this Section.

5.2 Termination for Cause

Upon Covered Entity's knowledge of a material breach by BUSINESS ASSOCIATE, Covered Entity shall provide written notice to BUSINESS ASSOCIATE and may terminate this BA Agreement and any underlying agreement with BUSINESS ASSOCIATE if BUSINESS ASSOCIATE does not cure the breach or end the violation within 30 days from the time of discovery.

5.3 Effect of Termination

(1) Except as provided below in paragraph 5.3(2) of this BA Agreement, upon termination of this Agreement, for any reason, BUSINESS ASSOCIATE shall return or destroy all Protected Health Information received from Covered Entity, or created or received by BUSINESS ASSOCIATE on behalf of Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of BUSINESS ASSOCIATE. BUSINESS ASSOCIATE shall retain no copies of the Protected Health Information.

(2) In the event that BUSINESS ASSOCIATE determines that returning or destroying the Protected Health Information is infeasible, BUSINESS ASSOCIATE shall provide to Covered Entity written notification of the conditions that make return or destruction infeasible, and, if Covered Entity determines that return or destruction is infeasible, BUSINESS ASSOCIATE shall extend the protections of this BA Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as BUSINESS ASSOCIATE maintains such Protected Health Information. If it is infeasible for BUSINESS ASSOCIATE to obtain, from a subcontractor or agent, any Protected Health Information in the possession of the subcontractor or agent, BUSINESS ASSOCIATE must provide a written explanation to Covered Entity and require the subcontractors and agents to agree in writing to extend any and all protections, limitations and restrictions contained in this BA Agreement to the subcontractors' and/or agents' use and/or disclosure of any Protected Health Information retained after the termination of this BA Agreement, and to limit any further uses and/or disclosures to the purposes that make the return or destruction of the Protected Health Information infeasible.

6. Interpretation and Amendment of this BA Agreement

A reference in this BA Agreement to a section of the Privacy Rule means the section as in effect or as amended. Any ambiguity or inconsistency in this BA Agreement shall be resolved in favor of a meaning that permits Covered Entity to comply with the Privacy Rule. The parties hereto agree to negotiate in good faith to amend this BA Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy Rule and HIPAA and for BUSINESS ASSOCIATE to provide services to Covered Entity. However, no change, amendment, or modification of this BA Agreement shall be valid unless it is set forth in writing and agreed to by both parties.

7. No Third Party Rights

The parties to this BA Agreement do not intend to create any rights in any third parties.

8. Notices

Any notice required or permitted by this BA Agreement to be given or delivered shall be in writing and shall be deemed given or delivered if delivered in person, or sent by courier or expedited delivery service, or sent by registered or certified mail, postage prepaid, return receipt requested, or sent by facsimile (if confirmed), to the address set forth below. Each party may change its address for purposes of this BA agreement by written notice to the other party.

IN WITNESS WHEREOF, the parties have executed this BA Agreement, effective June 30, 2009.

COVERED ENTITY:

By: _____

Title: Executive Vice President of Finance

Date: June 30, 2009

Address: 12935 South Gregory

Blue Island, Illinois 60406

Facsimile: 708-389-9480

BUSINESS ASSOCIATE:

By: William R Hayden

Title: Section Head, Pediatric Critical Care

Date: 30 June 2009

Address:1653 W. Congress Parkway
Chicago, IL 60612
Facsimile: 312-942-4320

5422667_v1

Rush University Medical Center

Name: William Hayden, MD

Title: Section Head, Department of Pediatric Critical Care

Signature: William R Hayden

Date: 30 June 2009

Name: Kenneth Boyer, MD

Title: Chairman, Department of Pediatrics

Signature:

Date: 6/30/09

Name: Robert Clapp, Jr.

Title: Senior Vice President for Hospital Affairs

Signature:

Date: 6/30/09

PATIENT TRANSFER AGREEMENT

This agreement is made and effective as of April 1, 2010 ("Effective Date") between Rush University Medical Center, an Illinois not for profit corporation ("Rush") and MetroSouth Medical Center ("Transferring Hospital").

PREAMBLE

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

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

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

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

The Parties agree as follows:

TERMS

Section 1: Transfer of Patients

1.1. **Acceptance of Patients.** The need for transfer of a patient to Rush shall be determined by the patient's attending physician at Transferring Hospital. When the attending physician determines that transfer is medically appropriate, the Transferring Hospital shall contact Rush regarding the need for transfer. Rush shall notify the Transferring Hospital if it can accept the patient after Rush has determined (i) it has the appropriate space, equipment and personnel to provide care to the patient; (ii) a member of Rush's medical staff has agreed to accept responsibility for the care of the patient; (iii) customary admission requirements are met and State and Federal laws and regulations are met; and (iv) the Transferring Hospital has provided sufficient information to permit Rush to determine it can provide the necessary patient care. Notice of the transfer shall be given by the Transferring Hospital as far in advance as possible.

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

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

1.4 **Standard of Performance.** Each Party shall provide patient care services in accordance with the same standards as services provided under similar circumstances to all other patients of such Party, and as required by federal and state laws and Medicare/Medicaid certification standards. Each Party shall maintain all legally required certifications and licenses from all applicable governmental and accrediting bodies, and shall maintain full eligibility for participation in Medicare and Medicaid.

1.5. **Billing and Collections.** Neither party shall assume any responsibility for the collection of any accounts receivable, other than those incurred as a result of rendering services directly to the patient; and neither institution shall be liable for any debts, obligations, or claims of a financial or legal nature incurred by the other institution.

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

1.7 **Return Transfer.** When the attending physician at Rush determines that the transfer is medically appropriate due to the patient no longer requiring the specialized care services offered by Rush, and in accordance with any relevant laws, regulations and Rush policies, Rush shall contact the Transferring Hospital regarding the need for a return transfer. The Transferring Hospital will notify Rush that it can accept the patient after the Transferring Hospital has determined (1) it has the appropriate space, equipment and personnel to provide care to the patient; (II) a member of the Transfer Hospital's medical staff has agreed to accept responsibility for the care of the patient; (III) customary admission requirements are met and State and Federal laws and regulations are met; and (iv) Rush has provided sufficient information to permit the Transferring Hospital to determine it can provide the necessary patient care. Notice of the transfer shall be given to the Transferring Hospital as far in advance as possible to allow for planning.

Section 2: Medical Records

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

Section 3: Term and Termination

3.1. **Term.** The term of this Agreement shall be five (5) years from the Effective Date.

3.2. **Termination.** This Agreement may be terminated by either party upon thirty (30) days prior written notice. Either Party may terminate this Agreement effective immediately upon the happening of any of the following:

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

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

(iii) Exclusion of either Party from participation in the Medicare or Medicaid programs or conviction of either Party of a felony.

(iv) Either Party's loss or suspension of any certification, license, accreditation (including The Joint Commision accreditation), or other approval necessary to render patient care services.

Section 4: Certification and Insurance

4.1. **Licenses, Permits, and Certification.** Each Party represents to the other that it and all of its employees, agents and representatives possess and shall maintain in valid and current status during the term of this Agreement all required licenses, permits and certifications enabling each Party to provide the services set forth in this Agreement.

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

Section 5: Liability

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

Section 6: Miscellaneous

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

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

6.3. **Notices.** All notices and other communications under this Agreement shall be in writing and shall be deemed received when delivered personally or when deposited in the U.S. mail, postage prepaid, sent registered or certified mail, return receipt requested or sent via a nationally recognized and receipted overnight courier service, to the Parties at their respective principal office of record as set forth below or designated in writing from time to time. No notice of a change of address shall be effective until received by the other Party:

Notices to the Transferring Hospital:
MetroSouth Medical Center
12935 S. Gregory St.
Blue Island, IL 60406
Attention: Executive Vice President

Notices to the Rush:

_____
_____
_____

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

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

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

6.6. **Governing Law.** This Agreement shall be construed and all of the rights, powers and liabilities of the Parties hereunder shall be determined in accordance with the laws of the State of Illinois; provided, however, that the conflicts of law principles of the State of Illinois shall not apply to the extent that they would operate to apply the laws of another state.

6.7. **Headings.** The headings of articles and sections contained in this Agreement are for reference purposes only and will not affect in any way the meaning or interpretation of this Agreement.

6.8. **Non-discrimination.** Neither Party shall discriminate against any individuals on the basis of race, color, sex, age, religion, national origin, or disability in providing services under this Agreement.

6.9. **Severability.** If any provision of this Agreement, or the application thereof to any person or circumstance, shall be held to be invalid, illegal or unenforceable in any respect by any court or other entity having the authority to do so, the remainder of this Agreement, or the application of such affected provision to persons or circumstances other than those to which it is held invalid or unenforceable, shall be in no way affected, prejudiced or disturbed, and each provision of this Agreement shall be valid and shall be enforced to the fullest extent permitted by law.

6.10. **Successors and Assigns.** This Agreement shall be binding upon, and shall inure to the benefit of the Parties hereto, their respective successors and permitted assigns.

6.11. **Waiver.** No failure by a Party to insist upon the strict performance of any covenant, agreement, term or condition of this Agreement, shall constitute a waiver of any such breach of such covenant, agreement, term or condition. Any Party may waive compliance by the other Party with any of the provisions of this Agreement if done so in writing. No waiver of any provision shall be construed as a waiver of any other provision or any subsequent waiver of the same provision.

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

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

6.14 **Exclusion:** Transferring Hospital shall immediately notify Rush in the event it becomes an excluded individual from a government health care program.

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

RUSH UNIVERSITY MEDICAL CENTER

By: _____ 3/15/10

J. Robert Clapp, Jr., FACHE
Senior Vice President for Hospital Affairs
Rush University Medical Center and
Executive Director, Rush University Hospitals

Date: _____

METROSOUTH MEDICAL CENTER

By: _____

Date: 3/3/10

TRANSFER AGREEMENT
BETWEEN
METROSOUTH MEDICAL CENTER
ADVOCATE HEALTH AND HOSPITALS CORPORATION
d/b/a ADVOCATE CHRIST MEDICAL CENTER
AND HOPE CHILDREN'S HOSPITAL

This Agreement is made and effective as of the 28th day of July, 2009, between **Advocate Health and Hospitals Corporation d/b/a Advocate Christ Medical Center and Hope Children's Hospital**, an Illinois not-for-profit corporation ("MEDICAL CENTER"), and **MetroSouth Medical Center**, an Illinois for-profit corporation ("FACILITY").

WHEREAS, both parties to this agreement desire to assure continuity of care and treatment appropriate to the needs of each patient in the MEDICAL CENTER and the FACILITY, and to use the skills, resources and physical plant of both patient care at both the acute and post-acute stages of illness.

NOW, THEREFORE, IN CONSIDERATION of the mutual advantage occurring to the parties hereto, the MEDICAL CENTER and FACILITY hereby covenant and agree with each other as follows:

1. Autonomy. The Board of Directors of the MEDICAL CENTER and the Board of Directors of the FACILITY shall continue to have exclusive control of the management, assets and affairs of their institutions, and neither party by virtue of this Agreement shall assume any liability for any debts or obligations which have been or which may be incurred by the other party to this Agreement.

2. Transfer of Patients. Whenever the attending physician of any patient confined in the MEDICAL CENTER or in the FACILITY shall determine that a transfer of such patient from one of these institutions to the other is medically appropriate, the parties shall take whatever steps may be necessary to effect such a transfer in their admissions policies to patients requiring such transfer, subject to availability of bed space, and provided that all the usual conditions for admission are met. Each party shall give notice to the other party, as far in advance as possible, of responsibility of the institution and attending physician initiating transfer to arrange for appropriate and safe transportation. Further, it shall be their responsibility for arranging for the care of the patient during transfer. These responsibilities will cease when the patient has been physically admitted at the designation designated.

3. Medical Center Admissions Priority. In establishing its preference in admission policies for patients subject to transfer from the FACILITY in accordance with Article II, the MEDICAL CENTER shall be guided by its usual admission requirements.

In accordance with criteria for admission:

A. Patients declared as emergencies by their attending physicians shall be admitted to the MEDICAL CENTER without delay.

B. Patients not strictly emergent, but requiring early admission to the MEDICAL CENTER, shall be placed on the MEDICAL CENTER's urgent list.

C. Elective cases shall be booked for future admission to the MEDICAL CENTER according to the established routine of the MEDICAL CENTER.

4. Facility Admissions Priority. In establishing its preference in admission policies for patients subject to transfer from the MEDICAL CENTER in accordance with Article II, the FACILITY shall be guided by the following plan:

A. To admit the patient from the MEDICAL CENTER as promptly as possible, provided general admission requirements established by the institution are met.

B. To give priority to re-admission of patients transferred from the FACILITY to the MEDICAL CENTER.

5. Interchange of Information. The parties shall interchange all pertinent medical records and other information which may be necessary or useful in the care and treatment of patients transferred between he parties or which may be revenant to determining whether such parties can be adequately cared for otherwise than in either the MEDICAL CENTER or FACILITY. All such information shall be provided by the transferring institution in advance, where possible, and in any event at the time of the transfer, and shall be recorded on a referral form which shall be mutually agreed upon by the parties. This information shall include but not be limited to current medical findings, diagnosis, rehabilitation potential, and a brief summary of the course of treatment followed in the MEDICAL CENTER or the care of the patient, ambulation status and pertinent administrative and social information.

6. Transfer of Personal Effects. Procedures for affecting the transfer of patients and their personnel effects and valuables shall be developed and adhered to by both parties. These procedures will include, but are not limited to, the provision of information concerning such valuables, money, and personal effects transferred with the patient so that a receipt may be given and received for same.

7. Final Financial Arrangements. Charges for services performed by either party for patients transferred from the other party pursuant to this Agreement shall be collected by the party rendering such services directly from the patient, third party payors or from other sources normally billed. Neither party shall have any liability to the other for such charges, except to the

extent that such liability would exist separate and apart from the Agreement. Nor shall either party receiving a transferred patient be responsible for collecting any previously outstanding account receivable due the other party from such patient.

8. Insurance. Each party shall maintain professional and public liability insurance coverage in the amount of One Million Dollars ($1,000,000.000) per occurrence or claim made with respect to the actions of its employees and agents connected with or arising out of services provided under this Agreement.

9. Independent Contractor. Nothing contained in this Agreement shall constitute or be construed to create a partnership, joint venture, employment, or agency relationship between the parties and/or their respective successors and assigns, it being mutually understood and agreed that the parties shall provide the services and fulfill the obligations hereunder as independent contractors. Further, it is mutually understood and agreed that nothing in this Agreement shall in any way affect the independent operation of either HOSPITAL or FACILITY. The governing body of HOSPITAL and FACILITY shall have exclusive control of the management, assets, and affairs at their respective institutions. No party by virtue of this Agreement shall assume any liability for any debts or obligations of a financial or legal nature incurred by the other, and neither institution shall look to the other to pay for service rendered to a patient transferred by virtue of this Agreement.

10. Nondiscrimination. The parties agree to comply with Title VI of the Civil Rights Act of 1964, all requirements imposed by regulations issued pursuant to that title, section 504 of the Rehabilitation Act of 1973, and all related regulations, to insure that neither party shall discriminate against any recipient of services hereunder on the basis of race, color, sex, creed, national origin, age or handicap, under any program or activity receiving Federal financial assistance.

11. Term and Termination. This Agreement shall commence on July 28, 2009, and shall automatically be renewed annually for one year periods unless terminated according to this Section 10. This Agreement may be terminated by either party at any time upon the giving of at least sixty (60) day's prior written notice. Notwithstanding any notice which may have been given, however, this Agreement shall be automatically terminated whenever either party shall have its license to operate revoked, suspended or non-renewed.

12. Notices. All notices required to be served under this Agreement may be served on any of the parties hereto personally or may be served by sending a letter duly addressed by registered or certified mail . Notices to be served on MEDICAL CENTER shall be served at or mailed to: Advocate Christ Medical Center and Hope Children's Hospital, attention President, with a copy to Chief Legal Officer, Advocate Health and Hospitals Corporation 2025 Windsor Drive, Oak Brook, Illinois 60521. Notices to be served on FACILITY shall be served at or mailed to: MetroSouth Medical Center, attention Executive Vice President, 12935 South Gregory, Blue Island, Illinois 60406, unless otherwise instructed.

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

14. Nonexclusive Clause. Nothing in this Agreement shall be construed as limiting the right of either party to affiliate or contract with any other MEDICAL CETNER or FACILITY, or either a limited or general basis, while this Agreement is in effect.

15. Amendment. This Agreement may be amended, modified, or supplemented by agreement of both parties, but no such modification, amendment, or supplement shall be binding on either party unless and until the same is attached hereto in writing and signed by authorized officials of both parties.

16. Governing Law. All questions concerning the validity or construction of this Agreement shall be determined in accordance with the laws of Illinois.

IN WITNESS WHEREOF, this Agreement has been executed by MEDICAL CENTER and FACILITY on the date first written above.

ADVOCATE HEALTH AND HOSPITALS CORPORATION
d/b/a ADVOCATE CHRIST MEDICAL CETNER AND HOPE CHILDREN'S HOSPITAL

By: _____
President

METROSOUTH MEDICAL CENTER

By: _____

Executive Vice President

28943

METROSOUTH MEDICAL CENTER

TRANSFER AGREEMENT

THIS TRANSFER AGREEMENT ("**Agreement**") is entered into as of the first day of July 2009 ("**Effective Date**") by and between MSMC Investors, a Delaware Corporation, d/b/a MetroSouth Medical Center ("**Transferring Facility**"), and Sisters of St. Francis Health Services, Inc. d/b/a St. James Hospital and Health Centers, an Indiana non-profit corporation ("**Receiving Hospital**") (each a "**Party**" and collectively the "**Parties**").

RECITALS

WHEREAS, Transferring Facility operates a general acute care hospital in Blue Island, Illinois; and

WHEREAS, Transferring Facility receives from time to time patients ("**Patient**" or "**Patients**") who are in need of pediatric services ("**Specialty**") not available at Transferring Facility, but available at Receiving Hospital; and

WHEREAS, Receiving Hospital operates general acute care hospitals in Chicago Heights and Olympia Fields, Illinois, and is willing to receive Patients from Transferring Facility in order to provide Specialty services; and

WHEREAS, the Parties wish to establish transfer arrangements in order to assure continuity of care and accessibility of services to Patients.

NOW, THEREFORE, for and in consideration of the terms, conditions, covenants, agreements and obligations contained herein, it is hereby mutually agreed by the Parties as follows:

ARTICLE I.

Patient Transfers

1.1. Acceptance of Patients. Upon recommendation of an attending physician and pursuant to the provisions of this Agreement, Receiving Hospital agrees to admit a Patient as promptly as possible, provided customary admission requirements are met, State and Federal laws and regulations are met, and Receiving Hospital has the capacity to treat the Patient. Notice of the transfer shall be given by Transferring Facility as far in advance as possible. Receiving Hospital shall give prompt confirmation of whether it can provide health care appropriate to the Patient's medical needs. Receiving Hospital agrees to exercise its best efforts to provide for prompt admission of transferred Patients.

1.2. Appropriate Transfer. It shall be the Transferring Facility's responsibility to arrange for, at no cost to Receiving Hospital, appropriate care and safe transportation of the Patient during a transfer. The Transferring Facility shall ensure that the transfer is an "appropriate transfer" under the Emergency Medical Treatment and Active Labor Act, as may be

ATTACHMENT 19C

/21-

amended from time to time ("**EMTALA**"), and carried out in accordance with all applicable laws and regulations.

(a) Prior to any Patient transfer to the Receiving Hospital, Transferring Facility shall provide sufficient information as far in advance as possible, and in any event prior to the Patient leaving Transferring Facility for transport, to allow the Receiving Hospital to determine whether it can provide the necessary Patient care and whether the anticipated transport time to Receiving Hospital is reasonable considering the Patient's medical needs, medical condition and proximity of other hospitals to Transferring Facility and the services offered by such alternative facilities. Prior to Patient transfer, the transferring physician or designee shall contact and secure acceptance by a receiving physician at Receiving Hospital who shall attend to the medical needs of the Patient and who will accept responsibility for the Patient's medical treatment at Receiving Hospital

(b) The Patient's medical record shall contain a physician's order to transfer, and the attending physician recommending the transfer shall communicate directly with Receiving Hospital's patient admissions, or, in the case of an emergency services patient who has been screened and stabilized for transfer, with the Receiving Hospital's Emergency Department.

(c) In addition to a Patient's medical records and the physician's order to transfer, Transferring Facility shall provide Receiving Hospital with a transfer authorization form executed by or on behalf of Patient and all information regarding a Patient's medications, and clear direction as to who may make medical decisions on behalf of the Patient, with copies of any power of attorney for medical decision making or, in the absence of such document, a list of next of kin, if feasible, to assist the Receiving Hospital in determining appropriate medical decision makers in the event a Patient is or becomes unable to do so on his or her own behalf.

1.3. Transfer Log. The Transferring Facility shall keep an accurate and current log of all Patients transferred to the Receiving Hospital and the disposition of such Patient transfers.

1.4. Admission to the Receiving Hospital from Transferring Facility. When a Patient's need for admission is determined by his/her attending physician, Receiving Hospital shall admit the Patient in accordance with the provisions of this Agreement as follows:

(a) Patients determined to be emergent by the attending physician shall be admitted, subject to bed, space, qualified personnel and equipment availability, provided that all usual conditions of admission to Receiving Hospital are met.

(b) All other Patients shall be admitted according to the established routine of Receiving Hospital.

1.5. Standard of Performance. Each Party shall, in performing its obligations under this Agreement, provide Patient care services in accordance with the same standards as services provided under similar circumstances to all other Patients of such Party, and as required by federal and state laws and Medicare/Medicaid certification standards. Each Party shall maintain

all legally required certifications and licenses from all applicable governmental and accrediting bodies, and shall maintain full eligibility for participation in Medicare and Medicaid.

1.6. Billing and Collections. Each Party shall be entitled to bill Patients, payors, managed care plans and any other third party responsible for paying a Patient's bill for services rendered to Patients by such Party and its employees, agents and representatives under this Agreement, and neither Party will have any liability to the other Party for such charges. Each Party shall be solely responsible for all matters pertaining to the billing and collection of such charges. The Parties shall reasonably cooperate with each other in the preparation and completion of all necessary forms and documentation and the determination of insurance coverage and managed care requirements for each transferred Patient. Each Party shall have the sole final responsibility for all forms, documentation, and insurance verification.

1.7. Personal Effects. Personal effects of any transferred Patient shall be delivered to the transfer team or admissions department of the Receiving Hospital. Personal effects include money, jewelry, personal papers and articles for personal hygiene.

ARTICLE II.

Medical Records

Subject to applicable confidentiality requirements, the Parties shall exchange all information which may be necessary or useful in the care and treatment of the transferred Patient or which may be relevant in determining whether such Patient can be adequately cared for by the other Party. All such information shall be provided by the Transferring Facility in advance, where possible, and in any event, no later than at the time of the transfer. The Transferring Facility shall send a copy of all Patient medical records that are available at the time of transfer to the Receiving Hospital. Other records shall be sent as soon as practicable after the transfer. The Patient's medical record shall contain evidence that the Patient was transferred promptly, safely and in accordance with all applicable laws and regulations. Each Party shall, and shall cause its employees and agents to protect the confidentiality of all Patient information (including, but not limited to, medical records, electronic data, radiology films, laboratory blocks, slides and billing information), and comply with all applicable state and federal laws and regulations protecting the confidentiality of Patients' records, including the Health Insurance Portability and Accountability Act of 1996 and the corresponding Standards for Privacy of Individually Identifiable Health Information regulations, each as amended from time to time (collectively, "**HIPAA**").

ARTICLE III.

Term and Termination

3.1. Term. The initial term of this Agreement shall begin on the Effective Date and continue for a period of one (1) year. **Thereafter, this Agreement shall automatically renew for successive one (1) year terms unless terminated pursuant to this Article.** The initial term and all renewal terms shall collectively be the "Term" of this Agreement.

3.2. Termination. This Agreement may be terminated as follows:

(a) Termination Without Cause. Either Party may terminate this Agreement, at any time without cause, upon ninety (90) days prior written notice to the other Party.

(b) Termination for Cause. The Parties shall have the right to immediately terminate this Agreement for cause upon the happening of any of the following:

(i) If either Party determines that the continuation of this Agreement would endanger Patient care.

(ii) Violation by the other Party of any material provision of this Agreement, provided such violation continues for a period of thirty (30) days after receipt of written notice by the other Party specifying the violation.

(iii) A general assignment by the other Party for the benefit of creditors; the institution by or against the other Party, as debtor, of proceedings of any nature under any law of the United States or any state, whether now existing or currently enacted or amended, for the relief of debtors, provided that in the event such proceedings are instituted against the other Party remain unstayed or undismissed for thirty (30) days; the liquidation of the other Party for any reason; or the appointment of a receiver to take charge of the other Party's affairs, provided such appointment remains undischarged for thirty (30) days. Such termination of the provisions of this Agreement shall not affect obligations which accrued prior to the effective date of such termination.

(iv) Exclusion of either Party from participation in the Medicare or Medicaid programs or conviction of either Party of a felony related to the provision of health care services.

(v) Except with respect to a change from one accrediting body to another, either Party's loss or suspension of any certification, license, accreditation (including JCAHO accreditation or other applicable accreditation), or other approval necessary to render Patient care services.

(vi) In the event of insufficient coverage as defined in **Article V** herein, or lapse of coverage.

ARTICLE IV.

Non-Exclusive Relationship

This Agreement shall be non-exclusive. Either Party shall be free to enter into any other similar arrangement at any time, and nothing in this Agreement shall be construed as limiting the

right of either Party to affiliate or contract with any other hospital, nursing home, home health agency, school or other entity on either a limited or general basis while this Agreement is in effect. Neither Party shall use the other Party's name or marks in any promotional or advertising material without first obtaining the written consent of the other Party. In entering into this Agreement, neither Party is acting to endorse or promote the services of the other Party.

ARTICLE V.

Certification and Insurance

5.1. Licenses, Permits, and Certification. Each Party represents to the other that it and all of its employees, agents and representatives possess and shall maintain in valid and current status during the term of this Agreement all required licenses, permits and certifications enabling each Party to provide the services set forth in this Agreement.

5.2. Insurance. Each Party shall maintain during the term of this Agreement, at its sole cost and expense, general liability and professional liability insurance in such amounts as are reasonable and customary in the industry to guard against those risks which are customarily insured against in connection with the operation of activities of comparable scope and size. A written certificate of such coverage shall be provided to each Party, upon request, together with a certification that such coverage may not be canceled without at least thirty (30) days notice to the other Party. Each Party shall notify the other Party within ten (10) days of any material change or cancellation in any policy of insurance required to be secured or maintained by such Party. In the event the form of insurance held by a party is claims made, such Party warrants and represents that it will purchase appropriate tail coverage for claims, demands, or actions reported in future years for acts of omissions during the Term of this Agreement. In the event of insufficient coverage as defined in this Article, or lapse of coverage, the non-breaching Party reserves the right to immediately and unilaterally terminate this Agreement.

5.3. Notification of Claims. Each Party shall notify the other in writing, by certified mail, of any action or suit filed and shall give prompt notice of any claim made against either by any person or entity which may result in litigation related in any way to this Agreement.

ARTICLE VI.

Indemnification

Each Party shall indemnify and hold harmless the other Party from and against any and all manner of claims, demands, causes of action, liabilities, damages, costs, and expenses (including costs and reasonable attorney's fees) arising from or incident to the performance of such Party's duties hereunder, except for negligent, grossly negligent, reckless or willful acts or omissions of the other Party. Notwithstanding anything to the contrary, a Party's obligations with respect to indemnification for acts described in this article shall not apply to the extent that such application would nullify any existing insurance coverage of such Party or as to that portion of any claim of loss in which an insurer is obligated to defend or satisfy.

ARTICLE VII.

Compliance With Laws

At all times, both Parties shall comply with all federal, state and local laws, rules and regulations now in effect or later adopted relating to the services to be provided hereunder and that may be applicable to the Parties including, but not limited to, laws, rules and regulations regarding confidentiality, disclosure and retention of Patient records, such as the regulations promulgated under HIPAA. A Party shall promptly notify the other Party if it receives notice of any actual or alleged infraction, violation, default or breach of the same. Neither Transferring Facility or Receiving Hospital, nor any employee, officer, director or agent thereof, is an "excluded person" under the Medicare rules and regulations.

Transferring Facility represents, warrants and covenants to Receiving Hospital that Transferring Hospital, prior to the first Patient transfer made under this Agreement and at all times thereafter during the term of the Agreement, will be licensed to operate a hospital in Illinois and will be a participating facility in Medicare and Medicaid. Receiving Hospital represents, warrants and covenants to Transferring Facility that Receiving Hospital is, and will be at all times during the term of this Agreement, licensed to operate a general acute care hospital, an approved provider of services required by the Specialty, a participant in Medicare and Medicaid.

ARTICLE VIII.

Miscellaneous

8.1. Non-Referral of Patients. Neither Party is under any obligation to refer or transfer Patients to the other Party, and neither Party will receive any payment for any Patient referred or transferred to the other Party. A Party may refer or transfer Patients to any facility based on its professional judgment and the individual needs and wishes of the Patients.

8.2. Relationship of the Parties. The Parties expressly acknowledge that in performing their respective obligations under this Agreement, they are acting as independent contractors. Transferring Facility and Receiving Hospital are not and shall not be considered joint venturers or partners, and nothing herein shall be construed to authorize either Party to act as general agent for the other. Neither Party, by virtue of this Agreement, assumes any liability for any debts or obligations of either a financial or legal nature incurred by the other Party. Each Party shall disclose in its respective dealings that they are separate entities.

8.3. No Third Party Rights. This Agreement shall not be construed under any circumstance to confer any rights or privileges on any third parties, and neither Party shall be under any obligation to any third party by reason of this Agreement or any term thereof.

8.4. Notices. All notices that may be given under this Agreement shall be in writing, addressed to the receiving Party's address as set forth below or otherwise designated in writing from time to time, and shall be delivered by hand, traceable courier service, or sent by certified or registered mail, return receipt requested:

To Transferring Facility: MetroSouth Medical Center
12935 South Gregory Street
Blue Island, IL 60406
Attn: Executive Vice President of Finance
Fax No.: 708-389-9480

ATTACHMENT 19C

To Receiving Hospital: St. James Hospital & Health Centers
1423 Chicago Road
Chicago, Heights, IL 60411
Attn: President
Fax No. 708-756-6863

All notices shall be deemed to have been given, if by hand or traceable courier service, at the time of the delivery to the receiving Party at the address set forth above or to such other address as the receiving Party may designate by notice hereunder, or if sent by certified or registered mail, on the 2nd business day after such mailing.

8.5. Assignment. Neither Party may assign its rights or delegate its obligations under this Agreement without the prior written consent of the other, except that either Party may assign all or part of its rights and delegate all or part of its obligations under this Agreement to any entity controlled by or under common control with such Party.

8.6. Entire Agreement; Amendment. This Agreement contains the entire agreement of the Parties with respect to the subject matter hereof and may not be amended or modified except in a writing signed by both Parties. All continuing covenants, duties, and obligations contained herein shall survive the expiration or termination of this Agreement.

8.7. Governing Law. This Agreement shall be governed by and construed according to the laws of the State of Illinois without regard to the conflict of laws provisions thereunder.

8.8. Headings. The headings of articles and sections contained in this Agreement are for reference purposes only and will not affect in any way the meaning or interpretation of this Agreement.

8.9. Non-discrimination. Neither Party shall discriminate against any individuals on the basis of race, color, sex, age, religion, national origin, or disability in providing services under this Agreement.

8.10. Severability. If any provision of this Agreement, or the application thereof to any person or circumstance, shall be held to be invalid, illegal or unenforceable in any respect by any court or other entity having the authority to do so, the remainder of this Agreement, or the application of such affected provision to persons or circumstances other than those to which it is held invalid or unenforceable, shall be in no way affected, prejudiced or disturbed, and each provision of this Agreement shall be valid and shall be enforced to the fullest extent permitted by law.

8.11. Successors and Assigns. This Agreement shall be binding upon, and shall inure to the benefit of the Parties hereto, their respective successors and permitted assigns.

8.12. Waiver. No covenant or condition of this Agreement can be waived, except to the extent set forth in writing by the waving Party.

8.13. Counterparts. This Agreement may be executed in two (2) counterparts, each of which shall be deemed an original, but all of which, when taken together, shall constitute one and the same Agreement.

IN WITNESS WHEREOF, the Parties have caused this Agreement to be executed and delivered as of the day and year written above.

TRANSFERRING FACILITY

Signature: _____ Date: 08/31/09

Name: Barbara Groux

Title: Executive Vice President of Finance

RECEIVING HOSPITAL

Signature: _____ Date: 7/14/09

Seth C.R. Warren, President

CHS

December 12, 2011

COMMUNITY
HEALTH
SYSTEMS

4000 Meridian Boulevard
Franklin, TN 37067
Tel: (615) 465-7000

P.O. Box 689020
Franklin, TN 37068-9020

Illinois Health Facilities
and Services Review Board
Springfield, IL

To Whom It May Concern:

Please be advised that the proposed acquisition of MetroSouth Medical Center will be funded entirely with cash and equivalents.

Sincerely,

Martin G. Schweinhart
Senior Vice President, Operations

Notarized: Mary Ann Eckman

MARY ANN ECKMAN
STATE OF TENNESSEE NOTARY PUBLIC
WILLIAMSON COUNTY, TN

My Comm. Expires
September 27, 2015

ATTACHMENT 42A

PROJECTED OPERATING and CAPITAL COSTS
per ADJUSTED PATIENT DAY

MetroSouth Medical Center
2013

ADJUSTED PATIENT DAYS:

$$\frac{\$57,236,400}{\$2,694} = 21,242$$

OPERATING COSTS

salaries & benefits	$83,247,000
supplies	$27,583,300
TOTAL	$110,830,300

Operating cost/adjusted pt day:	$5,217.50

CAPITAL COSTS

interest, depreciation & amortization	$3,996,200

Capital cost/adjusted pt day:	$188.13

ATTACHMENTS 42D 42E

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

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