ORIGINAL

11-116

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

RECEIVED
DEC 13 2011
HEALTH FACILITIES & SERVICES REVIEW BOARD

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	Vista Surgery Center to be renamed Lindenhurst Surgery Center			
Street Address:	1050 Red Oak Lane			
City and Zip Code:	Lindenhurst, IL 60046			
County:	Lake	Health Service Area VIII		Health Planning Area: N/A

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

Exact Legal Name:	Lindenhurst Surgery Center, LLC
Address:	c/o Administration 1324 North Sheridan Road Waukegan, IL 60085
Name of Registered Agent:	
Name of Chief Executive Officer:	Barbara Martin
CEO Address:	c/o Administration 1324 North Sheridan Road Waukegan, IL 60085
Telephone Number:	847/360-4109

Type of Ownership of Applicant/Co-Applicant

☐	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.

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:	Barbara J. Martin
Title:	President & CEO
Company Name:	Vista Health System
Address:	1324 North Sheridan Road Waukegan, IL 60085
Telephone Number:	847/360-4000
E-mail Address:	barbara_martin@chs.net
Fax Number:	847/360-4109

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

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	Vista Surgery Center to be renamed Lindenhurst Surgery Center
Street Address:	1050 Red Oak Lane
City and Zip Code:	Lindenhurst, IL 60046
County:	Lake Health Service Area VIII Health Planning Area: N/A

Applicant /Co-Applicant Identification

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

Exact Legal Name:	Waukegan Illinois Hospital Company, LLC d/b/a Vista Surgery Center
Address:	1324 North Sheridan Road Waukegan, IL 60085
Name of Registered Agent:	
Name of Chief Executive Officer:	Barbara J. Martin
CEO Address:	1324 North Sheridan Road Waukegan, IL 60085
Telephone Number:	847/360-4000

Type of Ownership of Applicant/Co-Applicant

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

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

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

Name:	Barbara J. Martin
Title:	President & CEO
Company Name:	Vista Health System
Address:	1324 North Sheridan Road Waukegan, IL 60085
Telephone Number:	847/360-4000
E-mail Address:	barbara_martin@chs.net
Fax Number:	847/360-4109

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

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	Vista Surgery Center to be renamed Lindenhurst Surgery center
Street Address:	1050 Red Oak Lane
City and Zip Code:	Lindenhurst, IL 60046
County:	Lake Health Service Area VIII Health Planning Area: N/A

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

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

- Corporations and limited liability companies must provide an **Illinois certificate of good standing.**
- 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:	Barbara J. Martin
Title:	President & CEO
Company Name:	Vista Health System
Address:	1324 North Sheridan Road Waukegan, IL 60085
Telephone Number:	847/360-4000
E-mail Address:	barbara_martin@chs.net
Fax Number:	847/360-4109

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

Additional Contact

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

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

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: same as primary contact person
Title:
Company Name:
Address:
Telephone Number:
E-mail Address:
Fax Number:

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Waukegan Illinois Hospital Company, LLC
Address of Site Owner: 4000 Meridian Blvd. Franklin, TN 37067
Street Address or Legal Description of Site: please see attached legal description that follows **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: Lindenhurst Surgery Center, LLC

Address: c/o Administration 1324 North Sheridan Road Waukegan, IL 60085

☐	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.

EXHIBIT A
LEGAL DESCRIPTION

PARCEL 1: (WEST PARCEL)

PART OF THE NORTH 2276.00 FEET OF THE EAST HALF OF GOVERNMENT LOTS 1 AND 2 OF THE NORTHWEST QUARTER OF SECTION 3, TOWNSHIP 45 NORTH, RANGE 10, EAST OF THE THIRD PRINCIPAL MERIDIAN, BEING DESCRIBED AS FOLLOWS: COMMENCING AT THE NORTHEAST CORNER OF SAID EAST HALF OF GOVERNMENT LOT 2; THENCE SOUTH 00 DEGREES 40 MINUTES 54 SECONDS WEST ALONG THE EAST LINE THEREOF, 2276.08 FEET TO THE SOUTHEAST CORNER OF THE NORTH 2276.00 FEET OF SAID EAST HALF OF GOVERNMENT LOTS 1 AND 2; THENCE NORTH 89 DEGREES 48 MINUTES 28 SECONDS WEST ALONG THE SOUTH LINE OF THE NORTH 2276.00 FEET OF SAID EAST HALF OF GOVERNMENT LOTS 1 AND 2, A DISTANCE OF 598.95 FEET TO THE PLACE OF BEGINNING; THENCE NORTH 00 DEGREES 25 MINUTES 06 SECONDS EAST, 220.48 FEET; THENCE NORTHWESTERLY 74.18 FEET ALONG A NON-TANGENT CURVE TO THE RIGHT, HAVING A RADIUS OF 265.00 FEET, CHORD LENGTH OF 73.94 FEET AND BEARS NORTH 23 DEGREES 07 MINUTES 26 SECONDS WEST; THENCE NORTHWESTERLY 314.28 FEET ALONG A CURVE TO THE LEFT, HAVING A RADIUS OF 310.00 FEET, CHORD LENGTH OF 300.89 FEET AND BEARS NORTH 44 DEGREES 08 MINUTES 52 SECONDS WEST; THENCE SOUTH 45 DEGREES 06 MINUTES 49 SECONDS WEST, 22.36 FEET; THENCE NORTH 44 DEGREES 53 MINUTES 11 SECONDS WEST, 44.09 FEET; THENCE NORTHEASTERLY 416.69 FEET ALONG A NON-TANGENT CURVE TO THE LEFT, HAVING A RADIUS OF 570.00 FEET, CHORD LENGTH OF 407.47 FEET AND BEARS NORTH 25 DEGREES 09 MINUTES 59 SECONDS EAST; THENCE NORTHWESTERLY 227.63 FEET ALONG A CURVE TO THE LEFT HAVING A RADIUS OF 360.00 FEET, CHORD LENGTH OF 223.86 FEET AND BEARS NORTH 13 DEGREES 53 MINUTES 25 SECONDS WEST; THENCE NORTHWESTERLY 221.41 FEET ALONG A CURVE TO THE RIGHT, HAVING A RADIUS OF 425.00 FEET, CHORD LENGTH OF 218.91 FEET AND BEARS NORTH 17 DEGREES 04 MINUTES 48 SECONDS WEST; THENCE NORTHEASTERLY 154.82 FEET ALONG A CURVE TO THE LEFT HAVING A RADIUS OF 200.00 FEET, CHORD LENGTH OF 151.08 FEET AND BEARS NORTH 01 DEGREES 03 MINUTES 15 SECONDS EAST; THENCE NORTHEASTERLY 389.34 FEET ALONG A CURVE TO THE RIGHT, HAVING A RADIUS OF 245.00 FEET, CHORD LENGTH OF 349.65 FEET AND BEARS NORTH 24 DEGREES 23 MINUTES 20 SECONDS EAST; THENCE NORTH 69 DEGREES 54 MINUTES 53 SECONDS EAST, 149.28 FEET; THENCE NORTH 00 DEGREES 25 MINUTES 06 SECONDS EAST, 217.93 FEET TO THE SOUTHERLY RIGHT-OF-WAY LINE OF STATE ROUTE 132; THENCE NORTH 89 DEGREES 38 MINUTES 59 SECONDS WEST ALONG SAID SOUTHERLY RIGHT-OF-WAY LINE, 329.79 FEET; THENCE SOUTH 00 DEGREES 02 MINUTES 06 SECONDS WEST ALONG A JOG IN SAID SOUTHERLY RIGHT-OF-WAY LINE, 15.00 FEET; THENCE SOUTH 89 DEGREES 54 MINUTES 13 SECONDS EAST ALONG SAID RIGHT-OF-WAY LINE, 55.55 FEET; THENCE NORTHWESTERLY 343.68 FEET ALONG A CURVE TO THE LEFT, HAVING A RADIUS OF 49,055.70 FEET, CHORD LENGTH OF 343.68 FEET AND BEARS NORTH 89 DEGREES 53 MINUTES 45 SECONDS WEST TO A LINE 66.00 FEET EAST OF AND PARALLEL WITH THE WEST LINE OF SAID EAST HALF OF GOVERNMENT LOTS 1 AND 2 OF THE NORTHWEST QUARTER OF SAID SECTION 3; THENCE SOUTH 00 DEGREES 53 MINUTES 19 SECONDS WEST ALONG SAID PARALLEL LINE, 277.07 FEET; THENCE SOUTH 89 DEGREES 48 MINUTES 28 SECONDS EAST PARALLEL WITH THE NORTH LINE OF SAID EAST HALF OF GOVERNMENT LOTS 1 AND 2, A DISTANCE OF 14.00 FEET TO A LINE 80.00 FEET EAST OF AND PARALLEL WITH THE WEST LINE OF SAID EAST HALF OF GOVERNMENT LOTS 1 AND 2; THENCE SOUTH 00 DEGREES 53 MINUTES 19 SECONDS WEST ALONG SAID PARALLEL LINE, 425.00 FEET TO A LINE 755.00 FEET SOUTH

CONTINUED ON NEXT PAGE

AND PARALLEL WITH THE NORTH LINE OF SAID EAST HALF OF GOVERNMENT LOTS 1 AND 2; THENCE NORTH 89 DEGREES 48 MINUTES 28 SECONDS WEST ALONG SAID PARALLEL LINE, 80.00 FEET TO THE WEST LINE OF SAID EAST HALF OF GOVERNMENT LOTS 1 AND 2; THENCE SOUTH 00 DEGREES 53 MINUTES 19 SECONDS WEST ALONG SAID WEST LINE 1521.17 FEET TO THE SOUTHWEST CORNER OF THE NORTH 2276.00 FEET OF SAID EAST HALF OF GOVERNMENT LOTS 1 AND 2; THENCE SOUTH 89 DEGREES 48 MINUTES 28 SECONDS EAST ALONG SAID SOUTH LINE, 735.14 FEET TO THE PLACE OF BEGINNING, IN LAKE COUNTY, ILLINOIS.

PARCEL 2:

INGRESS AND EGRESS EASEMENT FOR THE BENEFIT OF PARCEL 1 PURSUANT TO DECLARATION OF EASEMENTS AND COVENANTS DATED AS OF JUNE 27, 2006 AND RECORDED JUNE 29, 2006 AS DOCUMENT 6019319 BY VICTORY HEALTH SERVICES, AN ILLINOIS NOT FOR PROFIT CORPORATION OVER THAT PORTION OF THE LAND DESCRIBED IN EXHIBIT 'D' ATTACHED THERETO.

PARCEL 3:

DRIVEWAY EASEMENT FOR THE BENEFIT OF PARCEL 1 PURSUANT TO EASEMENT AND DEVELOPMENT AGREEMENT DATED NOVEMBER 25, 1997 AND RECORDED JUNE 2, 2006 AS DOCUMENT 6002626 BY AND BETWEEN VICTORY HEALTH SERVICES CORPORATION, AN ILLINOIS NOT-FOR-PROFIT CORPORATION JOHN W. GRIDLEY, AS TRUSTEE FOR THE JOHN W. GRIDLEY TRUST DATED MARCH 8, 1990, THE BOARD OF LIBRARY TRUSTEES OF THE LAKE VILLA PUBLIC LIBRARY DISTRICT.

Permanent Index Number: 06-03-100-044; 06-03-100-045; 06-03-100-046; 06-03-100-049; and 06-03-100-050

Commonly known as: 1050 Red Oak Lane, Lindenhurst, Illinois

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 proposed project is limited to the change of ownership of an existing ambulatory surgery center (ASTC) located on the Vista Health System campus in Lindenhurst. The ASTC currently is wholly owned and operated by Waukegan Illinois Hospital Company, LLC. Following the change of ownership, the ASTC will be operated by Lindenhurst Surgery Center, LLC. Waukegan Illinois Hospital Company, LLC will hold a majority ownership interest in Lindenhurst Surgery Center, LLC, with qualified area physicians holding minority interests.

This is a non-substantive project because it is limited to a change of ownership.

WAUKEGAN ILLINOIS HOSPITAL COMPANY, LLC
OFFICER CERTIFICATION

The undersigned, Waukegan Illinois Hospital Company, LLC ("WIHC"), hereby certifies to the Illinois Health Facilities and Services Review Board (the "Board") as follows:

1. Waukegan Illinois Hospital Company, L.L.C. is a wholly owned, direct or indirect subsidiary of Community Health Systems, Inc. and owns, operates and does business as Vista Surgery Center ("ASC").

2. Under the transaction for which Board approval is being requested, WIHC proposes to transfer certain Assets, as defined below, of the ASC to Lindenhurst Surgery Center, LLC, on or before _____, 20____.

3. The "Assets" comprise the fixed assets, real property, leases and contracts used by the Subsidiaries to operate the ASC at the following locations:

FACILITY NAME	ADDRESS	CITY/STATE	ZIP
Vista Surgery Center (to be Lindenhurst Surgery Center, LLC)	1050 Read Oak Lane	Lindenhurst, IL	60046

4. There is no cost associated with this transaction as the Assets simply are being transferred from one subsidiary of WIHC to another.

The foregoing certifications are made and delivered on _____, 20___.

WAUKEGAN ILLINOIS HOSPITAL COMPANY, LLC

By _____

Name: Martin G. Schweinhart

Title: President

#10716013_v2

#10716013_v2

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			
Movable or Other Equipment (not in construction contracts)			
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Existing ASTC	$4,750,000		$4,750,000
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS	$4,750,000		$4,750,000
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities			
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Fair Market Value of Existing ASTC	$4,750,000		$4,750,000
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	$4,750,000		$4,750,000

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

Related Project Costs

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

Land acquisition is related to project ☐ Yes X No
Purchase Price: $_____
Fair Market Value: $_____

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 $ 0.

Project Status and Completion Schedules

Indicate the stage of the project's architectural drawings:

X None or not applicable ☐ Preliminary
☐ Schematics ☐ Final Working

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

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

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

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.

Illinois Department of
PUBLIC HEALTH

Pat Quinn, Governor

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.idph.state.il.us

October 27, 2011

Barbara J. Martin, President CEO
Vista Health System
1324 N. Sheridan Road
Waukegan, IL 60085

Dear Ms. Martin:

Just a brief note subsequent to your e-mail to confirm that the following facilities are currently in compliance with reporting to ISCR.

Union County Hospital, Anna
Galesburg Cottage Hospital, Galesburg
Gateway Regional Medical Center, Granite City
Heartland Regional Medical Center, Marion
Crossroads Community Hospital, Mt. Vernon
Red Bud Regional Hospital, Red Bud
Vista Health System, Waukegan

Jan

Jan Snodgrass, CTR, Manager
Illinois State Cancer Registry
Illinois Department of Public Health
535 West Jefferson Street
Springfield, Illinois 62761
217-785-7132

Illinois Department of
PUBLIC HEALTH

Pat Quinn, Governor
Damon T. Arnold, M.D., M.P.H., Director

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.idph.state.il.us

November 1, 2011

Barbara J. Martin President CEO
Vista Health System
1324 N. Sheridan Road
Waukegan, IL 60085

Dear Ms. Martin:

This letter is to confirm that the following facilities are currently in compliance with reporting to the Adverse Pregnancy Outcome Reporting System (APORS.)

Union County Hospital, Anna
Galesburg Cottage Hospital, Galesburg
Gateway Regional Medical Center, Granite City
Heartland Regional Medical Center, Marion
Crossroads Community Hospital, Mt. Vernon
Red Bud Regional Hospital, Red Bud.

While Vista Health System, Waukegan is not currently in compliance, the APORS program has seen a concerted effort to improve the timeliness of reporting and anticipates that the hospital will be in compliance for 2011 reporting. I would therefore not oppose any Certificate of Need application at this time.

Jane Fornoff

Jane Fornoff, Ph.D., Manager
Adverse Pregnancy Outcomes Reporting System

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: Vista Medical Center-East		**CITY: Waukegan, IL**			
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	256	8,490	34,902	None	256
Obstetrics	29	1,595	3,512	None	29
Pediatrics	35	0	0	None	35
Intensive Care	16	1,534	5,807	None	16
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:	336	11,619	44,221	None	336

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 _Lindenhurst Surgery Center, 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

PRINTED NAME

EVP, General Counsel & Secretary

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 8th day of December, 2011

Signature of Notary

Seal

SIGNATURE

Martin G. Schweinhart

PRINTED NAME

President

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 8th day of December, 2011

Signature of Notary

Seal

*Insert EXACT legal name of the applicant

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

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

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

E.V.P., General Counsel & Secretary

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 8th 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 8th 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 Waukegan Illinois 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
PRINTED NAME

E.V.P., General Counsel & Secretary
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 8th 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 8th 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 VI - MERGERS, CONSOLIDATIONS AND ACQUISITIONS/CHANGES OF OWNERSHIP

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

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

A. Criterion 1110.240(b), Impact Statement

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

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

B. Criterion 1110.240(c), Access

Read the criterion and provide the following:

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

C. Criterion 1110.240(d), Health Care System

Read the criterion and address the following:

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

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

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

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

VIII. - 1120.120 - Availability of Funds **Audited Statement provided by PDF**

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:**

_____	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;
_$4,750,000__	g)	Fair Market (Insured) Value of ASTC—no cost to be incurred
$4,750,000	**TOTAL FUNDS AVAILABLE**	

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

IX. 1120.130 - Financial Viability **n/a, no debt to be incurred**

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

Financial Viability Waiver

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 **n/a, no debt to be incurred**

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.

XI. Safety Net Impact Statement n/a

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for ALL SUBSTANTIVE AND DISCONTINUATION PROJECTS:

1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.

2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.

3. How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

Safety Net Impact Statements shall also include all of the following:

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.

2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaidpatients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.

3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

A table in the following format must be provided as part of Attachment 43.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	**Year**	**Year**	**Year**
Inpatient			
Outpatient			
Total			
Charity (cost in dollars)			
Inpatient			
Outpatient			
Total			
MEDICAID			
Medicaid (# of patients)	**Year**	**Year**	**Year**
Inpatient			
Outpatient			
Total			
Medicaid (revenue)			
Inpatient			
Outpatient			
Total			

APPEND DOCUMENTATION AS ATTACHMENT-43, 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**	**$159,488,187**
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 0366383-3

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

LINDENHURST SURGERY CENTER, LLC, A DELAWARE LIMITED LIABILITY COMPANY HAVING OBTAINED ADMISSION TO TRANSACT BUSINESS IN ILLINOIS ON OCTOBER 20, 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* 30TH *day of* OCTOBER *A.D.* 2011 .

Jesse White

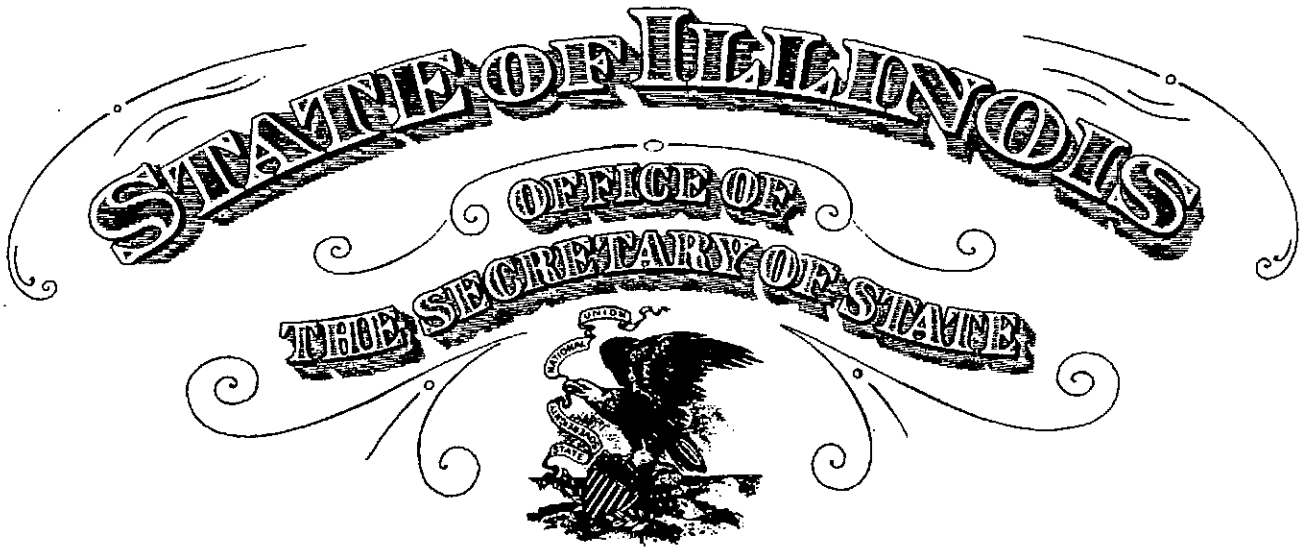
SECRETARY OF STATE

Authentication #: 1130300446

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

ATTACHMENT 1

File Number 0171523-2



To all to whom these Presents Shall Come, Greeting:

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

WAUKEGAN ILLINOIS HOSPITAL COMPANY, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON DECEMBER 20, 2005, AND HAVING ADOPTED THE ASSUMED NAME OF VISTA HEALTH SYSTEM ON JUNE 27, 2006, 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 DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.

Authentication #: 1130300454

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

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 30TH *day of* OCTOBER *A.D.* 2011 .

Jesse White

SECRETARY OF STATE

ATTACHMENT 1

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* 30TH *day of* OCTOBER *A.D.* 2011 .

Jesse White

SECRETARY OF STATE

Authentication #: 1130300450

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

ATTACHMENT 1

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YY) 05/24/11

COVERAGE IS INDEPENDENTLY PROCURED BY THE INSURED
COMMUNITY INSURANCE GROUP SPC, LTD.
P. O. BOX 69
GRAND CAYMAN, KY1-1102, CAYMAN ISLANDS
PHONE (345)945-2888 FAX (345)945-2889

THIS CERTIFICATE IS ISSUED AS A WRITTEN MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.

COMPANIES AFFORDING COVERAGE

COMPANY A: COMMUNITY INSURANCE GROUP SPC, LTD.

INSURED
Vista Victory Ambulatory
1050 Red Oak Lane
Lindenhurst, IL 60046

COMPANY B:

COMPANY C:

COMPANY D:

COVERAGES

THIS IS TO CERTIFY THAT 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 CERTIFICATE 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.

CO LTR	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS	
A	GENERAL LIABILITY				GENERAL AGGREGATE	unlimited
	X COMMERCIAL GENERAL LIABILITY	274/CIG11 Or prior policies which this policy renews	06/01/11	06/01/12	EACH OCCURRENCE	$4,750,000
	OCCURRENCE FORM					
	X CLAIMS MADE					
					RETRO DATE	1/1/2009
	AUTOMOBILE LIABILITY				COMBINED SINGLE LIMIT	$
	ANY AUTO				BODILY INJURY (Per Person)	$
	HIRED AUTOS					
	NON-OWNED AUTOS					
	EXCESS LIABILITY				EACH OCCURRENCE	$
	UMBRELLA FORM				AGGREGATE	$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY				WC STATUTORY LIMITS	OTHER
	THE PROPRIETOR/ PARTNERS/ EXECUTIVE OFFICERS ARE INCL				EL EACH ACCIDENT	$
					EL DISEASE – POLICY LIMIT	$
	Hospital Professional Liability				GENERAL AGGREGATE	unlimited
A	Hospital Professional Liability	274/CIG11 Or prior policies which this policy renews	06/01/11	06/01/12	PER OCCURRENCE	$4,750,000
					RETRO DATE	1/1/2009

DESCRIPTION OF OPERATIONS/LOCATIONS/VEHICLES/SPECIAL ITEMS
SELF INSURED RETENTION OF $250,000 PER OCCURRENCE.

Coverage herein is afforded to all employees including physicians and allied health professionals, when acting within the course and scope of their medical duties performed as employees of the Named Insured.

CERTIFICATE HOLDER

Vista Victory Ambulatory
1050 Red Oak Lane
Lindenhurst, IL 60046

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING COMPANY WILL ENDEAVOR TO MAIL 30 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, EXCEPT 10 DAYS NOTICE FOR NON-PAYMENT, BUT FAILURE TO MAIL SUCH NOTICE SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE COMPANY, ITS AGENTS OR REPRESENTATIVES.

AUTHORIZED REPRESENTATIVE

ATTACHMENT 2

File Number 0366383-3

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

LINDENHURST SURGERY CENTER, LLC, A DELAWARE LIMITED LIABILITY COMPANY HAVING OBTAINED ADMISSION TO TRANSACT BUSINESS IN ILLINOIS ON OCTOBER 20, 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* 30TH *day of* OCTOBER *A.D.* 2011 .

Jesse White

SECRETARY OF STATE

Authentication #: 1130300446

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

ATTACHMENT 3

INDIVIDUALS WITH 5% OR GREATER INTEREST IN THE LICENSEE

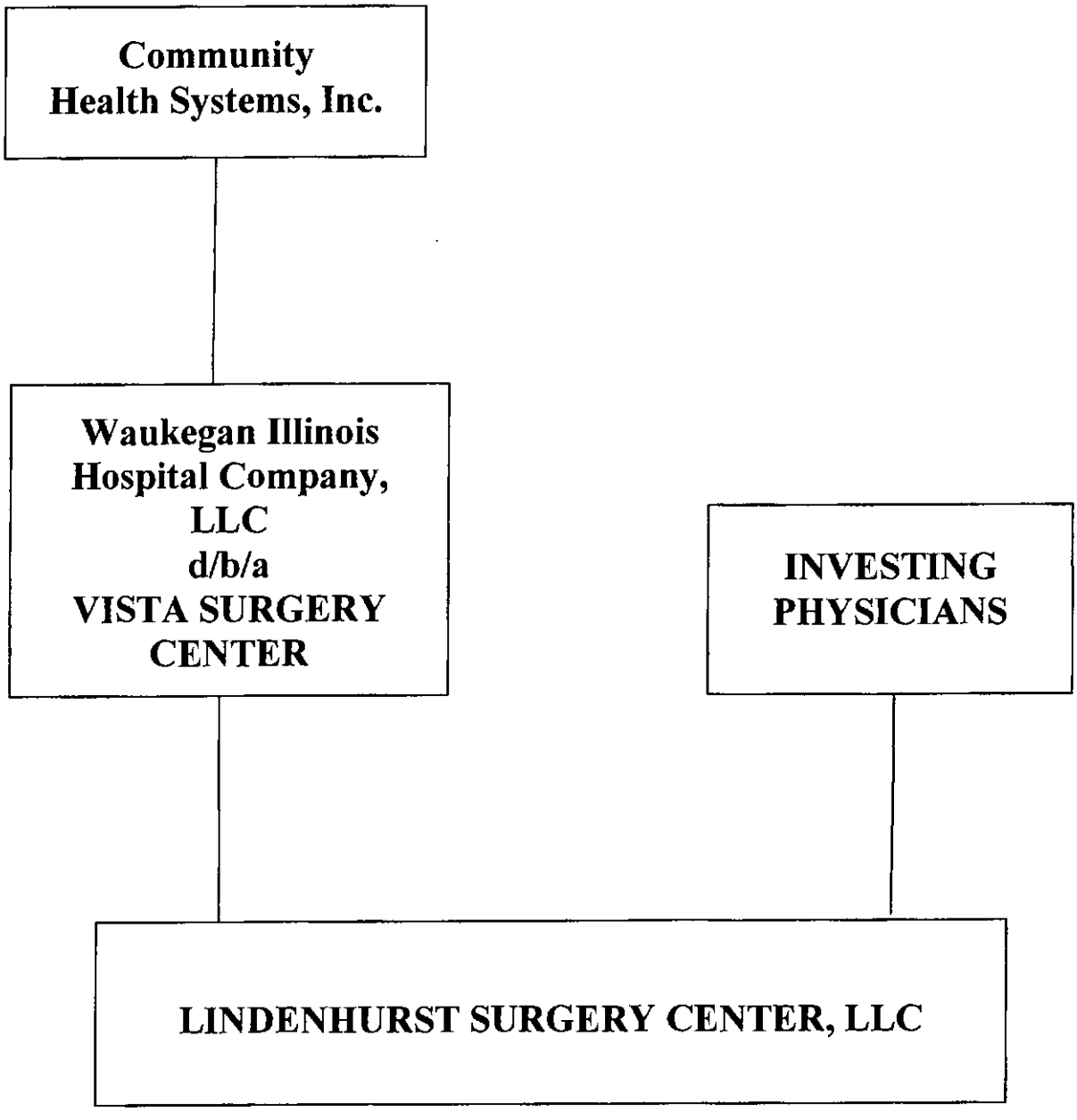
Individuals likely to secure a 5%+ ownership interest

Nejd Alskafi, MD
3 South Greenleaf Street
Suite J
Gurnee, IL

Note: Waukegan Illinois Hospital Company, LLC will maintain a minimum of a 51% ownership interest

ATTACHMENT 3

ORGANIZATIONAL CHART



Attachment 4

PROJECT COSTS

Fair Market Value of Existing ASTC ($4,750,000)

The insured value of the ASTC (see ATTACHMENT 2) was used to identify the fair market value.

BACKGROUND

Vista Surgery Center's IDPH identification number is 7003115. The table below identifies each of applicant Community Health Systems, Inc.'s other 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 is a letter addressing the requirements of Section 1110.230.a.

VISTA
HEALTH
SYSTEM

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 CMMS 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,

Barbara J. Martin
President and Chief Executive Officer

Notarized:

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

12/1/11

ATTACHMENT 11

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.

PURPOSE

Vista Surgery Center was approved for establishment (as Victory Ambulatory Surgery Center) in late 1996, and initiated services in 1999. Utilization of the ASTC has historically been well below the target utilization rate, and in 2010, the ASTC was approved by CMS to operate as a hospital-based outpatient department of Vista Medical Center-East.

Since its establishment the facility has been owned exclusively by Waukegan Illinois Hospital Company, LLC or its predecessor's subsidiary, Victory Ambulatory Services. Unlike virtually all ASTCs, physician ownership was never offered. It is believed by the applicants that Vista Surgery Center is the only ASTC in Lake County without partial or total physician ownership.

Waukegan Illinois Hospital Company, LLC also does business as Vista Medical Center-East and Vista Medical Center-West. The ASTC is located on Vista Health System's Lindenhurst campus, which also houses a freestanding emergency center, an imaging facility, and a variety of other services and programs to address the health care needs of the surrounding communities.

The proposed project will "reorganize" the ASTC to allow for physician investment. As a result, it is anticipated that utilization will increase and area residents will directly benefit from a lower-cost alternative to hospital-based outpatient surgery, which typically costs approximately 35% more than procedures performed in an ASTC.

Upon the proposed "reorganization" the IDPH license holder will change, but "control" as defined by the IHFSRB will be retained by Waukegan Illinois Hospital Company, LLC. In addition, virtually all policies and procedures currently in place will be retained, including the charity care policy.

The ASTC's service area is, and will continue to be Lake County. The table below identifies each ZIP Code area that provided 2.0%+ of the ASTC's patients during the 12-month period ending September 30, 2011. It is not anticipated that the patient origin will change in any appreciable way as a result of the change of ownership. With in excess of 76% of the patients historically residing in one of 13 Lake County ZIP Code areas, it is clear that the ASTC serves primarily residents of Lake County.

ZIP Code	Community	%	Cum. %
60046	Lindenhurst/Lk. Villa	12.1%	12.1%
60085	Waukegan	11.6%	23.7%
60002	Antioch	10.8%	34.5%
60031	Gurnee	10.0%	44.5%
60087	Waukegan	6.2%	50.7%
60073	Round Lake	6.1%	56.8%
60099	Zion/Beach Grove	6.0%	62.8%
60030	Grayslake	5.1%	67.9%
60096	Winthrop Harbor	2.9%	67.9%
60064	North Chicago	2.3%	70.2%
60083	Wadsworth	2.1%	72.3%
60020	Fox Lake	2.0%	74.3%
60060	Mundelein	2.0%	76.3%

The goal to be realized as a result of the proposed change of ownership will be increased utilization of the ASTC, and the increased access to the lower cost services that it provides. It is anticipated that the goal will be reached within the first six months following the closing of the transaction.

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.

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): An ASTC was approved for establishment on the Vista Health System (then Victory Memorial) campus in 1996, and operated as a freestanding ASTC owned by Waukegan Illinois Hospital Company, LLC and its predecessor until 2010.

The proposed change of ownership will allow the facility to be "re-organized" as an LLC, allowing for physician investment, as is the case with other area ASTCs.

The re-organizing of the ASTC to allow for physician investment was the only alternative considered by the applicants, and is believed to be the most appropriate path to increasing the utilization of the facility.

IMPACT STATEMENT

The proposed project is limited to a change in ownership, as defined by the Illinois Health Facilities and Services Review Board, and will involve no change to the type of services currently being provided. The operating entity and the licensee, once approved by IDPH, will be Lindenhurst Surgery Center, LLC. That entity will be "controlled" by the same entity that currently controls it, Waukegan Illinois Hospital Company, LLC.

The reason for the proposed change of ownership is to provide a vehicle through which qualified area physicians can hold an ownership interest in the ASTC, as is the case with most ASTCs.

During the two years following the transaction, no reduction in the number of employees is anticipated as the result of the proposed change of ownership. Rather, with the anticipated increase in the volume of surgical cases to be performed at the ASTC, it is reasonable to assume that the number of employees could increase.

The only costs associated with the proposed change of ownership, other than the investments made by interested physicians, are the relatively minimal transaction-associated costs, which will not be capitalized (and therefore are not included in the

"project cost"). The benefits that will result from the proposed change of ownership will be improved accessibility for those area patients of surgeons desiring to refer patients to the ASTC; and the reduced cost associated with ASTC usage, as compared to outpatient surgery performed in a hospital.

ACCESS

Vista Surgery Center currently operates under the same admissions policy as Vista Medical Center-East, which is attached. Following the proposed change of ownership, the ASTC will utilize a policy addressing the registration of patients that is modeled after the hospital's policy. A copy of the proposed policy, in draft form, is attached. As a result, access to the ASTC will not be diminished or become more restrictive, and a letter certifying such is attached, consistent with the requirements of Section 1110.240(c).

In addition, the surgery center will continue to operate under Vista's uninsured/self pay discount policy under which eligible patients unable to pay for services are provided discounts. A copy of that policy is attached.

VISTA
HEALTH
SYSTEM

November 10, 2011

Illinois Health Facilities and
Services Review Board
Springfield, IL 62761

To Whom It May Concern:

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

Sincerely,

Barbara J. Martin
President and Chief Executive Officer

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			

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

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_____

Exhibit A (continued)
Financial Assistance Program Application

INCOME

Patient/Guarantor:
Wages(monthly): _____

Other Income: Child Support: $_____

VA Benefits: $_____

Workers' Comp: $_____

SSI: $_____

Other: $_____

Spouse/Second Parent:
Wages(monthly): _____

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_____

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				

DRAFT.....

LINDENHURST SURGERY CENTER

Policy/Procedure Title: Registration of Patients

Effective Date:

POLICY:

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

No person will be denied access to care because of sex, race, nationality, creed, financial status, or age.

All patients are given a copy of their patient rights upon registration.

All patients are given a patient information guide that includes, but is not limited to: Patient Rights & Responsibilities, Addressing HIPAA, Speak Yp, 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

HEALTH CARE SYSTEM

Vista Surgery Center has been in operation since 1999, and the proposed change of ownership does not involve the addition of any services to the ASTC. As a result, it is not anticipated that the project will have any appreciable impact on other area providers.

The ASTC has and will continue to have two licensed health care facilities in its Health Care System:

Vista Medical Center-East
1324 N. Sheridan Road
Waukegan, IL
336 beds

Vista Medical Center-West
2615 West Washington Street
Waukegan, IL
71 beds

Copies of the first page of each of the two hospital's 2010 IDPH Hospital Profile are attached, to identify the services provided by each of the hospitals and the utilization of those services.

Vista Surgery Center operates as a department of Vista Medical Center-East, and as a result, does not have referral agreements with other hospitals. Attached is a copy of the referral agreement to be used between Lindenhurst Surgery Center and Vista Medical Center-East.

The ASTC does not and will not have any policies regarding the use of other Health Care System facilities over other area providers. Those decisions are made by the patient's physician, in consultation with the patient and his/her family, as appropriate.

The proposed project will not cause any duplication of services, as the project is limited to the change of ownership of an existing facility.

Due to the nature of an ASTC, interaction with "the community" is very limited. However, Waukegan Illinois Hospital Company, LLC, which will maintain "control" over the ASTC, provides a broad range of community programs, including many focusing on the disadvantaged and medically indigent in Lake County.

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	108,879

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 ($)	37.4%	26.0%	0.0%	28.2%	8.4%	100.0%	
	40,645,026	28,247,544	0	30,671,985	9,185,532	108,750,087	2,511,567
Outpatient Revenue ($)	25.2%	12.5%	0.0%	48.6%	13.7%	100.0%	
	12,777,278	6,357,375	0	24,673,552	6,929,895	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

Hospital Profile - CY 2010 — Vista Medical Center West — Waukegan

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

PATIENT TRANSFER AGREEMENT

THIS TRANSFER AGREEMENT (the "Agreement") is made as of 11/1/2011, by and between Waukegan Illinois Hospital Company, LLC doing business as Vista Medical Center East/ Vista Medical Center West and Lindenhurst Surgery Center, LLC, each individually referred to herein as "Transferring Facility" if transferring a patient, or "Receiving Facility" if receiving a patient, pursuant to the terms and provisions of the Agreement, and collectively as "facilities."

WITNESSETH:

WHEREAS, the parties hereto desire to enter into the Agreement governing the transfer of patients between the two facilities; and,

WHEREAS, the parties hereto desire to enter into the Agreement in order to specify the rights and duties of each of the parties and to specify the procedure for ensuring the timely transfer of patients between the facilities.

NOW, THEREFORE, to facilitate the continuity of care and the timely transfer of patients and records between the facilities, the parties agree as follows:

1. TRANSFER OF PATIENTS. In the event any patient of either facility is deemed by Transferring Facility as requiring the services of Receiving Facility and the transfer is deemed medically appropriate, a member of the nursing staff of Transferring Facility or the patient's attending physician will contact the admitting office or Emergency Department, whichever is applicable, of Receiving Facility to arrange for appropriate treatment as contemplated herein. All transfers between the facilities shall be made in accordance with applicable federal and state laws and regulations, the standards of The Joint Commission and any other applicable accrediting bodies, and reasonable policies and procedures of the facilities. Neither the decision to transfer a patient nor the decision to not accept a request to transfer a patient shall be predicated upon arbitrary, capricious, or unreasonable discrimination or based upon the patient's inability to pay for services rendered by either facility. Receiving Facility's responsibility for the patient's care shall begin when the patient is admitted to Receiving Facility.

2. RESPONSIBILITIES OF TRANSFERRING FACILITY. Transferring Facility shall be responsible for performing or ensuring performance of the following:

(A) Provide, within its capabilities, stabilizing treatment of the patient prior to transfer;

(B) Arrange for appropriate and safe transportation and care of the patient during transfer, in accordance with applicable federal and state laws and regulations;

(C) Designate a person who has authority to represent Transferring Facility and coordinate the transfer of the patient from the facility;

(D) Notify Receiving Facility's designated representative prior to transfer to receive confirmation as to availability of appropriate facilities, services, and staff necessary to provide care to the patient;

(E) Prior to patient transfer, if for direct admission, the transferring physician shall contact and secure a receiving physician at Receiving Facility who shall attend to the medical needs of the patient and who will accept responsibility for the patient's medical treatment and hospital care;

(F) Provide, within its capabilities, appropriate personnel, equipment, and services to assist the transferring physician with the coordination and transfer of the patient;

(G) Provide, within its capabilities, personnel, equipment, and life support measures determined appropriate for the transfer of the patient by the transferring physician;

(H) Forward to the receiving physician and Receiving Facility a copy of those portions of the patient's medical record that are available and relevant to the transfer and continued care of the patient, including records related to the patient's condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests, and a copy of the patient's executed Advance Directives. If all necessary and relevant medical records are not available at the time the patient is transferred, then the records will be forwarded by Transferring Facility as soon as possible;

(I) Transfer the patient's personal effects, including, but not limited to, money and valuables, and information related to those items;
(J) Notify Receiving Facility of the estimated time of arrival of the patient;

(K) Provide Receiving Facility any information available about the patient's coverage under a third party coverage plan, Medicare or Medicaid, or a healthcare assistance program established by a county, public hospital, or hospital district;

(L) Acknowledge any contractual obligations and comply with any statutory or regulatory obligations that might exist between a patient and a designated provider;

(M) Recognize the right of a patient to request to transfer into the care of a physician and facility of the patient's choosing;

(N) Recognize the right of a patient to refuse to consent to treatment or transfer;

(O) Establish a policy and/or protocols (i) for maintaining the confidentiality of the patient's medical records in accordance with applicable state and federal law and (ii) for the inventory and safekeeping of any patient valuables sent with the patient to Receiving Facility; and,

(P) Recognize and comply with the requirements of any state law and regulations or local ordinances that apply to the care and transfer of patients.

3. RESPONSIBILITIES OF RECEIVING FACILITY. Receiving Facility shall be responsible for performing or ensuring performance of the following:
(A) Provide, as promptly as possible, confirmation to Transferring Facility regarding the availability of bed(s), appropriate facilities, services, and staff necessary to treat the patient and confirmation that Receiving Facility has agreed to accept transfer of the patient. Receiving Facility shall respond to Transferring Facility promptly after receipt of the request to transfer a patient with an emergency medical condition or in active labor;

(B) Provide, within its capabilities, appropriate personnel, equipment, and services to assist the receiving physician with the receipt and treatment of the patient transferred, maintain a call roster of physicians at Receiving Facility and provide, on request, the names of on-call physicians to Transferring Facility;

(C) Reserve beds, facilities, and services as appropriate for patients being transferred from Transferring Facility who have been accepted by Receiving Facility and a receiving physician, if

deemed necessary by a transferring physician unless such are needed by Receiving Facility for an emergency;

(D) Designate a person who has authority to represent and coordinate the transfer and receipt of patients into the facility;

(E) When appropriate and within its capabilities, assist with the transportation of the patient as determined appropriate by the transferring or receiving physician;

(F) Upon discharge of the patient back to Transferring Facility, provide Transferring Facility with a copy of the patient's clinical or medical records, including any record generated in the emergency department;

(G) Maintain the confidentiality of the patient's clinical or medical records in accordance with applicable state and federal law;

(H) Establish a policy and/or protocols (i) for maintaining the confidentiality of the patient's clinical or medical records in accordance with applicable state and federal law, (ii) for the receipt of the patient into its facility, and (iii) for the acknowledgment and inventory of any patient valuables transported with the patient;

(I) Provide for the return transfer of the patients to Transferring Facility when requested by the patient or Transferring Facility and ordered by the patient's attending/transferring physician, if Transferring Facility has a statutory or regulatory obligation to provide health care assistance to the patient, and if transferred back to Transferring Facility, provide the items and services required of a Transferring Facility in Section 2 of the Agreement.

(J) Provide Transferring Facility any information available about the patient's coverage or eligibility under a third party coverage plan, Medicare or Medicaid, or a healthcare assistance program established by a county, public hospital, or hospital district;

(K) Upon request, provide current information concerning its eligibility standards and payment practices to Transferring Facility and patient;

(L) Acknowledge any contractual obligations and comply with any statutory or regulatory obligations that might exist between a patient and a designated provider;

(M) Recognize and comply with the requirements of any state law and regulations or local ordinances that apply to the care and transfer of patients.

4. BILLING. All claims or charges incurred with respect to any services performed by either facility for patients received from the other facility pursuant to the Agreement shall be billed and collected by the facility providing such services directly from the patient, third party payer, Medicare or Medicaid, or other sources appropriately billed by that facility, unless applicable law and regulations require that one facility bill the other facility for such services. In those cases in which the regulations apply, the facilities shall bill in accordance to the regulations that apply to skilled nursing facility prospective payment system ("SNF PPS") and consolidated billing. In those cases in which payment rates are consistent with SNF PPS regulations and have been negotiated, such payment shall be made in accordance with the payment fee schedule, labeled as Exhibit A, attached hereto, and incorporated herein by this reference. In addition, it is understood that professional fees will be billed by those physicians or other professional providers who actually participate in the care and treatment of the patient and who are entitled to bill for their professional services at usual and customary rates. Each facility agrees to provide information in its possession to the other facility and such physicians or professional providers sufficient to enable them to bill the patient, responsible party, or appropriate third party payer.

5. TRANSFER BACK; DISCHARGE; POLICIES. At such time as the patient is ready for transfer back to Transferring Facility or another health care facility or discharge from Receiving Facility, in accordance with the direction from the responsible physician in Transferring Facility and with the proper notification of the patient's family or guardian, the patient will be transferred to the agreed upon location. If the patient is to be transferred back to Transferring Facility, Receiving Facility will be responsible for the care of the patient up until the time the patient is re-admitted to Transferring Facility. In the event the "transferring facility" transfers a resident with a documented chronic antibiotic resistant infection to the "hospital," the "transferring facility" agrees to re-accept this resident upon discharge from the acute "hospital" provided all other transfer and admission criteria is met. Any return transfer must meet acute care admission criteria and be approved by Receiving Facility's case management nurse.

6. COMPLIANCE WITH LAW. Both facilities shall comply with all applicable federal and state laws, rules and regulations, including, without limitation, those laws and regulations governing the maintenance of clinical or medical records and confidentiality of patient information as well as with all standards promulgated by any relevant accrediting agency.

7. INDEMNIFICATION; INSURANCE. The facilities shall each be responsible for their own acts and omissions in the performance of their duties hereunder, and the acts and omissions of their own employees and agents, and shall indemnify and hold harmless the other party from and against any and all claims, liabilities, causes of action, losses, costs, damages and expenses (including reasonable attorney's fees) incurred by the other party as a result of such acts and omissions. In addition, each party shall maintain, throughout the term of the Agreement, comprehensive general and professional liability insurance and property damage insurance coverage in amounts not less than One Million ($1,000,000.00) per occurrence and Three Million ($3,000,000.00) in the aggregate, and shall provide evidence of such coverage upon request.

8. TERM; TERMINATION. The term of the Agreement shall be 12 months, commencing on the 11/1/2011, and ending on 10/31/2012, unless sooner terminated as provided herein. Either party may terminate the Agreement without cause upon 30 days advance written notice to the other party. Either party may terminate the Agreement upon breach by the other party of any material provision of the Agreement, provided such breach continues for five (5) days after receipt by the breaching party of written notice of such breach from the non-breaching party. The Agreement may be terminated immediately upon the occurrence of any of the following events:

(A) Either facility closes or discontinues operation to such an extent that patient care cannot be carried out adequately, or

(B) Either facility loses its license, or Medicare certification.

9. ENTIRE AGREEMENT; MODIFICATION. The Agreement contains the entire understanding of the parties with respect to the subject matter hereof and supersedes all prior agreements, oral or written, and all other communications between the parties relating to such subject matter. The Agreement may not be amended or modified except by mutual written agreement.

10. GOVERNING LAW. The Agreement shall be construed in accordance with the laws of the state in which Transferring Facility is located.

11. PARTIAL INVALIDITY. If any provision of the Agreement is prohibited by law or court decree of any jurisdiction, said prohibition shall not invalidate or affect the remaining provisions of the Agreement.

12. NOTICES. All notices hereunder by either party to the other shall be in writing, delivered personally, by certified or registered mail, return receipt requested, or by overnight courier, and shall be deemed to have been duly given when delivered personally or when deposited in the United States mail, postage prepaid, addressed as follows:

If to

Waukegan Illinois Hospital Company, LLC
d/b/a Vista Medical Center East & Vista Medical Center West
1324 North Sheridan Road
Waukegan, IL 60085
Attn: Chief Executive Officer

If to

Lindenhurst Surgery Center
1050 Red Oak Lane
Lindenhurst, Illinois 60046
Attention: Chief Executive Officer

With copy to:

Legal Department
4000 Meridian Blvd.
Franklin, TN 37067

or to such other persons or places as either party may from time to time designate by written notice to the other.

13. WAIVER. A waiver by either party of a breach or failure to perform hereunder shall not constitute a waiver of any subsequent breach or failure.

14. ASSIGNMENT; BINDING EFFECT. Facilities shall not assign or transfer, in whole or in part, the Agreement or any of Facilities' rights, duties or obligations under the Agreement without the prior written consent of the other Facility, and any assignment or transfer by either Facility without such consent shall be null and void. The Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective heirs, representatives, successors and permitted assigns.

15. CHANGE IN LAW. Notwithstanding any other provision of the Agreement, if the governmental agencies (or their representatives) which administer Medicare, any other payer, or any other federal, state or local government or agency passes, issues or promulgates any law, rule, regulation, standard or interpretation, or if any court of competent jurisdiction renders any decision or issues any order, at any time while the Agreement is in effect, which prohibits, restricts, limits or in any way substantially changes the method or amount of reimbursement or payment for services rendered under the Agreement, or which otherwise significantly affects either party's rights or obligations hereunder, either party may give the other notice of intent to amend the Agreement to the satisfaction of both parties, to compensate for such prohibition, restriction, limitation or change. If the Agreement is not so amended in writing within three (3) days after said notice was given, the Agreement shall terminate as of midnight local time on the third (3rd) day after said notice was given.

16. EXECUTION OF AGREEMENT. The Agreement shall not become effective or in force until all of the below named parties have fully executed the Agreement.

IN WITNESS WHEREOF, the parties hereto have executed the Agreement as of the day and year written above.

FACILITY

By: _____
Title: CEO
Date: _____

CHS HOSPITAL

By: _____
Title: Hospital CEO
Date: 1/-

VISTA
HEALTH
SYSTEM

November 10, 2011

Illinois Health Facilities
and Services Review Board
Springfield, IL

To Whom It May Concern:

All of the project related costs associated with the proposed change of ownership of Vista Surgery Center will be funded in cash, and none of those costs, which are limited to transactional and Certificate of Need related expenses, will be capitalized.

Sincerely,

Barbara Martin

Barbara J. Martin
President and Chief Executive Officer

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

Elizabeth D Neary
11/10/11

PROJECTED OPERATING COSTS
and
TOTAL EFFECT OF THE PROJECT ON CAPITAL COSTS

2012, based on projection of 1,400 patients

OPERATING COSTS

		ASTC
salaries & benefits	$	596,444
supplies	$	375,270
	$	971,714

OPERATING COST PER CASE:	$	694.08

CAPITAL COSTS

dep./amort./interest expense	$	36,644

CAPITAL COST PER CASE:	$	26.17

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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