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HEALTH FACILITIES & SERVICES REVIEW BOARD

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION 13-041

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	VHS-Weiss Memorial Hospital				
Street Address:	4646 North Marine Drive				
City and Zip Code:	Chicago, IL 60640				
County: Cook	Health Service Area	VI	Health Planning Area:	A-01	

Applicant /Co-Applicant Identification

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

Exact Legal Name:	Tenet Healthcare Corporation
Address:	13737 Noel Road Dallas, TX 75240
Name of Registered Agent:	
Name of Chief Executive Officer:	Trevor Fetter
CEO Address:	13737 Noel Road Dallas, TX 75240
Telephone Number:	469/893-2200

Type of Ownership of Applicant/Co-Applicant

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

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

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

Primary Contact

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

Name:	Jacob M. Axel
Title:	President
Company Name:	Axel & Associates, Inc.
Address:	675North Court Suite 210 Palatine, IL 6067
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:	Honey Jacobs Skinner
Title:	Partner
Company Name:	Sidley & Austin
Address:	1 South Dearborn Chicago, IL 60603
Telephone Number:	312/853-7577
E-mail Address:	mskinner@sidley.com
Fax Number:	312/853-7036

/

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:	VHS-Weiss Memorial Hospital			
Street Address:	4646 North Marine Drive			
City and Zip Code:	Chicago, IL 60640			
County: Cook	Health Service Area	VI	Health Planning Area:	A-01

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

Exact Legal Name:	VHS ACQUISITION SUBSIDIARY NUMBER 3, INC. d/b/a VHS Weiss Memorial Hospital
Address:	4646 North Marine Drive Chicago, IL 60640
Name of Registered Agent:	
Name of Chief Executive Officer:	Anthony J. Tedechi, MD
CEO Address:	4646 North Marine Drive Chicago, IL 60640
Telephone Number:	773/564-5098

Type of Ownership of Applicant/Co-Applicant

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E-mail Address:	jacobmaxel@msn.com
Fax Number:	847/776-7004

Additional Contact
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Name:	Honey Jacobs Skinner
Title:	Partner
Company Name:	Sidley & Austin
Address:	1 South Dearborn Chicago, IL 60603
Telephone Number:	312/853-7577
E-mail Address:	mskinner@sidley.com
Fax Number:	312/853-7036

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:	VHS-Weiss Memorial Hospital				
Street Address:	4646 North Marine Drive				
City and Zip Code:	Chicago, IL 60640				
County: Cook	Health Service Area	VI	Health Planning Area:	A-01	

Applicant /Co-Applicant Identification

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

Exact Legal Name:	Vanguard Health Systems, Inc.
Address:	20 Burton Hills Blvd. Suite 100 Nashville, TN 37215
Name of Registered Agent:	
Name of Chief Executive Officer:	Charles N. Martin, Jr.
CEO Address:	20 Burton Hills Blvd. Suite 100 Nashville, TN 37215
Telephone Number:	61/665-6000

Type of Ownership of Applicant/Co-Applicant

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

- Corporations and limited liability companies must provide an **Illinois certificate of good standing.**
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Title:	President
Company Name:	Axel & Associates, Inc.
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Additional Contact

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

Name:	Honey Jacobs Skinner
Title:	Partner
Company Name:	Sidley & Austin
Address:	1 South Dearborn Chicago, IL 60603
Telephone Number:	312/853-7577
E-mail Address:	mskinner@sidley.com
Fax Number:	312/853-7036

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:	Anthony J. Tedeschi, MD
Title:	Chief Executive Officer
Company Name:	VHS-Weiss Memorial Hospital
Address:	4646 North Marine Drive Chicago, IL 60640
Telephone Number:	773/564-5098
E-mail Address:	ttedschi@VHSChicago.com
Fax Number:	773/564-5101

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: VHS ACQUISITION SUBSIDIARY NUMBER 3, INC.

Address of Site Owner: 20 Burton Hills Blvd. Suite 100 Nashville, TN 37215

Street Address or Legal Description of Site: 4646 North Marine Drive Chicago, IL 60640

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: VHS ACQUISITION SUBSIDIARY NUMBER 3, INC.

Address: 20 Burton Hills Blvd. Suite 100 Nashville, TN 37215

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

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

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

Organizational Relationships

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

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

Flood Plain Requirements

[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

[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
	☐ Category A Project
X Non-substantive	X Category B Project
	☐ DHS or DVA Project

2. Narrative Description

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

Vanguard Health Systems, Inc. ("Vanguard"), through various subsidiaries, owns, among other assets, four Illinois Hospitals:

- VHS –West Suburban Medical Center
- VHS-Westlake Hospital
- VHS-MacNeal Hospital
- VHS-Weiss Memorial Hospital

On June 24, 2013, Vanguard entered into an Agreement and Plan of Merger to sell 100% of its stock (by way of merger) to Tenet Healthcare Corporation ("Tenet"). Vanguard, through various subsidiaries, currently owns hospitals in five states, and Illinois is the state with Vanguard's fewest holdings. The four Illinois hospitals, however, in addition to serving numerous neighborhoods and communities in metropolitan Chicago, employ over 5,300 area residents.

Both Vanguard and Tenet are publicly-traded companies, with shares traded on the New York Stock Exchange. The proposed stock acquisition will result in a change of control at the parent level of the hospitals—six corporate levels "above" (see ATTACHMENT 4) the hospitals. Vanguard will continue to have operational responsibility for each of the Illinois hospitals.

As a result of the merger, Tenet will assume all of Vanguard's indebtedness, liabilities and other obligations relating to the conduct of business of Vanguard's hospitals. Following the closing of the proposed transaction, Vanguard will operate as a wholly-owned subsidiary of Tenet, with Tenet having ultimate "control" over the hospitals, per the Illinois Health Facilities and Services Review Board's definition. There will be no change to the licensees of the Illinois hospitals.

This is a "non-substantive" project, with no new/replacement facility or IDPH-identified category of service being proposed, and no IDPH-identified categories of service being "discontinued" through this application.

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			
Stock Acquisition			**$60,452,240**
Assumed Debt*			**$83,961,861**
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 Leased Space or Equipment			
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS			**$144,414,401**
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities			**$60,452,240**
Assumed Debt*			**$83,961,861**
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS			**$144,414,401**

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

***assumed Vanguard debt will not be held at hospital level**

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
☐ Yes X 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.

not applicable, a subsidiary of Vanguard will continue to operate the hospital

Estimated start-up costs and operating deficit cost is $ _____.

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): ___December 31, 2013*_____

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.

*The national merger transaction is anticipated to occur well before this date. However, due to reporting requirements in Illinois as well as other states, the December 31, 2013 date is identified in this application for "completion" purposes.

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: VHS-Weiss Memorial Hospital		**CITY: Chicago**			
REPORTING PERIOD DATES:		**From: January 1, 2012**	**to: December 31, 2012**		
Category of Service	**Authorized Beds**	**Admissions**	**Patient Days**	**Bed Changes**	**Proposed Beds**
Medical/Surgical	184	4,831	22,998	None	184
Obstetrics					
Pediatrics					
Intensive Care	16	831	4,084	None	16
Comprehensive Physical Rehabilitation	26	386	4,049	None	26
Acute/Chronic Mental Illness	10	312	2,948	None	10
Neonatal Intensive Care					
General Long Term Care					
Specialized Long Term Care					
Long Term Acute Care					
Other ((identify)					
TOTALS:	236	6,360	34,079	None	236

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

SIGNATURE	SIGNATURE
Audrey T. Andrews	Paul A. Castanon
PRINTED NAME	PRINTED NAME
SVP and General Counsel	VP, Deputy General Counsel and Corporate Secretary
PRINTED TITLE	PRINTED TITLE
Notarization: Subscribed and sworn to before me this 9 day of July 2013	Notarization: Subscribed and sworn to before me this 9 day of July 2013
Signature of Notary	Signature of Notary
Seal: KATHLEEN M. KENNEDY Notary Public, State of Texas My Commission Expires September 30, 2015	Seal: KATHLEEN M. KENNEDY Notary Public, State of Texas My Commission Expires September 30, 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 VHS ACQUISITION SUBSIDIARY NUMBER 3, INC. (d/b/a VHS-Weiss Memorial Hospital)_*in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the permit application fee required for this application is sent herewith or will be paid upon request.

SIGNATURE

JAMES H. SPRAGUE

PRINTED NAME

EXECUTIVE VICE PRESIDENT

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 9th day of July 2013

Signature of Notary

Seal

SIGNATURE

Deborah T. McCormick

PRINTED NAME

Senior Vice President

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 9th day of July 2013

Signature of Notary

Seal

*Insert EXACT legal name of the applicant

CERTIFICATION

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

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

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

James H. Spalding
SIGNATURE

James H. Spalding
PRINTED NAME

Executive Vice President
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 9th day of July 2013

Signature of Notary

Seal

Deborah T. McCormick
SIGNATURE

Deborah T. McCormick
PRINTED NAME

Senior Vice President
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 9th day of July 2013

Signature of Notary

Seal

*Insert EXACT legal name of the applicant

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

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

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

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

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

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

PURPOSE OF PROJECT

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

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

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

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

ALTERNATIVES

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

Alternative options **must** include:

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

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

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

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

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

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

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

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

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

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

A. Criterion 1110.240(b), Impact Statement

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

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

B. Criterion 1110.240(c), Access

Read the criterion and provide the following:

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

C. Criterion 1110.240(d), Health Care System

Read the criterion and address the following:

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

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

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

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

VIII. - 1120.120 - Availability of Funds

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

_$60,452,240__	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;
_$83,961,861_	g)	All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project. Assumed debt (see ATTACHMENT 7)
$144,414,401	**TOTAL FUNDS AVAILABLE**	

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

IX. 1120.130 - Financial Viability

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

Financial Viability Waiver

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.

not applicable, funded completely through internal sources

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

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

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

2. Variance

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

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

X. 1120.140 - Economic Feasibility

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

A. Reasonableness of Financing Arrangements

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

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

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

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

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

B. Conditions of Debt Financing

not applicable, funded completely through internal sources

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

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

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

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

C. **Reasonableness of Project and Related Costs**

Read the criterion and provide the following:

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

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE

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

* Include the percentage (%) of space for circulation

XI. Safety Net Impact Statement

not applicable, non-substantive project

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.

D. Projected Operating Costs

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

E. Total Effect of the Project on Capital Costs

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

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

XII. Charity Care Information

VHS-Weiss Memorial Hospital

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			
	2010	**2011**	**2012**
Net Patient Revenue	**$135,931,480**	**$142,160,025**	**$135,026,260**
Amount of Charity Care (charges)	$6,534,080	$6,391,892	$7,215,458
Cost of Charity Care	$1,739,141	$1,689,488	$1,450,380

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

XII. Charity Care Information

VHS-MacNeal Hospital

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			
	2010	**2011**	**2012**
Net Patient Revenue	**$244,442,965**	**$248,332,243**	**$249,655,296**
Amount of Charity Care (charges)	$9,341,676	$9,741,520	$9,593,585
Cost of Charity Care	$2,152,107	$2,244,223	$1,683,674

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

XII. Charity Care Information

VHS-Westlake Hospital

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			
	2010	**2011**	**2012**
Net Patient Revenue	**$91,289,060**	**$89,999,234**	**$95,763,808**
Amount of Charity Care (charges)	$5,279,333	$3,507,209	$4,183,415
Cost of Charity Care	$922,480	$1,048,655	$842,958

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

XII. Charity Care Information — VHS-West Suburban Medical Center

Charity Care information MUST be furnished for ALL projects.

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

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

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

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

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

CHARITY CARE			
	2010	**2011**	**2012**
Net Patient Revenue	**$183,522,653**	**$159,532,992**	**$163,459,975**
Amount of Charity Care (charges)	$12,217,704	$11,739,610	$6,676,019
Cost of Charity Care	$2,444,614	$3,127,248	$1,289,807

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

File Number 6878-488-3

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

TENET HEALTHCARE CORPORATION, INCORPORATED IN NEVADA AND LICENSED TO TRANSACT BUSINESS IN THIS STATE ON JULY 01, 2013, 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* 1ST *day of* JULY *A.D.* 2013 .

Jesse White

SECRETARY OF STATE

Authentication #: 1318202178

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

ATTACHMENT 1

File Number 6214-303-7

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

VHS ACQUISITION SUBSIDIARY NUMBER 3, INC., INCORPORATED IN DELAWARE AND LICENSED TO TRANSACT BUSINESS IN THIS STATE ON MARCH 29, 2002, 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* 1ST *day of* JULY *A.D.* 2013 .

Jesse White

SECRETARY OF STATE

Authentication #: 1318201366

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

ATTACHMENT 1

File Number 6402-314-4

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

VANGUARD HEALTH SYSTEMS, INC., INCORPORATED IN DELAWARE AND LICENSED TO TRANSACT BUSINESS IN THIS STATE ON FEBRUARY 02, 2005, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE BUSINESS CORPORATION ACT OF THIS STATE RELATING TO THE PAYMENT OF FRANCHISE TAXES, AND AS OF THIS DATE, IS A FOREIGN CORPORATION IN GOOD STANDING AND AUTHORIZED TO TRANSACT BUSINESS IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 23TH *day of* APRIL *A.D.* 2013 .

Jesse White

SECRETARY OF STATE

Authentication #: 1311301992

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

ATTACHMENT 1

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VHS ACQUISITION SUBSIDIARY NUMBER 3, INC.
(d/b/a Louis A. Weiss Memorial Hospital)

Form of Entity:	Delaware Corporation [Seal] Y Delaware Control No. 3414388
Date of Organization:	July 13, 2001
Tax ID No.	62-1861142
Consolidated Subsidiaries:	None
Registered Agent and Office:	National Registered Agents, Inc. 160 Greentree Drive Suite 101 Dover, DE 19904
Qualifications (Date):	Illinois (March 29, 2002)
Nature of Business:	To own & operate Louis A. Weiss Memorial Hospital
Fictitious/Assumed/DBA Names:	Chicago Bariatric Institute (IL) Chicago Center for Orthopedics (IL) ENT at Vanguard Weiss Memorial Hospital (IL) Jacob M. Arvey Health Center at Vanguard Weiss Memorial Hospital (IL) Louis A. Weiss Memorial Hospital (IL) Strauss Infusion Center (IL) Unity Health Weiss Memorial Hospital (IL) Vanguard Chicago Center for Orthopedics (IL) Vanguard Weiss Memorial Hospital (IL)
Trade/Service Marks:	Weiss Memorial Hospital logo (IL)
Previous Names (date of change):	None
Status:	Active
Capitalization and Holdings:	
Par Value of Shares:	Common Stock, $.01 par value
Shares Authorized:	100,000
Shares Issued:	25,000
Shareholder(s):	Vanguard Health Financial Company, LLC (80.10%) The University of Chicago Hospitals (19.9%)

Management:

Directors:
Deborah W. Larios
Deborah T. McCormick
James H. Spalding

ATTACHMENT 2

Officers:

Charles N. Martin, Jr.	President & CEO
Mark R. Montoney, M.D.	Executive Vice President & Chief Medical Officer
Joseph D. Moore	Executive Vice President
Bradley A. Perkins	Executive Vice President-Strategy & Innovation & Chief Transformation Officer
Timothy M. Petrikin	Executive Vice President-Ambulatory Care Services
Keith B. Pitts	Executive Vice President
Phillip W. Roe	Executive Vice President, CFO & Treasurer
James H. Spalding	Executive Vice President, General Counsel & Secretary
Alan G. Thomas	Executive Vice President-Operations Finance
Kelvin M. Ault	Senior Vice President-Tax
Carol A. Bailey	Senior Vice President-Reimbursement
Scott Blanchette	Senior Vice President & Chief Information Officer
Bruce F. Chafin	Senior Vice President-Compliance & Ethics
William T. Foley	Senior Vice President-Operations
Larry Lee Fultz	Senior Vice President & Chief Human Resources Officer
Deborah T. McCormick	Senior Vice President, Assistant General Counsel & Assistant Secretary
Harold H. Pilgrim, III	Senior Vice President & Chief Development Officer
Sunil M. Somaney	Senior Vice President-Business Office Services
Gary D. Willis	Senior Vice President, Controller & Chief Accounting Officer
Harold K. Bandy	Vice President-Information Technology
Richard W. Brasher	Vice President-Risk Management
Devin C. Carty	Vice President-Culture & Chief Marketing & Experience Officer
M.E. Cleary	Vice President-Regional Financial Operations Controller
John J. Faldetta	Vice President, Assistant General Counsel & Assistant Secretary
Pamela R. Farrell	Vice President-Health Information Management
John M. Geer	Vice President-Development
Dennis K. Jacobs	Vice President-Facilities Development
Robert F. Jay	Vice President-Development
G. Bryan Jones	Vice President-Financial Reporting
Deborah W. Larios	Vice President, Assistant General Counsel & Assistant Secretary
John R. McCaslin	Vice President-Internal Audit
Elizabeth B. Minkoff	Vice President, Assistant General Counsel & Assistant Secretary
Shannon E. Pinkston	Vice President, Assistant General Counsel & Assistant Secretary
Ronald L. Rosenberger	Vice President-Development
Tony Tedeschi, M.D.	Vice President-Operations & CEO of Louis A. Weiss Memorial Hospit
Davis W. Turner	Vice President, Assistant General Counsel & Assistant Secretary
Michael Weaver	Vice President-Development
Herman Williams, M.D.	Vice President-Medical Affairs

ATTACHMENT 2

Securities Ownership of Certain Shareholders

Based on reports filed with the SEC, each of the following entities owns more than 5% of Tenet outstanding common stock. Tenet knows of no other entity or person that beneficially owns more than 5% of its outstanding common stock.

Name and Address	Number of Shares Beneficially Owned	Percent of Class as of September 7, 2011
FMR LLC 82 Devonshire Street Boston, MA 02109	40,425,730(1)	9.172%
Franklin Mutual Advisers, LLC 101 John F. Kennedy Parkway Short Hills, NJ 07078-2789	30,574,641(2)	7.00%
Harris Associates L.P. Two North LaSalle Street, Suite 500 Chicago, IL 60602-3790	28,511,200(3)	6.60%
The Vanguard Group, Inc. 100 Vanguard Blvd. Malvern, PA 19355	28,170,815(4)	6.48%
BlackRock, Inc. 40 East 52nd Street New York, NY 10022	27,674,892(5)	6.37%
Glenview Capital Management, LLC 767 Fifth Avenue, 44th Floor New York, NY 10153	22,405,900(6)	5.46%

(1) Based on a Schedule 13G/A filed with the SEC on February 14, 2012 by FMR LLC, on behalf of itself and its named subsidiaries and affiliates, as of December 31, 2011. Fidelity Management & Research Company ("Fidelity"), a wholly owned subsidiary of FMR LLC and a registered investment advisor to various investment companies, is described as the beneficial owner of 40,140,719 of the shares indicated above, or 9.107% as of December 31, 2011. The number of shares owned by the investment companies and indicated above includes 6,410,255 shares of common stock resulting from the assumed conversion of 45,000 shares of our 7.00% Mandatory Convertible Preferred Stock at a rate of 142.4501 shares of common stock for each share of preferred stock. The group collectively reported sole voting power with respect to 285,011 of the shares indicated above and sole investment power with respect to all of the shares indicated above. Edward C. Johnson 3d, through his control of Fidelity, has sole voting power with regard to 139,767 of the shares indicated above and sole investment power with regard to 40,280,486 of the shares indicated above.

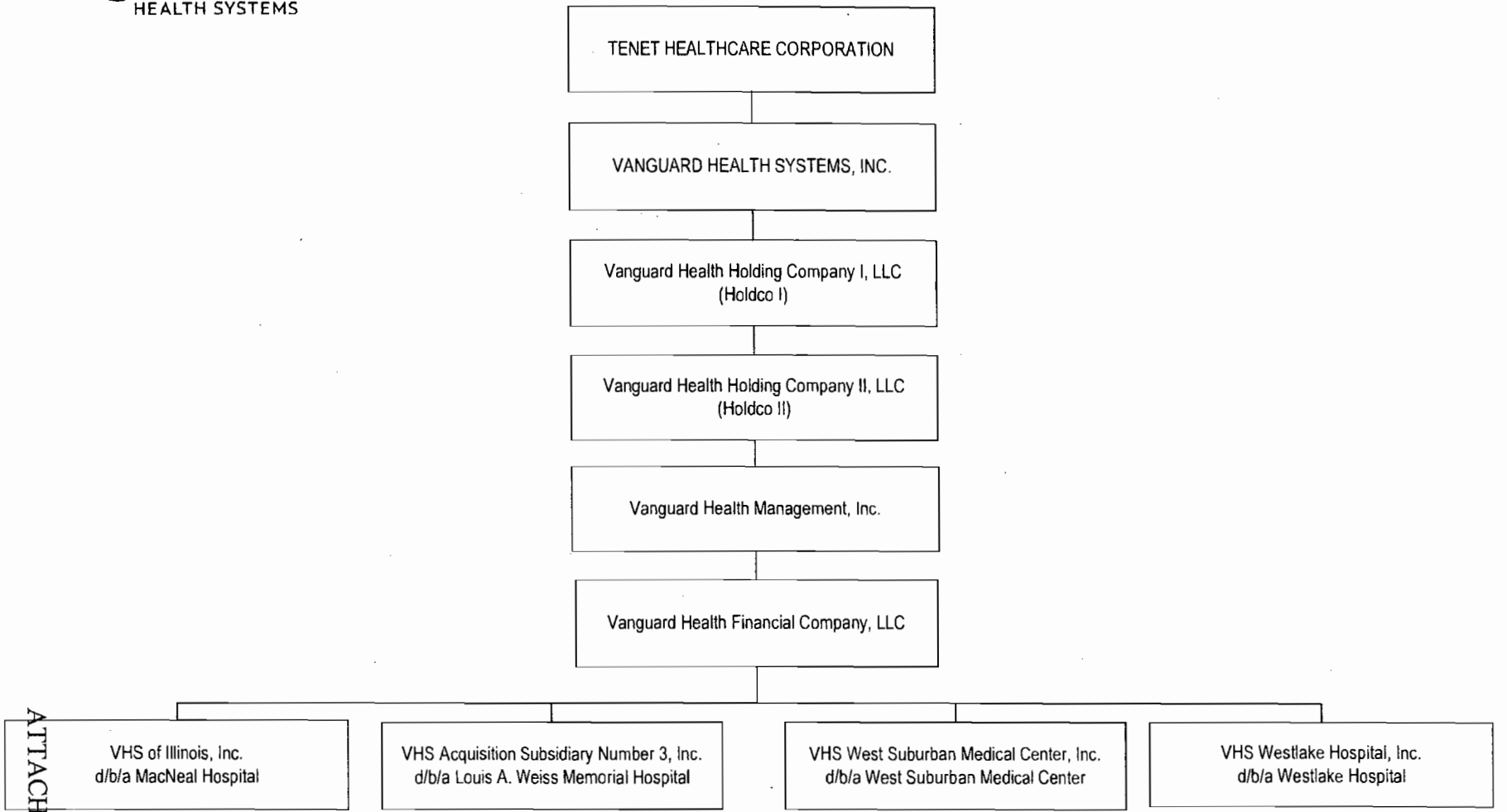
(2) Based on a Schedule 13G/A filed with the SEC on February 6, 2012 by Franklin Mutual Advisers, LLC ("Franklin"), on behalf of itself and its named subsidiaries and affiliates, as of December 31, 2011. Franklin reported sole voting and investment power with respect to all of the shares indicated above.

(3) Based on a Schedule 13G filed with the SEC by Harris Associates L.P. ("Harris") on February 14, 2012, along with its general partner Harris Associates, Inc. ("HAI"), as of December 30, 2011. Harris and HAI reported sole voting and investment power with respect to all of the shares indicated above.

(4) Based on a Schedule 13G/A filed with the SEC on February 9, 2012 by The Vanguard Group, Inc. ("Vanguard"), on behalf of itself and its named subsidiaries and affiliates, as of December 31, 2011. The group reported sole voting power with respect to 592,789 of the shares indicated above, sole investment power with respect to 27,578,026 of the shares indicated above and shared investment power with respect to 592,789 of the shares indicated above.

Vanguard
HEALTH SYSTEMS

ILLINOIS



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ATTACHMENT 4

June 25, 2013

PROJECT COSTS AND SOURCES OF FUNDS

Stock Acquisition:
Tenet Healthcare Corporation ("Tenet") is acquiring 100% of the stock of Vanguard Health Systems, Inc., ("Vanguard") for $1.8B in cash, and as a consequence of the acquisition will assume Vanguard's outstanding debt, as discussed below. The applicant has confirmed that its most recent audited financial statements confirmed that it had cash or equivalents in excess of the imputed purchase price of the Illinois hospitals being acquired in this stock acquisition. A total of 7,027 beds are located in the Vanguard hospitals, system-wide. As a result, $256,155 has been allocated to each bed located in a Vanguard hospital ($1.8B / 7,027 = $256,155).

Assumption of Vanguard Debt:
Tenet will assume responsibility for $2.5B in outstanding Vanguard debt. This debt will not be held at the individual hospital level. However, and consistent with technical guidance provided by IDPH staff, for purposes of the Illinois CON applications, a portion of that debt will be attributed to each of the Illinois hospitals. Consistent with the methodology discussed above, the debt to be assumed by Tenet is allocated at the rate of $355,771 per bed ($2,500,000,000 / 7,027 = $355,771).

ATTACHMENT 7

Paul A. Castanon
Vice President & Deputy General Counsel
Tel: 469-893-6733
Fax: 469-893-7733
paul.castanon@tenethealth.com

July 10, 2013

Ms. Courtney Avery
Illinois Health Facilities
And Services review Board
525 West Jefferson
Springfield, IL 62761

Dear Ms. Avery:

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

1. Tenet Healthcare Corporation does not own or operate any licensed health care facilities in Illinois;
2. Tenet Health Care Corporation does not have any Adverse Actions against any facility owned and operated by the applicant during the three (3) year period prior to the filing of this application; and
3. Tenet Healthcare Corporation authorizes the State Board and Agency access to information to verify documentation or information submitted in response to the requirements of Review Criterion 1110.230.b or to obtain any documentation or information which the State Board or Agency finds pertinent to this application.

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

Sincerely,

Paul A. Castanon
VP, Deputy General Counsel

PAC/sms

ATTACHMENT 11

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ATTACHMENT 11

State of Illinois 2127907
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

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

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

LA MAR HASBROUCK, MD, MPH
DIRECTOR

EXPIRATION DATE	CATEGORY	I.D. NUMBER
05/31/14	8680	0005249

FULL LICENSE
GENERAL HOSPITAL
EFFECTIVE: 06/01/13

BUSINESS ADDRESS

VHS ACQUISITION SUBSIDIARY NUMBER 3, INC
D/B/A LOUIS A. WEISS MEMORIAL HOSPITAL
4646 N. MARINE DRIVE
CHICAGO IL 60640

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

← DISPLAY THIS PART IN A CONSPICUOUS PLACE

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State of Illinois 2127907
Department of Public Health
LICENSE, PERMIT, CERTIFICATION, REGISTRATION

VHS ACQUISITION SUBSIDIARY NUMBER 3,

EXPIRATION DATE	CATEGORY	I.D. NUMBER
05/31/14	8680	0005249

FULL LICENSE
GENERAL HOSPITAL
EFFECTIVE: 06/01/13

04/06/13

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

FEE RECEIPT NO.

The Joint Commission

April 22, 2011

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

Joint Commission ID #: 7286
Program: Hospital Accreditation
Accreditation Activity: 60-day Evidence of Standards Compliance
Accreditation Activity Completed: 04/22/2011

Dear Mr. Molinaro:

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

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

- Comprehensive Accreditation Manual for Hospitals

This accreditation cycle is effective beginning February 17, 2011. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 36 months.

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

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

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

Sincerely,

Ann Scott Blouin RN, PhD

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

ATTACHMENT 11

The Joint Commission

Louis A. Weiss Memorial Hospital
4646 North Marine Drive
Chicago, IL 60640

Organization Identification Number: 7286

Program(s)	**Survey Date(s)**
Hospital Accreditation	07/17/2012-07/17/2012

Executive Summary

As a result of the survey conducted on the above date(s), there are no survey findings identified. Your official report will be posted to your organization's confidential extranet site.

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

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

HOSPITALS OWNED OR LEASED BY TENET

The following table lists, by state, the hospitals owned or leased and operated by our subsidiaries as of December 31, 2012:

Hospital	Location	Licensed Beds	Status
Alabama			
Brookwood Medical Center	Birmingham	631	Owned
California			
Desert Regional Medical Center(1)	Palm Springs	387	Leased
Doctors Hospital of Manteca	Manteca	73	Owned
Doctors Medical Center	Modesto	461	Owned
Fountain Valley Regional Hospital & Medical Center	Fountain Valley	400	Owned
John F. Kennedy Memorial Hospital	Indio	156	Owned
Lakewood Regional Medical Center	Lakewood	172	Owned
Los Alamitos Medical Center	Los Alamitos	167	Owned
Placentia Linda Hospital	Placentia	114	Owned
San Ramon Regional Medical Center(2)	San Ramon	123	Owned
Sierra Vista Regional Medical Center	San Luis Obispo	164	Owned
Twin Cities Community Hospital	Templeton	122	Owned
Florida			
Coral Gables Hospital	Coral Gables	245	Owned
Delray Medical Center	Delray Beach	493	Owned
Good Samaritan Medical Center	West Palm Beach	333	Owned
Hialeah Hospital	Hialeah	378	Owned
North Shore Medical Center	Miami	357	Owned
North Shore Medical Center – FMC Campus	Lauderdale Lakes	459	Owned
Palm Beach Gardens Medical Center(3)	Palm Beach Gardens	199	Leased
Palmetto General Hospital	Hialeah	360	Owned
Saint Mary's Medical Center	West Palm Beach	464	Owned
West Boca Medical Center	Boca Raton	195	Owned
Georgia			
Atlanta Medical Center	Atlanta	460	Owned
North Fulton Regional Hospital(3)	Roswell	202	Leased
South Fulton Medical Center(4)	East Point	338	Owned
Spalding Regional Hospital	Griffin	160	Owned
Sylvan Grove Hospital(5)	Jackson	25	Leased
Missouri			
Des Peres Hospital	St. Louis	143	Owned
St. Louis University Hospital	St. Louis	356	Owned
North Carolina			
Central Carolina Hospital	Sanford	137	Owned
Frye Regional Medical Center(3)	Hickory	355	Leased
Pennsylvania			
Hahnemann University Hospital	Philadelphia	496	Owned
St. Christopher's Hospital for Children	Philadelphia	189	Owned
South Carolina			
Coastal Carolina Hospital	Hardeeville	41	Owned
East Cooper Medical Center	Mount Pleasant	140	Owned
Hilton Head Hospital	Hilton Head	93	Owned
Piedmont Medical Center	Rock Hill	288	Owned
Tennessee			
Saint Francis Hospital	Memphis	519	Owned
Saint Francis Hospital – Bartlett	Bartlett	196	Owned

ATTACHMENT 11

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Texas			
Centennial Medical Center	Frisco	118	Owned
Cypress Fairbanks Medical Center	Houston	181	Owned
Doctors Hospital at White Rock Lake	Dallas	218	Owned
Houston Northwest Medical Center(6)	Houston	430	Owned
Lake Pointe Medical Center(7)	Rowlett	112	Owned
Nacogdoches Medical Center	Nacogdoches	153	Owned
Park Plaza Hospital	Houston	444	Owned
Providence Memorial Hospital	El Paso	508	Owned
Sierra Medical Center	El Paso	351	Owned
Sierra Providence East Medical Center	El Paso	110	Owned

(1) Lease expires in 2027.
(2) In January 2013, we announced that we were creating a joint venture partnership with John Muir Health, a not-for-profit integrated system of doctors, hospitals and other health care services in the San Francisco Bay area, through which John Muir Health will invest approximately $100 million to acquire a 49% ownership interest in San Ramon Regional Medical Center.
(3) The current lease terms for Palm Beach Gardens Medical Center, North Fulton Regional Hospital and Frye Regional Medical Center expire in February 2014, but may be renewed through at least February 2039, in each case subject to certain conditions contained in the respective leases. In February 2013, we exercised our options under the leases to purchase the hospitals.
(4) Effective January 1, 2013, South Fulton Medical Center was consolidated with Atlanta Medical Center and renamed Atlanta Medical Center – South Campus.
(5) Designated by the Centers for Medicare and Medicaid Services ("CMS") as a critical access hospital. Although it has not sought to be accredited, the hospital participates in the Medicare and Medicaid programs by otherwise meeting the Medicare Conditions of Participation. The current lease term for this facility expires in December 2016, but may be renewed through December 2046, subject to certain conditions contained in the lease.
(6) Owned by a limited liability company in which a Tenet subsidiary owned an 86.61% interest at December 31, 2012 and is the managing member.
(7) Owned by a limited liability company in which a Tenet subsidiary owned a 94.59% interest at December 31, 2012 and is the managing member.

As of December 31, 2012, the largest concentrations of licensed beds in our hospitals were in Florida (26.4%), Texas (19.9%) and California (17.7%). Strong concentrations of hospital beds within market areas help us contract more successfully with managed care payers, reduce management, marketing and other expenses, and more efficiently utilize resources. However, these concentrations increase the risk that, should any adverse economic, regulatory, environmental or other condition occur in these areas, our overall business, financial condition, results of operations or cash flows could be materially adversely affected.

The following table presents the number of hospitals operated by our subsidiaries, as well as the total number of licensed beds at those facilities, at December 31, 2012, 2011 and 2010:

	December 31,		
	2012	2011	2010
Total number of facilities(1)	49	50	50
Total number of licensed beds(2)	13,216	13,453	13,428

(1) Includes all general hospitals and our critical access facility, as well as one facility at December 31, 2011 and 2010 that is classified in discontinued operations for financial reporting purposes as of December 31, 2012.
(2) Information regarding utilization of licensed beds and other operating statistics can be found in Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, of this report.

ATTACHMENT 11

PURPOSE OF PROJECT

The project is limited to a change of ownership/control of one of four Illinois hospitals currently owned by subsidiaries of Vanguard Health Systems, Inc. ("Vanguard"), with the Illinois acquisitions representing a fraction of the hospitals being acquired by subsidiaries of Tenet Healthcare Corporation ("Tenet") as part of the acquisition by merger of 100% of Vanguard's stock. Similar CON applications were concurrently filed, addressing the change of ownership of each of the other three Vanguard hospitals in Illinois. The continued operation of VHS-Weiss Memorial Hospital will improve the well-being of the communities served by the hospital, as the hospital has done since its opening; and the merger of Vanguard and Tenet will enhance the hospitals' ability to serve their surrounding communities.

The following table, taken from hospital discharge data, presents the hospital's inpatient origin, for the 12-month period ending May 31, 2013. Each of the eleven ZIP Code areas contributing a minimum of 1.0% of the hospital's admissions during that period are identified. As documented in the inpatient origin analysis presented below, VHS-Weiss Memorial Hospital primarily serves the north side of Chicago, with a geographically-concentrated patient population. Nearly three-quarters of the patients admitted to the hospital during the analysis period resided within the eleven ZIP Code area.

No changes in patient origin are anticipated as a result of the proposed change of ownership.

Zip	City	%	Cum. %
60640	Chicago	38.6%	38.6%
60660	Chicago	11.2%	49.8%
60626	Chicago	6.6%	56.5%
60613	Chicago	6.5%	63.0%
60625	Chicago	2.7%	65.7%
60659	Chicago	1.8%	67.6%
60618	Chicago	1.7%	69.2%
60645	Chicago	1.6%	70.8%
60657	Chicago	1.1%	71.9%
60647	Chicago	1.0%	72.9%
60641	Chicago	1.0%	73.9%
	other, <1.0%	26.1%	100.0%

Due to the limited nature of the proposed project, specific service-related goals are not applicable to the project, with the exception of the hospital's continued service to the surrounding communities.

ALTERNATIVES

As noted in the NARRATIVE DESCRIPTION provided in Section I of this application, the proposed change of ownership of the four Illinois hospitals owned by Vanguard Health Systems, Inc. ("Vanguard") is the result of the acquisition by merger of 100% of Vanguard's stock by Tenet Healthcare Corporation. This stock acquisition will result in a change to the hospital's "ultimate parent", but will not result in a change in the Vanguard subsidiary that owns the hospital or holds the IDPH license. This application is being filed to reflect that change in the ultimate parent/control of the hospital. As a result, there are no alternatives to the proposed project, which is limited to a change of ownership/control.

MERGERS, CONSOLIDATIONS, and
ACQUISITIONS/CHANGES OF OWNERSHIP

A. Impact Statement

It is not anticipated that the proposed change of ownership resulting from the acquisition by merger will have any material impact on the manner in which services are provided at VHS-Weiss Memorial Hospital. No changes to the staffing levels of the hospital, other than those changes normally associated with the ongoing operations of a hospital are anticipated during the first two years following the transaction, nor are any changes anticipated in the number of IDPH-approved beds or the hospital's IDPH-designated "categories of service".

The change of ownership is a result of the stock acquisition discussed in this application's NARRATIVE DESCRIPTION. The operating entity will continue to be VHS Acquisition Subsidiary Number 3, Inc., and Tenet will honor commitments made by Vanguard in conjunction with Vanguard's acquisition of its four Illinois hospitals.

The cost associated with the proposed change of ownership is limited to those costs identified in ATTACHMENT 7; and the primary benefit of the project is the ongoing operation of the facility.

B. Access

The proposed change of ownership will not result in any change in accessibility to the hospital's services for residents of the area. The hospital will, following the change in control,

operate with the admissions, charity care and financial assistance policies currently in place at the hospital. Confirmation, as required by review criterion 1110.240(c) is attached.

The admissions, charity care, and financial assistance policies are attached.

Consistent with the current practices of the hospital, services will continue to be provided to Medicaid recipients.

C. Health Care System

The proposed change of ownership will not have any impact on any other area provider.

Neither Tenet Healthcare Corporation ("Tenet") nor any of its subsidiaries currently own or operate any hospitals in Illinois. As noted in this application's NARRATIVE DESCRIPTION, four Illinois hospitals are being acquired by subsidiaries of Tenet. The other three hospitals are:

- VHS-Westlake Hospital, 1225 Lake Street, Melrose Park (20.33 mi/36 min)
- VHS-MacNeal Hospital, 3249 S. Oak Park Avenue, Berwyn (7.26 mi/18 min)
- VHS-West Suburban Medical Center, 3 Erie Court, Oak Park (4.08 mi/12 min)

All four of those hospitals are located in the metropolitan Chicago area. Neither Tenet nor any of its subsidiaries currently own or operate any licensed health care facilities in Illinois. Certificate of Need applications addressing Tenet's intended acquisition through its merger with Vanguard of the three other hospitals identified above have been filed with the IHFSRB.

A table, identifying the IDPH-designated categories of services provided by each of Vanguard's currently-owned Illinois hospitals, along with each service's 2012 utilization is provided in this ATTACHMENT.

Photocopies of all patient transfer/referral agreements currently in place at the hospital are attached. Those agreements will stay in effect following the change in control, and additional agreements are not anticipated.

Patient transfers and referrals are made by the patient's physician and family, with no requirement that transfers or referrals be made to specific facilities. There are currently no restrictions on the use of other area care providers, and the same will apply following the proposed change of control.

As part of management's commitment to address the needs of the communities that the individual Vanguard hospitals serve, the need to provide redundant clinical services is reviewed on an ongoing basis. As appropriate for the communities being served and the individual hospitals, the potential exists (as it does at any hospital) for the consolidation of duplicated services. Any decision to do so would be made consistent with all IDPH/IHFSRB requirements.

VHS-Weiss Memorial Hospital is a vital community resource on the north side of Chicago, is an active participant in community activities, and provides a broad spectrum of community-related services. As is the case with all hospitals, it is anticipated that VHS-Weiss Memorial Hospital's role in its community will continue to evolve following the change of

control. It is unclear at this time, however, what additional community services will be provided. A sampling of the community programs offered by the hospital is attached.

ATTACHMENT 19

Vanguard Health Systems-Illinois Hospitals
IDPH-Designated Categories of Service
Calendar 2012 Utilization

	Weiss	W. Suburban	MacNeal	Westlake
Medical Surgical beds	184	135	250	111
Medical Surgical patient days	22,998	22,999	52,415	14,647
Obstetrics bed		20	25	24
Obstetrics patient days		4,878	4,674	2,279
Pediatrics beds		5	10	5
Pediatrics patient days		1,435	714	613
ICU beds	16	24	26	12
ICU patient days	4,084	3,595	4,600	2,461
Comp. Physical Rehab. beds	26			40
Comp. Phys. Rehab. patient days	4,049			4,592
Acute Mental Illness beds	10		62	33
Acute Mental Illness patient days	2,948		17,884	10,327
Gen'l Long Term Care beds		50		
Gen'l LTC patient days		11,971		
Open Heart Surgery cases	32	40	82	11
Cardiac Catheterization cases	753	738	1,127	758

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ATTACHMENT 19

Trevor Fetter
President & Chief Executive Officer
Tel: 469-893-6175
Fax: 469-893-8653
trevor.fetter@tenethealth.com

July 11, 2013

Ms. Courtney Avery
Illinois Health Facilities
and Services Review Board
525 West Jefferson
Springfield, IL 62761

Dear Ms. Avery:

Pursuant to Review Criterion 1110.240(c), I hereby certify in my capacity as President and Chief Executive Officer of Tenet Healthcare Corporation ("Tenet") that, as specified in the Application for Permit being submitted to the Illinois Health Facilities and Services Review Board:

(i) no reductions in access to care will result from the proposed acquisition by Tenet of the four Illinois hospitals currently owned by Vanguard Health Systems, Inc. (the "Vanguard Illinois Hospitals"); and

(ii) following the acquisition, Tenet will not amend the admissions, charity care and financial assistance policies currently in place at the Vanguard Illinois Hospitals to reduce access to care.

Very truly yours,

Trevor Fetter
President and CEO

Vanguard HEALTH SYSTEMS
health forward

Date: January 24, 2013	Approved By: Neal Somaney
Section: Business Office	
Subsection: Charity Care, Financial Assistance and Billing & Collection Policies for Uninsured Patients	
Policy Procedure No. – **PPREVC801**	
Effective Date: January 24, 2009	Previous Date: N/A

POLICIES & PROCEDURES

SCOPE:
All Company-affiliated hospitals.

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

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

2. Billing and Collection Processes for Uninsured Patients. All uninsured patients receiving care at the Company's Hospitals will be treated with respect and in a professional manner before, during and after receiving care. Each of the Company's Hospitals should adopt a written policy in conformity with the Company's Policy and Procedure set forth herein for its billing and collection practices in respect of all uninsured patients, including those uninsured patients who qualify for classification as Financially Indigent or Medically Indigent under this Policy.

ATTACHMENT 19

Vanguard HEALTH SYSTEMS
health forward

Date: January 24, 2013	Approved By: Neal Somaney
Section: Business Office	
Subsection: Charity Care, Financial Assistance and Billing & Collection Policies for Uninsured Patients	
Policy Procedure No. – **PPREVC801**	
Effective Date: January 24, 2009	Previous Date: N/A

POLICIES & PROCEDURES

PROCEDURE:

A. CHARITY CARE AND FINANCIAL ASSISTANCE PROCESS

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

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

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

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

B. Calculation of Income.

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

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

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

ATTACHMENT 19

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

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

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

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

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

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

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

D. Homeless Patients. Homeless patients may be deemed to have no Income for purposes of the Hospital's calculation of Income. Documentation of Income is not required

for homeless patients. Income verification is still required for any other family members (members of family are as defined in section "Calculation of Immediate Family Members") only if other family information is available.

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

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

G. Eligibility Cannot be Determined. If and when Hospital personnel cannot clearly determine eligibility, the Hospital personnel will use best judgment and submit a memorandum (such memorandum should be the first sheet in the documentation packet) listing reasons for judgment along with Financial Assistance documentation to appropriate supervisor. The Hospital Supervisor will then review the memorandum and documentation. If the Supervisor agrees to approve the eligibility, they will sign Eligibility Determination form and continue with normal Approval process. If the Supervisor does not approve eligibility of the patient under this Policy, the Supervisor should sign the submitted memorandum and return all documentation to Hospital personnel who will note account and send documentation to the Hospital's Business Office for filing. If Supervisor disagrees with hospital personnel's judgment, Supervisor should state reasons for new judgment and will return documentation to hospital personnel who will follow either denial process or approval process as determined by Supervisor.

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

I.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10. **Document Retention Procedures.** Hospital will maintain documentation sufficient to identify for each patient qualified as Financially Indigent or Medically Indigent, the patient's Income, the method used to verify the patient's Income, the amount owed by the patient, and the person who approved granting the patient status as Financially Indigent or Medically Indigent. All documentation will be forwarded and filed within the Hospital's Business Office for audit purposes. Financial Assistance applications and all documentation will be retained within the Hospital's Business Office for 1 calendar year. After which, the documents will be boxed and marked as: Charity Docs, JANUARY YYYY-DECEMBER YYYY and forwarded to the Hospital Warehouse, where it will then be retained for an additional 6 years before shredding.

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

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

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

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

2. **Trained Financial Counselors.** All uninsured patients at the Company's

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

3. **Additional Invoice Statements or Enclosures.** When sending a bill to uninsured patients, the Hospital should include (a) a statement on the bill or in an enclosure to the bill that indicates that if the patient meets certain income requirements, the patient may be eligible for a government-sponsored program or for financial assistance from the Hospital under its charity care or financial assistance policy; and (b) a statement on the bill or in an enclosure to the bill that provides the patient a telephone number of a hospital employee or office from whom or which the patient may obtain information about such financial assistance policy for patients and how to apply for such assistance. The following statement on the bill or in an enclosure to the bill complies with the above requirements of this Section B.3.: "Please note, based on your household income, you may be eligible for Medicaid *[Note: please refer to MediCal for California patients and Arizona's AHCCCS program for Arizona patients]* or financial assistance from the Hospital. For further information, please contact our customer service department at (XXX) XXX-XXXX."

4. **Notices.** Each of the Company's hospitals should post notices regarding the availability of financial assistance to uninsured patients. These notices should be posted in visible locations throughout the hospital such as admitting/registration, billing office and emergency department. The notices also should include a contact telephone number that a patient or family member can call for more information. The following specific language complies the above notice requirements of this Section B.4.: "For help with your Hospital bill or Financial Assistance, please call or ask to see our Financial Counselor or call (XXX) XXX-XXXX (M-F 8:30 am to 4:30 pm)."

5. **Liens on Primary Residences.** The Company's hospitals shall not, in dealing with patients who quality as Financially Indigent or Medically Indigent under this Policy, place or foreclose liens on primary residences as a means of collecting unpaid hospital bills. However, as to those patients who qualify as Medically Indigent but have income in

excess of 500% of the Federal Poverty Guidelines, the Company may place liens on primary residences as a means of collecting discounted hospital bills, but the Company's hospitals may not pursue foreclosure actions in respect of such liens.

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

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

8. **Interest Free, Extended Payment Plans**. All uninsured patients shall be offered extended payment plans by the Company's hospitals to assist the patients in settling past due outstanding hospital bills. The Company's hospitals will not charge uninsured patients any interest under such extended payment plans.

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

10.

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

C. **RESERVATION OF RIGHTS AGAINST THIRD PARTIES.**

Nothing in this Policy shall preclude the Company's hospitals from pursuing reimbursement from third party payors, third party liability settlements or tortfeasors or other legally responsible third parties.

REFERENCES

HHS, Office of Inspector General, Guidance dated February 2, 2004, entitled " Hospital Discounts

Offered to Patients Who Cannot Afford To Pay Their Hospital Bills".

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

Federal Poverty Guidelines published by US Department of Health and Human Services from time to time. (Most recent publication at effective date of this Policy is *Federal Register*, Volume 77, No. 7 FR 4150-05-P, January 23, 2012.

FINANCIAL ASSISTANCE ELIGIBILITY GUIDELINES

Based on Federal Poverty Guidelines Effective January 23, 2013

Schedule A (shaded)
Financially Indigent

Schedule B (unshaded)
Medically Indigent

Number In Household	100%	200%	300%	400%	500%
1	11,490	22,980	34,470	45,960	57,450
2	15,510	31,020	46,530	62,040	77,550
3	19,530	39,060	58,590	78,120	97,650
4	23,550	47,100	70,650	94,200	######
5	27,570	55,140	82,710	######	######
6	31,590	63,180	94,770	######	######
7	35,610	71,220	######	######	######
8	39,630	79,260	######	######	######
Discount	100%		80%	60%	40%
Financially Indigent Classification					

Schedule C

Catastrophic Eligibility as Medically Indigent

Includes patient's income that exceeds 500% of the Federal Poverty Guidelines

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

ATTACHMENT 19

[HOSPITAL LETTERHEAD]

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

[DATE]

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

Dear «GUARANTOR»,

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

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

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

Sincerely,

[Customer Service Representative]

FINANCIAL ASSISTANCE ELIGIBILITY DETERMINATION
OFFICE USE ONLY

Patient Name _____

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

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

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

YES Approved for 100% financial assistance as Financially Indigent.

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

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

YES Continue to Step 3.

NO Patient does not qualify for Financial Assistance.

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

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

NO Continue to Step 4

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

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

NO: Patient does not qualify for Financial Assistance.

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

Employee Name (Print)_____

Employee Signature_____ Approved By _____

Date _____ Approved By _____

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

Income Verification Codes

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

ATTACHMENT 19

FINANCIAL ASSISTANCE APPLICATION INSTRUCTIONS

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

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

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

_____ Hospital
_____
_____
_____

Income Verification:

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

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

PLEASE ALSO INCLUDE ONE OR MORE OF THE FOLLOWING:

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

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

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

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

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

GRNTOR #: _____

HOSP CODE: _____

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PATIENT INFORMATION/INFORMACION DEL PACIENTE

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

GUARANTOR INFORMATION/PERSONA RESPONSABLE

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

FINANCIAL INFORMATION/INFORMACION FINANCIAL

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

RESOURCES/RECURSOS

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

MONTHLY EXPENSES/GASTOS MENSUALES

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

HOUSEHOLD COMPOSITION/INFORMACION DE LA CASA

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

If unable to provide requested documents, please explain below/

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

COMMENTS/COMETARIOS:

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Signature Approval Date

ATTACHMENT 19

Notes

mapquest

Trip to:
Macneal Hospital
3249 Oak Park Ave
Berwyn, IL 60402
(708) 783-3150
20.04 miles / 35 minutes

ATM - Louis Weiss Memorial Hospital
4646 N Marine Dr, Chicago, IL 60637
(800) 432-1000

1. Start out going **south** on **N Marine Dr** toward **W Wilson Ave**. Map	**0.3 Mi** *0.3 Mi Total*
2. Merge onto **US-41 S**. Map	**8.1 Mi** *8.4 Mi Total*
3. Merge onto **I-55 S / Stevenson Expy S** toward **I-90 / St Louis / I-94**. Map	**8.3 Mi** *16.7 Mi Total*
4. Take the **Central Ave** exit, **EXIT 285**. Map	**0.3 Mi** *17.0 Mi Total*
5. Turn **right** onto **S Central Ave**. Map	**0.7 Mi** *17.7 Mi Total*
6. Turn **left** onto **W Pershing Rd / W 39th St**. Map	**1.5 Mi** *19.2 Mi Total*
7. Turn **right** onto **Oak Park Ave**. Map	**0.8 Mi** *20.0 Mi Total*
8. **3249 OAK PARK AVE**. Map	

Macneal Hospital
Radiology
3249 Oak Park Ave, Berwyn, IL 60402
(708) 783-3150

Total Travel Estimate: **20.04 miles - about 35 minutes**

BOOK TRAVEL with **mapquest** (877) 577-5766

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ATTACHMENT 19

Notes

mapquest

Trip to:
West Suburban Medical Center
3 Erie Ct
Oak Park, IL 60302
(708) 383-6200
16.46 miles / 29 minutes

ATM - Louis Weiss Memorial Hospital
4646 N Marine Dr, Chicago, IL 60637
(800) 432-1000

1. Start out going **south** on **N Marine Dr** toward **W Wilson Ave**. Map	**0.3 Mi** *0.3 Mi Total*
2. Merge onto **US-41 S**. Map	**6.3 Mi** *6.6 Mi Total*
3. Turn **right** onto **E Jackson Dr**. Map	**0.2 Mi** *6.8 Mi Total*
4. Turn **left** onto **S Columbus Dr**. Map	**0.2 Mi** *7.0 Mi Total*
5. Turn **right** onto **E Congress Pky**. Map	**0.9 Mi** *7.8 Mi Total*
6. **E Congress Pky** becomes **I-290 W / IL-110 W / Eisenhower Expy W**. Map	**6.8 Mi** *14.7 Mi Total*
7. Take the **Austin Blvd** exit, **EXIT 23A**, on the **left**. Map	**0.3 Mi** *15.0 Mi Total*
8. Turn **right** onto **S Austin Blvd**. Map	**1.4 Mi** *16.4 Mi Total*
9. Turn **left** onto **Erie St**. Map	**0.05 Mi** *16.4 Mi Total*
10. Take the 1st **left** to stay on **Erie St**. Map	**0.02 Mi** *16.5 Mi Total*
11. **3 ERIE CT**. Map	

West Suburban Medical Center
3 Erie Ct, Oak Park, IL 60302
(708) 383-6200

Total Travel Estimate: **16.46 miles - about 29 minutes**

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ATTACHMENT 19

LF

Notes

mapquest

Trip to:
Westlake Hospital-ER
1225 W Lake St
Melrose Park, IL 60160
(708) 938-7190
20.30 miles / 35 minutes

ATM - Louis Weiss Memorial Hospital
4646 N Marine Dr, Chicago, IL 60637
(800) 432-1000

1. Start out going **south** on **N Marine Dr** toward **W Wilson Ave**. Map	**0.3 Mi**	*0.3 Mi Total*
2. Merge onto **US-41 S**. Map	**6.3 Mi**	*6.6 Mi Total*
3. Turn **right** onto **E Jackson Dr**. Map	**0.2 Mi**	*6.8 Mi Total*
4. Turn **left** onto **S Columbus Dr**. Map	**0.2 Mi**	*7.0 Mi Total*
5. Turn **right** onto **E Congress Pky**. Map	**0.9 Mi**	*7.8 Mi Total*
6. **E Congress Pky** becomes **I-290 W / IL-110 W / Eisenhower Expy W**. Map	**10.0 Mi**	*17.8 Mi Total*
7. Take the **IL-171 / 1st Ave** exit, **EXIT 20**. Map	**0.1 Mi**	*18.0 Mi Total*
8. Stay **straight** to go onto **Harrison St**. Map	**0.07 Mi**	*18.0 Mi Total*
9. Take the 1st **right** onto **S 1st Ave / IL-171**. Map	**1.5 Mi**	*19.6 Mi Total*
10. Turn **left** onto **Chicago Ave**. Map	**0.7 Mi**	*20.3 Mi Total*
11. Turn **left**. Map	**0.04 Mi**	*20.3 Mi Total*
12. **1225 W LAKE ST**. Map		

Westlake Hospital-ER
1225 W Lake St, Melrose Park, IL 60160
(708) 938-7190

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Total Travel Estimate: **20.30 miles - about 35 minutes**

BOOK TRAVEL with **mapquest** (877) 577-5766

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ATTACHMENT 19

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TRANSFER AGREEMENT

THIS TRANSFER AGREEMENT ("Agreement"), made and effective as of September 1, 2007 (the "Effective Date"), is by and between **MID AMERICA CARE CENTER, LLC**, an Illinois limited liability company d/b/a **MID AMERICA CARE CENTER**, and Weiss Memorial Hospital, a VHS Acquisition Subsidiary No. 3 corporation d/b/a **WEISS MEMORIAL HOSPITAL** (the parties are sometimes referred to individually as a "Facility" and collectively as the "Facilities").

RECITALS:

WHEREAS, the parties desire to enter into this Agreement governing the transfer of patients between the two facilities located in Illinois ("State").

WHEREAS, the parties desire to enter into this 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 hereto agree as follows:

AGREEMENT:

1. Transfer of Patients. If either facility believes that a patient of that facility ("Transferring Facility") requires the services of the other facility ("Receiving Facility") and the transfer is deemed medically appropriate, a member of the nursing staff of the Transferring Facility (or the patient's attending physician) will contact the Receiving Facility's admitting office or Emergency Department to arrange for appropriate treatment as provided 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 on the Accreditation of Healthcare Organizations ("JCAHO") 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. The Receiving Facility's responsibility for the patient's care shall begin when the patient is admitted to the Receiving Facility.

2. Responsibilities of the Transferring Facility. The Transferring Facility shall be responsible to:

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

(d) Notify the Receiving Facility's designated representative before transfer to confirm availability of appropriate facilities, services and staff necessary to provide care to the patient.

(e) Before patient transfer, the transferring physician shall contact and secure a receiving physician at the 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 the 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 without limitation: records relating to the patient's condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and, with respect to a patient with an emergency medical condition that has not been stabilized, a copy of the patient's informed consent to the transfer or physician certification that the medical benefits of the transfer outweigh the risk of transfer. If all necessary and relevant medical records are not available at the time the patient is transferred, then the Transferring Facility shall forward the records as soon as possible.

(i) Transfer the patient's personal effects, including without limitation money and valuables, and information related to those items.

(j) Provide the Receiving Facility any information that is available concerning the patient's coverage or eligibility under a third party coverage plan, Medicare or Medicaid, or a health care assistance program established by a county, public hospital, or hospital district.

(k) Notify the Receiving Facility of an estimated time of arrival for the patient.

(l) Provide for the completion of a certification statement, summarizing the risk and benefits of the transfer of a patient with an emergency medical condition that has not been stabilized, by the transferring physician or other qualified personnel if the physician is not physically present at the facility at the time of transfer.

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

(n) Recognize the right of a patient to request a transfer to the care of a physician and hospital of the patient's choosing.

(o) Recognize the right of a patient to refuse consent to treatment or transfer.

(p) Complete, execute and forward a memorandum of transfer form to the Receiving Facility for every patient who is transferred.

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

3. Responsibilities of the Receiving Facility. The Receiving Facility shall be responsible to:

(a) Confirm with the Transferring Facility, as promptly as possible, that the Receiving Facility has available beds and appropriate facilities, services and staff necessary to treat the patient and that the Receiving Facility has agreed to accept transfer of the patient. The Receiving Facility shall respond to the Transferring Facility within three minutes 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 the Receiving Facility and provide, on request, the names of on-call physicians to the Transferring Facility.

(c) Reserve appropriate beds, facilities and services for patients being transferred from the Transferring Facility who have been accepted by the Receiving Facility and a receiving physician, if deemed necessary by a transferring physician, unless the Receiving Facility needs them 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) Provide the Transferring Facility with a copy of the medical records of the patient that were generated at the Receiving Facility, if the Receiving Facility returns the patient to the Transferring Facility.

(g) Maintain the confidentiality of the patient's medical records in accordance with applicable state and federal law.

(h) Establish policies and/or protocols for (i) maintaining the confidentiality of the patient's medical records in accordance with applicable state and federal law, (ii) the receipt of patients into the facility, and (iii) the acknowledgment and inventory of patient valuables transported with patients.

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

(j) Upon request, provide to the Transferring Facility and patient current information concerning the Receiving Facility's eligibility standards and payment practices.

(k) Acknowledge any contractual obligations and comply with any statutory or regulatory obligations that might exist between a patient and a designated provided.

(l) Complete, execute, and return the memorandum of transfer form to the Transferring Facility.

4. Billing. All charges incurred with respect to any services performed by either facility for patients received from the other facility pursuant to this Agreement shall be billed and collected by the facility providing such services directly from the patient, third party coverage, Medicare or Medicaid, or other sources normally billed by that facility. In addition, it is understood that the physicians or other professional providers that may participate in the care and treatment of the patient will bill professional fees at usual and customary charges. Each facility shall provide information in its possession to the other facility and such physicians/providers sufficient to enable them to bill the patient, responsible party, or appropriate third-party payer.

5. Retransfer; Discharge. At such time as the patient is ready for transfer back to the Transferring Facility or another health care facility or for discharge from the Receiving Facility, in accordance with the direction from the Transferring Facility and with the proper notification of the patient's family or guardian, the Receiving Facility will transfer the patient to the agreed-upon location. If the Receiving Facility is to transfer the patient back to the Transferring Facility, the Receiving Facility will be responsible for the care of the patient up until the time the patient is re-admitted to the Transferring Facility.

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 medical records and confidentiality of patient information

as well as with all standards promulgated by any relevant accrediting agency. Each party represents and warrants to the other party, that it is not an Ineligible Person. An "Ineligible Person" is an individual or entity who: (i) is currently excluded, debarred, suspended, or otherwise ineligible to participate in the Federal health care programs or in Federal procurement or non-procurement programs; or (ii) has been convicted of a criminal offense that falls within the range of activities described in 42 U.S.C. § 1320a-7(a), but has not yet been excluded, debarred, suspended, or otherwise declared ineligible.

7. Responsibility; 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 each facility's own employees and agents. In addition, each party shall maintain, throughout the term of this Agreement, comprehensive general and professional liability insurance and property damage insurance coverage in amounts reasonably acceptable to the other party and shall provide evidence of such coverage upon request.

8. Term. The initial term of this Agreement ("Initial Term") shall be for a period of one year, commencing on the Effective Date. Thereafter, this Agreement shall automatically be renewed for an additional period of one (1) year unless either party terminates this Agreement in accordance with the provisions set forth in paragraph 9 herein. To the extent that this Agreement is automatically renewed, each such renewal term shall be upon the same terms and conditions of the immediate, preceding renewal term.

9. Termination.

(a) Termination Without Cause. Either party may terminate this Agreement at any time without cause by giving the other party at least 30 days prior written notice of such termination (a "Without Cause Notice of Termination").

(b) Termination for Breach: Either party may terminate this Agreement upon breach by the other party of any material provision of this Agreement, *provided* that, to effect such termination, the non-breaching party must give the breaching party at least 15 days prior written notice of the termination (a "Breach Notice of Termination") and describe in such notice the breach claimed by the terminating party.

(c) Immediate Termination. Either facility may terminate this Agreement immediately by written notice to the other facility (an "Immediate Notice of Termination") upon the occurrence of any of the following events:

(1) The other facility's license in the State lapses or is denied, suspended, revoked, terminated, relinquished or made subject to terms of probation or other restriction;

(2) The other facility becomes debarred, excluded, or suspended, or if any other event occurs that makes the other facility an Ineligible Person;

(3) The other facility closes or ceases patient care operations to such an extent that patient care cannot be carried out adequately.

(d) Effective Date of Termination; Opportunity to Cure. The effective date of termination of this Agreement shall be (i) in the case of a termination pursuant to Section 9(a), the date of termination specified in the Without Cause Notice of Termination, *provided* that such date shall not be less than 30 days after the date such Without Cause Notice of Termination is given, (ii) in the case of a termination pursuant to Section 9(b), the date of termination specified in the Breach Notice of Termination, *provided* such date shall not be less than 15 days after the date such Breach Notice of Termination is given, and (iii) in the case of a termination pursuant to Section 9(c), the date on which the Immediate Notice of Termination is given. If a party terminates this Agreement pursuant to either Section 9(a) or Section 9(c), the other party shall have no rights to cure or contest the termination of this Agreement. If a party terminates this Agreement pursuant to Section 9(b), the other party shall have the right to cure the breach described in the Breach Notice of Termination prior to the effective date of termination set forth in such notice, *provided* that, if the breach is not cured during such period, this Agreement shall automatically terminate on the date of termination set forth in the Breach Notice of Termination.

(e) Effect of Termination. As of the effective date of termination of this Agreement, neither party shall have any further rights or obligations hereunder except for rights and obligations accruing prior to such effective date of termination, or arising as a result of any breach of this Agreement. Notwithstanding the foregoing, the following provisions of this Agreement shall survive the expiration or termination of this Agreement, regardless of the reason of such termination: Sections 4, 7, 8(e), and 12.

10. Disputes. In the event that there is any question regarding the interpretation or implementation of this Agreement, the facilities agree to form a joint committee of three persons from each facility, who shall meet and attempt to reach a mutually satisfactory resolution of the issue within three business days of a request by either facility for such meeting.

11. Entire Agreement; Modification. This 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. This Agreement may not be amended or modified except by mutual written agreement. Any reference to this Agreement shall include each and every exhibit, each of which is fully incorporated into this Agreement where referenced.

12. Governing Law. This Agreement shall be construed in accordance with the laws of the State. The provisions of this Section shall survive expiration or termination of this Agreement regardless of the cause of such termination.

13. Counterparts. This Agreement may be executed in one or more counterparts, all of which together shall constitute only one Agreement.

14. Notices. Any notice, demand or communication required, permitted or desired to be given hereunder shall be deemed effectively given if given in writing (i) on the date tendered by personal delivery, (ii) on the date received by facsimile or other electronic means, (iii) on the date tendered for delivery by nationally recognized overnight courier, or (iv) on the date tendered for delivery by United States mail, with postage prepaid thereon, certified or registered mail, return receipt requested, in any event addressed as follows:

If to Weiss Memorial Hospital
4646 N. Marine Drive
Chicago, IL
60640
Attention: Chief Executive Officer
Facsimile 773-564-5101
Email Address:

With copy to:
Vanguard Health Systems, Inc.
20 Burton Hills Blvd., Ste. 100
Nashville, Tennessee 37215
Attn: General Counsel
Facsimile: 615.665.6197
Email:rsoltman@vanguardhealth.com

If to Mid America Care Center:
Mid America Care Center
C/O ManagCare, Inc.
Attn: General Counsel
3553 W. Peterson Ave., Suite 300
Chicago, IL 60659
Facsimile No.: 773-463-5311
Email Address: smklem@managcare.com

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

15. 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.

16. Captions. The captions contained herein are used solely for convenience and shall not be deemed to define or limit the provisions of this Agreement.

17. Assignment; Binding Effect. Neither facility may assign or transfer this Agreement in whole or in part, or assign or delegate any of facility's rights, duties or obligations under this Agreement, in each case without the prior written consent of the other facility, and any assignment, transfer or delegation by the facility without such consent shall be null and void. Notwithstanding the foregoing, either facility may assign this Agreement,

in whole but not in part, without the consent of (but with prior notice to) the other facility in connection with the sale of all or substantially all of the assets constituting the facility. This Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective heirs, representatives, successors and permitted assigns.

18. Referrals. The parties acknowledge than none of the benefits granted either facility hereunder are conditioned on any requirement that a facility make referrals to, be in a position to make or influence referrals to, or otherwise generate business for the other facility.

19. Financial Obligation. Neither facility shall incur any financial obligation on behalf of the other facility without the prior written approval of the other facility.

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

MID AMERICA CARE CENTER, LLC
D/B/A **MID AMERICA CARE CENTER**

By: _____
Name: Stanley M. Klem
Title: Agent
Date signed: 9/12/2007
[Insert actual date executed]

VHS Acquisition Subsidiary No. 3
D/B/A **WEISS MEMORIAL HOSPITAL**

By: _____
Name: _____
Title: CFO
Date signed: 10-8-07
[Insert actual date executed]

TRANSFER AGREEMENT

THIS TRANSFER AGREEMENT ("Agreement"), made and effective as of September 1, 2007 (the "Effective Date"), is by and between **MID AMERICA CARE CENTER, LLC**, an Illinois limited liability company d/b/a **MID AMERICA CARE CENTER**, and Weiss Memorial Hospital, a VHS Acquisition Subsidiary No. 3 corporation d/b/a **WEISS MEMORIAL HOSPITAL** (the parties are sometimes referred to individually as a "Facility" and collectively as the "Facilities").

RECITALS:

WHEREAS, the parties desire to enter into this Agreement governing the transfer of patients between the two facilities located in Illinois ("State").

WHEREAS, the parties desire to enter into this 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 hereto agree as follows:

AGREEMENT:

1. Transfer of Patients. If either facility believes that a patient of that facility ("Transferring Facility") requires the services of the other facility ("Receiving Facility") and the transfer is deemed medically appropriate, a member of the nursing staff of the Transferring Facility (or the patient's attending physician) will contact the Receiving Facility's admitting office or Emergency Department to arrange for appropriate treatment as provided 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 on the Accreditation of Healthcare Organizations ("JCAHO") 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. The Receiving Facility's responsibility for the patient's care shall begin when the patient is admitted to the Receiving Facility.

2. Responsibilities of the Transferring Facility. The Transferring Facility shall be responsible to:

(a) Provide, within its capabilities, the medical screening and stabilizing treatment of the patient before 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 the Transferring Facility and coordinate the transfer of the patient from the facility.

(d) Notify the Receiving Facility's designated representative before transfer to confirm availability of appropriate facilities, services and staff necessary to provide care to the patient.

(e) Before patient transfer, the transferring physician shall contact and secure a receiving physician at the 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 the 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 without limitation: records relating to the patient's condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and, with respect to a patient with an emergency medical condition that has not been stabilized, a copy of the patient's informed consent to the transfer or physician certification that the medical benefits of the transfer outweigh the risk of transfer. If all necessary and relevant medical records are not available at the time the patient is transferred, then the Transferring Facility shall forward the records as soon as possible.

(i) Transfer the patient's personal effects, including without limitation money and valuables, and information related to those items.

(j) Provide the Receiving Facility any information that is available concerning the patient's coverage or eligibility under a third party coverage plan, Medicare or Medicaid, or a health care assistance program established by a county, public hospital, or hospital district.

(k) Notify the Receiving Facility of an estimated time of arrival for the patient.

(l) Provide for the completion of a certification statement, summarizing the risk and benefits of the transfer of a patient with an emergency medical condition that has not been stabilized, by the transferring physician or other qualified personnel if the physician is not physically present at the facility at the time of transfer.

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

(n) Recognize the right of a patient to request a transfer to the care of a physician and hospital of the patient's choosing.

(o) Recognize the right of a patient to refuse consent to treatment or transfer.

(p) Complete, execute and forward a memorandum of transfer form to the Receiving Facility for every patient who is transferred.

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

3. Responsibilities of the Receiving Facility. The Receiving Facility shall be responsible to:

(a) Confirm with the Transferring Facility, as promptly as possible, that the Receiving Facility has available beds and appropriate facilities, services and staff necessary to treat the patient and that the Receiving Facility has agreed to accept transfer of the patient. The Receiving Facility shall respond to the Transferring Facility within three minutes 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 the Receiving Facility and provide, on request, the names of on-call physicians to the Transferring Facility.

(c) Reserve appropriate beds, facilities and services for patients being transferred from the Transferring Facility who have been accepted by the Receiving Facility and a receiving physician, if deemed necessary by a transferring physician, unless the Receiving Facility needs them 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) Provide the Transferring Facility with a copy of the medical records of the patient that were generated at the Receiving Facility, if the Receiving Facility returns the patient to the Transferring Facility.

(g) Maintain the confidentiality of the patient's medical records in accordance with applicable state and federal law.

(h) Establish policies and/or protocols for (i) maintaining the confidentiality of the patient's medical records in accordance with applicable state and federal law, (ii) the receipt of patients into the facility, and (iii) the acknowledgment and inventory of patient valuables transported with patients.

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

(j) Upon request, provide to the Transferring Facility and patient current information concerning the Receiving Facility's eligibility standards and payment practices.

(k) Acknowledge any contractual obligations and comply with any statutory or regulatory obligations that might exist between a patient and a designated provided.

(l) Complete, execute, and return the memorandum of transfer form to the Transferring Facility.

4. Billing. All charges incurred with respect to any services performed by either facility for patients received from the other facility pursuant to this Agreement shall be billed and collected by the facility providing such services directly from the patient, third party coverage, Medicare or Medicaid, or other sources normally billed by that facility. In addition, it is understood that the physicians or other professional providers that may participate in the care and treatment of the patient will bill professional fees at usual and customary charges. Each facility shall provide information in its possession to the other facility and such physicians/providers sufficient to enable them to bill the patient, responsible party, or appropriate third-party payer.

5. Retransfer; Discharge. At such time as the patient is ready for transfer back to the Transferring Facility or another health care facility or for discharge from the Receiving Facility, in accordance with the direction from the Transferring Facility and with the proper notification of the patient's family or guardian, the Receiving Facility will transfer the patient to the agreed-upon location. If the Receiving Facility is to transfer the patient back to the Transferring Facility, the Receiving Facility will be responsible for the care of the patient up until the time the patient is re-admitted to the Transferring Facility.

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 medical records and confidentiality of patient information

as well as with all standards promulgated by any relevant accrediting agency. Each party represents and warrants to the other party, that it is not an Ineligible Person. An "Ineligible Person" is an individual or entity who: (i) is currently excluded, debarred, suspended, or otherwise ineligible to participate in the Federal health care programs or in Federal procurement or non-procurement programs; or (ii) has been convicted of a criminal offense that falls within the range of activities described in 42 U.S.C. § 1320a-7(a), but has not yet been excluded, debarred, suspended, or otherwise declared ineligible.

7. Responsibility; 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 each facility's own employees and agents. In addition, each party shall maintain, throughout the term of this Agreement, comprehensive general and professional liability insurance and property damage insurance coverage in amounts reasonably acceptable to the other party and shall provide evidence of such coverage upon request.

8. Term. The initial term of this Agreement ("Initial Term") shall be for a period of one year, commencing on the Effective Date. Thereafter, this Agreement shall automatically be renewed for an additional period of one (1) year unless either party terminates this Agreement in accordance with the provisions set forth in paragraph 9 herein. To the extent that this Agreement is automatically renewed, each such renewal term shall be upon the same terms and conditions of the immediate, preceding renewal term.

9. Termination.

(a) Termination Without Cause. Either party may terminate this Agreement at any time without cause by giving the other party at least 30 days prior written notice of such termination (a "Without Cause Notice of Termination").

(b) Termination for Breach: Either party may terminate this Agreement upon breach by the other party of any material provision of this Agreement, *provided* that, to effect such termination, the non-breaching party must give the breaching party at least 15 days prior written notice of the termination (a "Breach Notice of Termination") and describe in such notice the breach claimed by the terminating party.

(c) Immediate Termination. Either facility may terminate this Agreement immediately by written notice to the other facility (an "Immediate Notice of Termination") upon the occurrence of any of the following events:

(1) The other facility's license in the State lapses or is denied, suspended, revoked, terminated, relinquished or made subject to terms of probation or other restriction;

(2) The other facility becomes debarred, excluded, or suspended, or if any other event occurs that makes the other facility an Ineligible Person;

(3) The other facility closes or ceases patient care operations to such an extent that patient care cannot be carried out adequately.

(d) Effective Date of Termination; Opportunity to Cure. The effective date of termination of this Agreement shall be (i) in the case of a termination pursuant to Section 9(a), the date of termination specified in the Without Cause Notice of Termination, *provided* that such date shall not be less than 30 days after the date such Without Cause Notice of Termination is given, (ii) in the case of a termination pursuant to Section 9(b), the date of termination specified in the Breach Notice of Termination, *provided* such date shall not be less than 15 days after the date such Breach Notice of Termination is given, and (iii) in the case of a termination pursuant to Section 9(c), the date on which the Immediate Notice of Termination is given. If a party terminates this Agreement pursuant to either Section 9(a) or Section 9(c), the other party shall have no rights to cure or contest the termination of this Agreement. If a party terminates this Agreement pursuant to Section 9(b), the other party shall have the right to cure the breach described in the Breach Notice of Termination prior to the effective date of termination set forth in such notice, *provided* that, if the breach is not cured during such period, this Agreement shall automatically terminate on the date of termination set forth in the Breach Notice of Termination.

(e) Effect of Termination. As of the effective date of termination of this Agreement, neither party shall have any further rights or obligations hereunder except for rights and obligations accruing prior to such effective date of termination, or arising as a result of any breach of this Agreement. Notwithstanding the foregoing, the following provisions of this Agreement shall survive the expiration or termination of this Agreement, regardless of the reason of such termination: Sections 4, 7, 8(e), and 12.

10. Disputes. In the event that there is any question regarding the interpretation or implementation of this Agreement, the facilities agree to form a joint committee of three persons from each facility, who shall meet and attempt to reach a mutually satisfactory resolution of the issue within three business days of a request by either facility for such meeting.

11. Entire Agreement; Modification. This 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. This Agreement may not be amended or modified except by mutual written agreement. Any reference to this Agreement shall include each and every exhibit, each of which is fully incorporated into this Agreement where referenced.

12. Governing Law. This Agreement shall be construed in accordance with the laws of the State. The provisions of this Section shall survive expiration or termination of this Agreement regardless of the cause of such termination.

13. Counterparts. This Agreement may be executed in one or more counterparts, all of which together shall constitute only one Agreement.

14. Notices. Any notice, demand or communication required, permitted or desired to be given hereunder shall be deemed effectively given if given in writing (i) on the date tendered by personal delivery, (ii) on the date received by facsimile or other electronic means, (iii) on the date tendered for delivery by nationally recognized overnight courier, or (iv) on the date tendered for delivery by United States mail, with postage prepaid thereon, certified or registered mail, return receipt requested, in any event addressed as follows:

If to Weiss Memorial Hospital
4646 N. Marine Drive
Chicago, IL
60640
Attention: Chief Executive Officer
Facsimile 773-564-5101
Email Address:

With copy to:
Vanguard Health Systems, Inc.
20 Burton Hills Blvd., Ste. 100
Nashville, Tennessee 37215
Attn: General Counsel
Facsimile: 615.665.6197
Email:rsoltman@vanguardhealth.com

If to Mid America Care Center:
Mid America Care Center
C/O ManagCare, Inc.
Attn: General Counsel
3553 W. Peterson Ave., Suite 300
Chicago, IL 60659
Facsimile No.: 773-463-5311
Email Address: smklem@managcare.com

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

15. 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.

16. Captions. The captions contained herein are used solely for convenience and shall not be deemed to define or limit the provisions of this Agreement.

17. Assignment; Binding Effect. Neither facility may assign or transfer this Agreement in whole or in part, or assign or delegate any of facility's rights, duties or obligations under this Agreement, in each case without the prior written consent of the other facility, and any assignment, transfer or delegation by the facility without such consent shall be null and void. Notwithstanding the foregoing, either facility may assign this Agreement,

in whole but not in part, without the consent of (but with prior notice to) the other facility in connection with the sale of all or substantially all of the assets constituting the facility. This Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective heirs, representatives, successors and permitted assigns.

18. Referrals. The parties acknowledge than none of the benefits granted either facility hereunder are conditioned on any requirement that a facility make referrals to, be in a position to make or influence referrals to, or otherwise generate business for the other facility.

19. Financial Obligation. Neither facility shall incur any financial obligation on behalf of the other facility without the prior written approval of the other facility.

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

MID AMERICA CARE CENTER, LLC
D/B/A **MID AMERICA CARE CENTER**

By: _____
Name: Stanley M. Klem
Title: Agent
Date signed: 9/12/2007
[Insert actual date executed]

VHS Acquisition Subsidiary No. 3
D/B/A **WEISS MEMORIAL HOSPITAL**

By: _____
Name: _____
Title: _____
Date signed: _____
[Insert actual date executed]

Weiss Memorial Hospital	
June, 2012 - June, 2013	
	Total Number of Sessions
Alzheimer's Support Group	12
Ballroom Dance Class	34
Blood Pressure Screening	12
Book Club	10
Cancer Patient Support Group	12
Chair Yoga	16
Chi Gung	52
Classical Movie	12
Classical Movie Discussion	11
Exercise with Elizabeth	6
Exercise with Paul	204
Grief Support Group	12
Just US: Cancer Patient Support Group	12
Men's Cancer Support Group	12
Scrabble Club	11
Senior Care Support Group	50
SHIP	46
Tai Chi	52
The Learning Café	12
Weiss "WISE" Walkers	1
What Happens if I Get Cancer	12

ATTACHMENT 19

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Board of Directors and Shareholders of
Tenet Healthcare Corporation
Dallas, Texas

We have audited the internal control over financial reporting of Tenet Healthcare Corporation and subsidiaries (the "Company") as of December 31, 2012, based on criteria established in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission. The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Management's Report on Internal Control Over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed by, or under the supervision of, the company's principal executive and principal financial officers, or persons performing similar functions, and effected by the company's board of directors, management, and other personnel to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of the inherent limitations of internal control over financial reporting, including the possibility of collusion or improper management override of controls, material misstatements due to error or fraud may not be prevented or detected on a timely basis. Also, projections of any evaluation of the effectiveness of the internal control over financial reporting to future periods are subject to the risk that the controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2012, based on the criteria established in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated financial statements and financial statement schedule as of and for the year ended December 31, 2012 of the Company and our report dated February 25, 2013 expressed an unqualified opinion on those financial statements and financial statement schedule.

/s/ DELOITTE & TOUCHE LLP
Dallas, Texas
February 25, 2013

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Board of Directors and Shareholders of
Tenet Healthcare Corporation
Dallas, Texas

We have audited the accompanying consolidated balance sheets of Tenet Healthcare Corporation and subsidiaries (the "Company") as of December 31, 2012 and 2011, and the related consolidated statements of operations, other comprehensive income,changes in equity, and cash flows for each of the three years in the period ended December 31, 2012. Our audits also included the financial statement schedule listed in the Index at Item 15. These financial statements and financial statement schedule are the responsibility of the Company's management. Our responsibility is to express an opinion on the financial statements and financial statement schedule based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, such consolidated financial statements present fairly, in all material respects, the financial position of Tenet Healthcare Corporation and subsidiaries at December 31, 2012 and 2011, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2012, in conformity with accounting principles generally accepted in the United States of America. Also, in our opinion, such financial statement schedule, when considered in relation to the basic consolidated financial statements taken as a whole, presents fairly, in all material respects, the information set forth therein.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the Company's internal control over financial reporting as of December 31, 2012, based on the criteria established in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated February 25, 2013 expressed an unqualified opinion on the Company's internal control over financial reporting.

/s/ DELOITTE & TOUCHE LLP
Dallas, Texas
February 25, 2013

ATTACHMENT 39

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CONSOLIDATED BALANCE SHEETS
Dollars in Millions

ASSETS	December 31, 2012	December 31, 2011
Current assets:		
Cash and cash equivalents	$ 364	$ 113
Accounts receivable, less allowance for doubtful accounts ($401 at December 31, 2012 and $397 at December 31, 2011)	1,345	1,278
Inventories of supplies, at cost	153	161
Income tax receivable	7	7
Current portion of deferred income taxes	354	418
Assets held for sale	0	2
Other current assets	458	378
Total current assets	**2,681**	**2,357**
Investments and other assets	162	156
Deferred income taxes, net of current portion	342	374
Property and equipment, at cost, less accumulated depreciation and amortization ($3,494 at December 31, 2012 and $3,386 at December 31, 2011)	4,293	4,350
Goodwill	916	736
Other intangible assets, at cost, less accumulated amortization ($426 at December 31, 2012 and $360 at December 31, 2011)	650	489
Total assets	**$ 9,044**	**$ 8,462**
LIABILITIES AND EQUITY		
Current liabilities:		
Current portion of long-term debt	$ 94	$ 66
Accounts payable	722	760
Accrued compensation and benefits	415	376
Professional and general liability reserves	64	75
Accrued interest payable	125	112
Accrued legal settlement costs	8	64
Other current liabilities	335	362
Total current liabilities	**1,763**	**1,815**
Long-term debt, net of current portion	5,158	4,294
Professional and general liability reserves	292	337
Accrued legal settlement costs	2	2
Other long-term liabilities	595	506
Total liabilities	**7,810**	**6,954**
Commitments and contingencies		
Redeemable noncontrolling interests in equity of consolidated subsidiaries	16	16
Equity:		
Shareholders' equity:		
Preferred stock, $0.15 par value; authorized 2,500,000 shares; 345,000 of 7% mandatory convertible shares with a liquidation preference of $1,000 per share issued at December 31, 2011	0	334
Common stock, $0.05 par value; authorized 262,500,000 shares; 142,363,915 shares issued at December 31, 2012 and 137,867,138 shares issued at December 31, 2011	7	7
Additional paid-in capital	4,471	4,427
Accumulated other comprehensive loss	(68)	(52)
Accumulated deficit	(1,288)	(1,440)
Common stock in treasury, at cost, 37,730,431 shares at December 31, 2012 and 34,110,674 shares at December 31, 2011	(1,979)	(1,853)
Total shareholders' equity	**1,143**	**1,423**
Noncontrolling interests	**75**	**69**
Total equity	**1,218**	**1,492**
Total liabilities and equity	**$ 9,044**	**$ 8,462**

See accompanying Notes to Consolidated Financial Statements.

ATTACHMENT 39

CONSOLIDATED STATEMENTS OF OPERATIONS
Dollars in Millions, Except Per-Share Amounts

	Years Ended December 31,		
	2012	2011	2010
Net operating revenues:			
Net operating revenues before provision for doubtful accounts	$ 9,904	$ 9,371	$ 8,992
Less: Provision for doubtful accounts	785	717	727
Net operating revenues	**9,119**	**8,654**	**8,265**
Operating expenses:			
Salaries, wages and benefits	4,257	4,015	3,830
Supplies	1,552	1,548	1,542
Other operating expenses, net	2,147	2,020	1,857
Electronic health record incentives	(40)	(55)	0
Depreciation and amortization	430	398	380
Impairment of long-lived assets and goodwill, and restructuring charges, net	19	20	10
Litigation and investigation costs	5	55	12
Operating income	**749**	**653**	**634**
Interest expense	(412)	(375)	(424)
Loss from early extinguishment of debt	(4)	(117)	(57)
Investment earnings	1	3	5
Income from continuing operations, before income taxes	**334**	**164**	**158**
Income tax benefit (expense)	(125)	(61)	977
Income from continuing operations, before discontinued operations	**209**	**103**	**1,135**
Discontinued operations:			
Income (loss) from operations	(2)	(18)	11
Impairment of long-lived assets and goodwill, and restructuring charges, net	(100)	(6)	(1)
Litigation and investigation costs	0	(17)	0
Net gains on sales of facilities	1	0	0
Income tax benefit	25	32	7
Income (loss) from discontinued operations	**(76)**	**(9)**	**17**
Net income	**133**	**94**	**1,152**
Less: Preferred stock dividends	11	24	24
Less: Net income (loss) attributable to noncontrolling interests			
Continuing operations	13	11	10
Discontinued operations	(32)	1	(1)
Net income attributable to Tenet Healthcare Corporation common shareholders	**$ 141**	**$ 58**	**$ 1,119**
Amounts attributable to Tenet Healthcare Corporation common shareholders			
Income from continuing operations, net of tax	$ 185	$ 68	$ 1,101
Income (loss) from discontinued operations, net of tax	(44)	(10)	18
Net income attributable to Tenet Healthcare Corporation common shareholders	**$ 141**	**$ 58**	**$ 1,119**
Earnings (loss) per share attributable to Tenet Healthcare Corporation common shareholders:			
Basic			
Continuing operations	$ 1.77	$ 0.58	$ 9.09
Discontinued operations	(0.42)	(0.09)	0.15
	$ 1.35	**$ 0.49**	**$ 9.24**
Diluted			
Continuing operations	$ 1.70	$ 0.56	$ 8.03
Discontinued operations	(0.40)	(0.08)	0.13
	$ 1.30	**$ 0.48**	**$ 8.16**
Weighted average shares and dilutive securities outstanding (in thousands):			
Basic	104,200	117,182	121,080
Diluted	108,926	121,295	140,158

See accompanying Notes to Consolidated Financial Statements.

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CONSOLIDATED STATEMENTS OF OTHER COMPREHENSIVE INCOME
Dollars in Millions

	Years Ended December 31,		
	2012	2011	2010
Net income	$ 133	$ 94	$ 1,152
Other comprehensive income (loss):			
Adjustments for supplemental executive retirement plans	(25)	(15)	(20)
Unrealized gains on securities held as available-for-sale	0	0	1
Reclassification adjustments for realized losses included in net income	0	0	1
Other comprehensive loss before income taxes	**(25)**	**(15)**	**(18)**
Income tax benefit related to items of other comprehensive loss	9	6	7
Total other comprehensive loss, net of tax	**(16)**	**(9)**	**(11)**
Comprehensive income	**117**	**85**	**1,141**
Less: Preferred stock dividends	**11**	**24**	**24**
Less: Comprehensive income (loss) attributable to noncontrolling interests	**(19)**	**12**	**9**
Comprehensive income attributable to Tenet Healthcare Corporation common shareholders	**$ 125**	**$ 49**	**$ 1,108**

See accompanying Notes to Consolidated Financial Statements.

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CONSOLIDATED STATEMENTS OF CHANGES IN EQUITY
Dollars in Millions,
Share Amounts in Thousands

	Tenet Healthcare Corporation Shareholders' Equity									
	Preferred Stock		Common Stock							
	Shares Outstanding	Issued Amount	Shares Outstanding	Issued Par Amount	Additional Paid-in Capital	Accumulated Other Comprehensive Loss	Accumulated Deficit	Treasury Stock	Noncontrolling Interests	Total Equity
Balances at December 31, 2009	**345,000**	**$ 334**	**120,284**	**$ 7**	**$ 4,481**	**$ (32)**	**$ (2,665)**	**$ (1,479)**	**$ 51**	**$ 697**
Net income	0	0	0	0	0	0	1,143	0	9	1,152
Distributions paid to noncontrolling interests	0	0	0	0	0	0	0	0	(8)	(8)
Contributions from noncontrolling interests	0	0	0	0	0	0	0	0	1	1
Other comprehensive income	0	0	0	0	0	(11)	0	0	0	(11)
Preferred stock dividends	0	0	0	0	(24)	0	0	0	0	(24)
Stock-based compensation expense and issuance of common stock	0	0	1,162	0	12	0	0	0	0	12
Balances at December 31, 2010	**345,000**	**$ 334**	**121,446**	**$ 7**	**$ 4,469**	**$ (43)**	**$ (1,522)**	**$ (1,479)**	**$ 53**	**$ 1,819**
Net income	0	0	0	0	0	0	82	0	12	94
Distributions paid to noncontrolling interests	0	0	0	0	0	0	0	0	(10)	(10)
Other comprehensive income	0	0	0	0	0	(9)	0	0	0	(9)
Purchases of businesses or joint venture interests	0	0	0	0	0	0	0	0	14	14
Preferred stock dividends	0	0	0	0	(24)	0	0	0	0	(24)
Repurchases of common stock	0	0	(18,942)	0	0	0	0	(374)	0	(374)
Stock-based compensation expense and issuance of common stock	0	0	1,252	0	(15)	0	0	0	0	(18)
Balances at December 31, 2011	**345,000**	**$ 334**	**103,756**	**$ 7**	**$ 4,427**	**$ (52)**	**$ (1,440)**	**$ (1,853)**	**$ 69**	**$ 1,492**
Net income (loss)	0	0	0	0	0	0	152	0	(22)	130
Distributions paid to noncontrolling interests	0	0	0	0	0	0	0	0	(12)	(12)
Contributions from noncontrolling interests	0	0	0	0	0	0	0	0	3	3
Other comprehensive income	0	0	0	0	0	(16)	0	0	0	(16)
Purchases of businesses or joint venture interests	0	0	0	0	0	0	0	0	37	37
Preferred stock dividends	0	0	0	0	(11)	0	0	0	0	(11)
Repurchases of common stock	0	0	(4,733)	0	0	0	0	(126)	0	(126)
Repurchases of preferred stock	(298,700)	(289)	0	0	0	0	0	0	0	(289)
Conversion of preferred stock to common stock	(46,300)	(45)	1,979	0	45	0	0	0	0	0
Stock-based compensation expense and issuance of common stock	0	0	3,631	0	10	0	0	0	0	10
Balances at December 31, 2012	**0**	**$ 0**	**104,633**	**$ 7**	**$ 4,471**	**$ (68)**	**$ (1,288)**	**$ (1,979)**	**$ 75**	**$ 1,218**

See accompanying Notes to Consolidated Financial Statements.

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CONSOLIDATED STATEMENTS OF CASH FLOWS
Dollars in Millions

	Years Ended December 31,		
	2012	2011	2010
Net income	$ 133	$ 94	$ 1,152
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	430	398	380
Provision for doubtful accounts	785	717	727
Deferred income tax expense (benefit)	92	81	(952)
Stock-based compensation expense	32	24	22
Impairment of long-lived assets and goodwill, and restructuring charges, net	19	20	10
Litigation and investigation costs	5	55	12
Loss from early extinguishment of debt	4	117	57
Fair market value adjustments related to interest rate swap and LIBOR cap agreements	0	0	3
Amortization of debt discount and debt issuance costs	22	30	31
Pre-tax loss (gain) from discontinued operations	101	41	(10)
Other items, net	(12)	(13)	(5)
Changes in cash from operating assets and liabilities:			
Accounts receivable	(868)	(850)	(731)
Inventories and other current assets	(59)	(35)	(15)
Income taxes	(5)	(63)	3
Accounts payable, accrued expenses and other current liabilities	9	(32)	(87)
Other long-term liabilities	3	(5)	(58)
Payments against reserves for restructuring charges and litigation costs and settlements	**(63)**	**(44)**	**(83)**
Net cash provided by (used in) operating activities from discontinued operations, excluding income taxes	**(35)**	**(38)**	**16**
Net cash provided by operating activities	**593**	**497**	**472**
Cash flows from investing activities:			
Purchases of property and equipment — continuing operations	(506)	(467)	(433)
Construction of new and replacement hospitals	0	0	(13)
Purchases of property and equipment — discontinued operations	(2)	(8)	(30)
Purchases of businesses or joint venture interests	(211)	(84)	(65)
Proceeds from sales of facilities and other assets — discontinued operations	45	0	19
Proceeds from sales of marketable securities, long-term investments and other assets	17	59	84
Release of escrow funds	0	0	15
Other items, net	(5)	(3)	3
Net cash used in investing activities	**(662)**	**(503)**	**(420)**
Cash flows from financing activities:			
Repayments of borrowings under credit facility	(1,773)	(365)	0
Proceeds from borrowings under credit facility	1,693	445	0
Repayments of other borrowings	(248)	(843)	(886)
Proceeds from other borrowings	1,092	900	601
Repurchases of preferred stock	(292)	0	0
Deferred debt issuance costs	(17)	(21)	(27)
Repurchases of common stock	(126)	(374)	0
Cash dividends on preferred stock	(14)	(24)	(24)
Distributions paid to noncontrolling interests	(15)	(10)	(8)
Other items, net	20	6	7
Net cash provided by (used in) financing activities	**320**	**(286)**	**(337)**
Net increase (decrease) in cash and cash equivalents	251	(292)	(285)
Cash and cash equivalents at beginning of period	113	405	690
Cash and cash equivalents at end of period	**$ 364**	**$ 113**	**$ 405**
Supplemental disclosures:			
Interest paid, net of capitalized interest	$ (376)	$ (347)	$ (402)
Proceeds from interest rate swap agreement	$ 0	$ 30	$ 0
Income tax (payments) refunds, net	$ (13)	$ (10)	$ 34

See accompanying Notes to Consolidated Financial Statements.

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

NOTE 1. SIGNIFICANT ACCOUNTING POLICIES

Description of Business

Tenet Healthcare Corporation (together with our subsidiaries, referred to herein as "Tenet," the "Company," "we" or "us") is an investor-owned health care services company whose subsidiaries and affiliates as of December 31, 2012 primarily operated 49 hospitals with a total of 13,216 licensed beds, 117 outpatient centers and Conifer Health Solutions ("Conifer"), which provides business process solutions to more than 600 hospital and other clients nationwide.

Basis of Presentation

Our Consolidated Financial Statements include the accounts of Tenet and its wholly owned and majority-owned subsidiaries. We eliminate intercompany accounts and transactions in consolidation, and we include the results of operations of businesses that are newly acquired in purchase transactions from their dates of acquisition. We account for significant investments in other affiliated companies using the equity method. Unless otherwise indicated, all financial and statistical data included in these notes to our Consolidated Financial Statements relate to our continuing operations, with dollar amounts expressed in millions (except per-share amounts). Certain balances in the accompanying Consolidated Financial Statements and these notes have been reclassified to give retrospective presentation for the discontinued operations described in Note 4. Furthermore, all amounts related to shares, share prices and earnings per share have been restated to give retrospective presentation for the reverse stock split described in Note 2.

Effective December 31, 2011, we adopted Accounting Standards Update ("ASU") 2011-07, "Health Care Entities (Topic 954): Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities," which requires health care entities to present the provision for doubtful accounts relating to patient service revenue as a deduction from patient service revenue in the statement of operations rather than as an operating expense. All periods presented have been reclassified in accordance with the provisions of ASU 2011-07.

Use of Estimates

The preparation of financial statements, in conformity with accounting principles generally accepted in the United States of America ("GAAP"), requires us to make estimates and assumptions that affect the amounts reported in our Consolidated Financial Statements and these accompanying notes. We regularly evaluate the accounting policies and estimates we use. In general, we base the estimates on historical experience and on assumptions that we believe to be reasonable given the particular circumstances in which we operate. Although we believe all adjustments considered necessary for a fair presentation have been included, actual results may vary from those estimates. Financial and statistical information we report to other regulatory agencies may be prepared on a basis other than GAAP or using different assumptions or reporting periods and, therefore, may vary from amounts presented herein. Although we make every effort to ensure that the information we report to those agencies is accurate, complete and consistent with applicable reporting guidelines, we cannot be responsible for the accuracy of the information they make available to the public.

Net Operating Revenues Before Provision for Doubtful Accounts

We recognize net operating revenues before provision for doubtful accounts in the period in which our services are performed. Net operating revenues before provision for doubtful accounts primarily consist of net patient service revenues that are recorded based on established billing rates (i.e., gross charges), less estimated discounts for contractual and other allowances, principally for patients covered by Medicare, Medicaid, managed care and other health plans, as well as certain uninsured patients under our *Compact with Uninsured Patients* ("Compact").

Gross charges are retail charges. They are not the same as actual pricing, and they generally do not reflect what a hospital is ultimately paid and, therefore, are not displayed in our consolidated statements of operations. Hospitals are typically paid amounts that are negotiated with insurance companies or are set by the government. Gross charges are used to calculate Medicare outlier payments and to determine certain elements of payment under managed care contracts (such as stop-loss payments). Because Medicare requires that a hospital's gross charges be the same for all patients (regardless of payer category), gross charges are also what hospitals charge all other patients prior to the application of discounts and allowances.

Revenues under the traditional fee-for-service Medicare and Medicaid programs are based primarily on prospective payment systems. Retrospectively determined cost-based revenues under these programs, which were more prevalent in earlier

periods, and certain other payments, such as Indirect Medical Education, Direct Graduate Medical Education, disproportionate share hospital and bad debt expense, which are based on our hospitals' cost reports, are estimated using historical trends and current factors. Cost report settlements under these programs are subject to audit by Medicare and Medicaid auditors and administrative and judicial review, and it can take several years until final settlement of such matters is determined and completely resolved. Because the laws, regulations, instructions and rule interpretations governing Medicare and Medicaid reimbursement are complex and change frequently, the estimates recorded by us could change by material amounts.

We have a system and estimation process for recording Medicare net patient revenue and estimated cost report settlements. This results in us recording accruals to reflect the expected final settlements on our cost reports. For filed cost reports, we record the accrual based on those cost reports and subsequent activity, and record a valuation allowance against those cost reports based on historical settlement trends. The accrual for periods for which a cost report is yet to be filed is recorded based on estimates of what we expect to report on the filed cost reports, and a corresponding valuation allowance is recorded as previously described. Cost reports generally must be filed within five months after the end of the annual cost reporting period. After the cost report is filed, the accrual and corresponding valuation allowance may need to be adjusted. Adjustments for prior-year cost reports and related valuation allowances, principally related to Medicare and Medicaid, increased revenues in the years ended December 31, 2012, 2011 and 2010 by $114 million ($81 million related to the industry-wide Medicare Rural Floor Budget Neutrality Adjustment settlement), $1 million and $1 million, respectively. Estimated cost report settlements and valuation allowances are deducted from accounts receivable in the accompanying Consolidated Balance Sheets (see Note 3). We believe that we have made adequate provision for any adjustments that may result from final determination of amounts earned under all the above arrangements with Medicare and Medicaid.

Revenues under managed care plans are based primarily on payment terms involving predetermined rates per diagnosis, per-diem rates, discounted fee-for-service rates and/or other similar contractual arrangements. These revenues are also subject to review and possible audit by the payers. The payers are billed for patient services on an individual patient basis. An individual patient's bill is subject to adjustment on a patient-by-patient basis in the ordinary course of business by the payers following their review and adjudication of each particular bill. We estimate the discounts for contractual allowances at the individual hospital level utilizing billing data on an individual patient basis. At the end of each month, on an individual hospital basis, we estimate our expected reimbursement for patients of managed care plans based on the applicable contract terms. Contractual allowance estimates are periodically reviewed for accuracy by taking into consideration known contract terms as well as payment history. Although we do not separately accumulate and disclose the aggregate amount of adjustments to the estimated reimbursement for every patient bill, we believe our estimation and review process enables us to identify instances on a timely basis where such estimates need to be revised. We do not believe there were any adjustments to estimates of individual patient bills that were material to our revenues. In addition, on a corporate-wide basis, we do not record any general provision for adjustments to estimated contractual allowances for managed care plans. Managed care accounts, net of contractual allowances recorded, are further reduced to their net realizable value through provision for doubtful accounts based on historical collection trends for these payers and other factors that affect the estimation process.

We know of no material claims, disputes or unsettled matters with any payer that would affect our revenues for which we have not adequately provided for in the accompanying Consolidated Financial Statements.

Under our Compact, the discount offered to uninsured patients is recognized as a contractual allowance, which reduces net operating revenues at the time the self-pay accounts are recorded. The uninsured patient accounts, net of contractual allowances recorded, are further reduced to their net realizable value through provision for doubtful accounts based on historical collection trends for self-pay accounts and other factors that affect the estimation process.

We also provide charity care to patients who are financially unable to pay for the health care services they receive. Most patients who qualify for charity care are charged a per-diem amount for services received, subject to a cap. Except for the per-diem amounts, our policy is not to pursue collection of amounts determined to qualify as charity care; therefore, we do not report these amounts in net operating revenues or in provision for doubtful accounts. Patient advocates from Conifer's Medical Eligibility Program screen patients in the hospital to determine whether those patients meet eligibility requirements for financial assistance programs. They also expedite the process of applying for these government programs.

The table below shows the sources of net operating revenues before provision for doubtful accounts from continuing operations:

	Years Ended December 31,		
	2012	2011	2010
General Hospitals:			
Medicare	$2,195	$2,068	$2,050
Medicaid	783	802	740
Managed care	5,382	5,128	4,897
Indemnity, self-pay and other	1,007	958	954
Acute care hospitals – other revenue	69	105	115
Other:			
Other operations	468	310	236
Net operating revenues before provision for doubtful accounts	**$9,904**	**$9,371**	**$8,992**

Provision for Doubtful Accounts

Although outcomes vary, our policy is to attempt to collect amounts due from patients, including co-payments and deductibles due from patients with insurance, at the time of service while complying with all federal and state laws and regulations, including, but not limited to, the Emergency Medical Treatment and Active Labor Act ("EMTALA"). Generally, as required by EMTALA, patients may not be denied emergency treatment due to inability to pay. Therefore, services, including the legally required medical screening examination and stabilization of the patient, are performed without delaying to obtain insurance information. In non-emergency circumstances or for elective procedures and services, it is our policy to verify insurance prior to a patient being treated; however, there are various exceptions that can occur. Such exceptions can include, for example, instances where (1) we are unable to obtain verification because the patient's insurance company was unable to be reached or contacted, (2) a determination is made that a patient may be eligible for benefits under various government programs, such as Medicaid or Victims of Crime, and it takes several days or weeks before qualification for such benefits is confirmed or denied, and (3) under physician orders we provide services to patients that require immediate treatment.

We provide for an allowance against accounts receivable that could become uncollectible by establishing an allowance to reduce the carrying value of such receivables to their estimated net realizable value. We estimate this allowance based on the aging of our accounts receivable by hospital, our historical collection experience by hospital and for each type of payer over an 18-month look-back period, and other relevant factors. A significant portion of our provision for doubtful accounts relates to self-pay patients, as well as co-payments and deductibles owed to us by patients with insurance. Payment pressure from managed care payers also affects our provision for doubtful accounts. We typically experience ongoing managed care payment delays and disputes; however, we continue to work with these payers to obtain adequate and timely reimbursement for our services. There are various factors that can impact collection trends, such as changes in the economy, which in turn have an impact on unemployment rates and the number of uninsured and underinsured patients, the volume of patients through our emergency departments, the increased burden of co-payments and deductibles to be made by patients with insurance, and business practices related to collection efforts. These factors continuously change and can have an impact on collection trends and our estimation process.

Electronic Health Record Incentives

Under certain provisions of the American Recovery and Reinvestment Act of 2009 ("ARRA"), federal incentive payments are available to hospitals, physicians and certain other professionals ("Providers") when they adopt, implement or upgrade ("AIU") certified electronic health record ("EHR") technology or become "meaningful users," as defined under ARRA, of EHR technology in ways that demonstrate improved quality, safety and effectiveness of care. Providers can become eligible for annual Medicare incentive payments by demonstrating meaningful use of EHR technology in each period over four periods. Medicaid providers can receive their initial incentive payment by satisfying AIU criteria, but must demonstrate meaningful use of EHR technology in subsequent years in order to qualify for additional payments. Hospitals may be eligible for both Medicare and Medicaid EHR incentive payments; however, physicians and other professionals may be eligible for either Medicare or Medicaid incentive payments, but not both. Hospitals that are meaningful users under the Medicare EHR incentive payment program are deemed meaningful users under the Medicaid EHR incentive payment program and do not need to meet additional criteria imposed by a state. Medicaid EHR incentive payments to Providers are 100% federally funded and administered by the states. The Centers for Medicare and Medicaid Services ("CMS") established calendar year 2011 as the first year states could offer EHR incentive payments. Before a state may offer EHR incentive payments, the state must submit and CMS must approve the state's incentive plan.

We recognize Medicaid EHR incentive payments in our consolidated statements of operations for the first payment year when: (1) CMS approves a state's EHR incentive plan; and (2) our hospital or employed physician acquires certified EHR technology (i.e., when AIU criteria are met). Medicaid EHR incentive payments for subsequent payment years are recognized in the period during which the specified meaningful use criteria are met. We recognize Medicare EHR incentive payments when: (1) the specified meaningful use criteria are met; and (2) contingencies in estimating the amount of the incentive payments to be received are resolved. During the years ended December 31, 2012 and 2011, certain of our hospitals and physicians satisfied the CMS AIU and/or meaningful use criteria. As a result, we recognized approximately $40 million and $55 million of Medicare and Medicaid EHR incentive payments as a reduction to expense in our Consolidated Statement of Operations for years ended December 31, 2012 and 2011, respectively.

Cash Equivalents

We treat highly liquid investments with original maturities of three months or less as cash equivalents. Cash and cash equivalents were approximately $364 million and $113 million at December 31, 2012 and 2011, respectively. As of December 31, 2012 and 2011, our book overdrafts were approximately $232 million and $252 million, respectively, which were classified as accounts payable.

At December 31, 2012 and 2011, approximately $65 million and $92 million, respectively, of total cash and cash equivalents in the accompanying Consolidated Balance Sheets were intended for the operations of our captive insurance subsidiaries. During the year ended December 31, 2011, we repatriated $21 million of excess cash from our foreign insurance subsidiary to our corporate domestic bank account.

Also at December 31, 2012 and 2011, we had $98 million and $109 million, respectively, of property and equipment purchases accrued for items received but not yet paid. Of these amounts, $93 million and $104 million, respectively, were included in accounts payable.

During the years ended December 31, 2012 and 2011, we entered into non-cancellable capital leases of approximately $88 million and $23 million, respectively, primarily for equipment.

Investments in Debt and Equity Securities

We classify investments in debt and equity securities as either available-for-sale, held-to-maturity or as part of a trading portfolio. At December 31, 2012 and 2011, we had no significant investments in securities classified as either held-to-maturity or trading. We carry securities classified as available-for-sale at fair value. We report their unrealized gains and losses, net of taxes, as accumulated other comprehensive income (loss) unless we determine that a loss is other-than-temporary, at which point we would record a loss in our consolidated statements of operations. We include realized gains or losses in our consolidated statements of operations based on the specific identification method.

Property and Equipment

Additions and improvements to property and equipment costing $500 or more with a useful life greater than one year are capitalized at cost. Expenditures for maintenance and repairs are charged to expense as incurred. We use the straight-line method of depreciation for buildings, building improvements and equipment. The estimated useful life for buildings and improvements is primarily 25 to 40 years and, for equipment, three to 15 years. We record capital leases at the beginning of the lease term as assets and liabilities. The value recorded is the lower of either the present value of the minimum lease payments or the fair value of the asset. Such assets, including improvements, are amortized over the shorter of either the lease term or their estimated useful life. Interest costs related to construction projects are capitalized. In the years ended December 31, 2012, 2011 and 2010, capitalized interest was $6 million, $8 million and $4 million, respectively.

We evaluate our long-lived assets for possible impairment annually or whenever events or changes in circumstances indicate that the carrying amount of the asset, or related group of assets, may not be recoverable from estimated future undiscounted cash flows. If the estimated future undiscounted cash flows are less than the carrying value of the assets, we calculate the amount of an impairment if the carrying value of the long-lived assets exceeds the fair value of the assets. The fair value of the assets is estimated based on appraisals, established market values of comparable assets or internal estimates of future net cash flows expected to result from the use and ultimate disposition of the asset. The estimates of these future cash flows are based on assumptions and projections we believe to be reasonable and supportable. They require our subjective judgments and take into account assumptions about revenue and expense growth rates. These assumptions may vary by type of facility and presume stable, improving or, in some cases, declining results at our hospitals, depending on their circumstances.

We report long-lived assets to be disposed of at the lower of their carrying amounts or fair values less costs to sell. In such circumstances, our estimates of fair value are based on appraisals, established market prices for comparable assets or internal estimates of future net cash flows.

Asset Retirement Obligations

We recognize the fair value of a liability for legal obligations associated with asset retirements, primarily related to asbestos abatement and costs associated with underground storage tanks, in the period in which it is incurred if a reasonable estimate of the fair value of the obligation can be made. When the liability is initially recorded, we capitalize the cost of the asset retirement obligation by increasing the carrying amount of the related long-lived asset. Over time, the liability is accreted to its present value each period, and the capitalized cost associated with the retirement obligation is depreciated over the useful life of the related asset. Upon settlement of the obligation, any difference between the cost to settle the asset retirement obligation and the liability recorded is recognized as a gain or loss in our consolidated statements of operations.

Goodwill and Other Intangible Assets

Goodwill represents the excess of costs over the fair value of assets of businesses acquired. Goodwill and other intangible assets acquired in purchase business combinations and determined to have indefinite useful lives are not amortized, but instead are subject to impairment tests performed at least annually. For goodwill, we perform the test at the reporting unit level when events occur that require an evaluation to be performed or at least annually. If we determine the carrying value of goodwill is impaired, or if the carrying value of a business that is to be sold or otherwise disposed of exceeds its fair value, we reduce the carrying value, including any allocated goodwill, to fair value. Estimates of fair value are based on appraisals, established market prices for comparable assets or internal estimates of future net cash flows and presume stable, improving or, in some cases, declining results at our hospitals, depending on their circumstances.

Other intangible assets primarily consist of capitalized software costs, which are amortized on a straight-line basis over the estimated useful life of the software, which ranges from three to 15 years. Also included in intangible assets are costs associated with the issuance of our long-term debt, which are primarily being amortized under the effective interest method based on the terms of the specific notes.

Accruals for General and Professional Liability Risks

We accrue for estimated professional and general liability claims, when they are probable and can be reasonably estimated. The accrual, which includes an estimate for incurred but not reported claims, is updated each quarter based on an actuarial calculation of projected payments using case-specific facts and circumstances and our historical loss reporting, development and settlement patterns and is discounted to its net present value using a risk-free discount rate (1.18% at December 31, 2012 and 1.35% at December 31, 2011). To the extent that subsequent claims information varies from our estimates, the liability is adjusted in the period such information becomes available. Malpractice expense is presented within other operating expenses in the accompanying Consolidated Statements of Operations.

Income Taxes

We account for income taxes using the asset and liability method. This approach requires the recognition of deferred tax assets and liabilities for the expected future tax consequences of temporary differences between the carrying amounts and the tax bases of assets and liabilities. Income tax receivables and liabilities and deferred tax assets and liabilities are recognized based on the amounts that more likely than not will be sustained upon ultimate settlement with taxing authorities.

Developing our provision for income taxes and analysis of uncertain tax positions items requires significant judgment and knowledge of federal and state income tax laws, regulations and strategies, including the determination of deferred tax assets and liabilities and, if necessary, any valuation allowances that may be required for deferred tax assets.

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

- Cumulative profits/losses in recent years, adjusted for certain nonrecurring items;
- Income/losses expected in future years;

- Unsettled circumstances that, if unfavorably resolved, would adversely affect future operations and profit levels;
- The availability, or lack thereof, of taxable income in prior carryback periods that would limit realization of tax benefits; and
- The carryforward period associated with the deferred tax assets and liabilities.

We consider many factors when evaluating our uncertain tax positions, and such judgments are subject to periodic review. Tax benefits associated with uncertain tax positions are recognized in the period in which one of the following conditions is satisfied: (1) the more likely than not recognition threshold is satisfied; (2) the position is ultimately settled through negotiation or litigation; or (3) the statute of limitations for the taxing authority to examine and challenge the position has expired. Tax benefits associated with an uncertain tax position are derecognized in the period in which the more likely than not recognition threshold is no longer satisfied.

Segment Reporting

We primarily operate acute care hospitals and related health care facilities. Our general hospitals generated 95.3%, 96.7% and 97.4% of our net operating revenues before provision for doubtful accounts in the years ended December 31, 2012, 2011 and 2010, respectively. Each of our operating regions reports directly to our president of hospital operations. Major decisions, including capital resource allocations, are made at the consolidated level, not at the regional, market or hospital level.

Historically, our business has consisted of one reportable segment, Hospital Operations and other. However, during 2012, our Hospital Operations and other segment and our Conifer subsidiary entered into formal agreements, pursuant to which it was agreed that services provided by both parties to each other would be billed based on estimated third-party pricing terms. As a result, we have presented Conifer as a separate reportable business segment for all periods presented. The factors for determining the reportable segments include the manner in which management evaluates operating performance combined with the nature of the individual business activities.

Costs Associated With Exit or Disposal Activities

We recognize costs associated with exit (including restructuring) or disposal activities when they are incurred and can be measured at fair value, rather than at the date of a commitment to an exit or disposal plan.

NOTE 2. EQUITY

Reverse Stock Split

On October 11, 2012, our common stock began trading on the New York Stock Exchange on a split-adjusted basis following a one-for-four reverse stock split we announced on October 1, 2012. Every four shares of our issued and outstanding common stock were exchanged for one issued and outstanding share of common stock, without any change in the par value per share, and our authorized shares of common stock were proportionately decreased from 1,050,000,000 shares to 262,500,000 shares. No fractional shares were issued in connection with the stock split. All current and prior period amounts in the accompanying Consolidated Financial Statements and these notes related to shares, share prices and earnings per share have been restated to give retrospective presentation for the reverse stock split.

Share Repurchase Programs

In October 2012, we announced that our board of directors had authorized the repurchase of up to $500 million of our common stock through a share repurchase program expiring in December 2013. Under the program, shares may be purchased in the open market or through privately negotiated transactions in a manner consistent with applicable securities laws and regulations, including pursuant to a Rule 10b5-1 plan maintained by the Company. Shares will be repurchased at times and in amounts based on market conditions and other factors. Pursuant to the share repurchase program, we paid approximately $100 million to repurchase a total of 3,406,324 shares during the period from the commencement of the program through December 31, 2012.

Period	Total Number of Shares Purchased (In Thousands)	Average Price Paid Per Share	Total Number of Shares Purchased as Part of Publicly Announced Program (In Thousands)	Maximum Dollar Value of Shares That May Yet Be Purchased Under the Program (In Millions)
November 1, 2012 through November 30, 2012	1,095	$ 27.00	1,095	$ 470
December 1, 2012 through December 31, 2012	2,311	30.47	2,311	400
Total	**3,406**	**$ 29.36**	**3,406**	**$ 400**

In May 2011, we announced that our board of directors had authorized the repurchase of up to $400 million of our common stock through a share repurchase program. Under the program, shares could be purchased in the open market or through privately negotiated transactions in a manner consistent with applicable securities laws and regulations, including pursuant to a Rule 10b5-1 plan maintained by the Company, at times and in amounts based on market conditions and other factors. The share repurchase program, which was scheduled to expire on May 9, 2012, was completed in January 2012. Pursuant to the program, we repurchased a total of 20,268,466 shares for approximately $400 million.

Period	Total Number of Shares Purchased (In Thousands)	Average Price Paid Per Share	Total Number of Shares Purchased as Part of Publicly Announced Program (In Thousands)	Maximum Dollar Value of Shares That May Yet Be Purchased Under the Program (In Millions)
May 12, 2011 through December 31, 2011	18,942	$ 19.75	18,942	$ 26
January 1, 2012 through January 31, 2012	1,327	19.74	1,327	0
Total	**20,269**	**$ 19.75**	**20,269**	**$ 0**

Repurchased shares are recorded based on settlement date and are held as treasury stock.

Mandatory Convertible Preferred Stock

In April 2012, we repurchased and subsequently retired 298,700 shares of our 7% mandatory convertible preferred stock with a carrying value of $289 million. In a related private financing, we issued an additional $141 million aggregate principal amount of our 6¼% senior secured notes due 2018 at a premium for $142 million of cash proceeds and an additional $150 million aggregate principal amount of our 8% senior notes due 2020. We recorded the difference between the carrying value and the amount paid to redeem the preferred stock in April 2012 as preferred stock dividends in the accompanying Consolidated Statements of Operations. On October 1, 2012, the remaining 46,300 shares outstanding of our mandatory convertible preferred stock automatically converted to 1,978,633 shares of our common stock. We accrued approximately $6 million, or $17.50 per share, for dividends on the preferred stock in the three months ended March 31, 2012 and $1 million in each of the three months ended June 30, 2012 and September 30, 2012, and paid the dividends in April, July and October 2012, respectively.

NOTE 3. ACCOUNTS RECEIVABLE AND ALLOWANCE FOR DOUBTFUL ACCOUNTS

The principal components of accounts receivable are shown in the table below:

	December 31,	
	2012	2011
Continuing operations:		
Patient accounts receivable	$ 1,668	$ 1,605
Allowance for doubtful accounts	(396)	(382)
Estimated future recoveries from accounts assigned to our Conifer subsidiary	88	62
Net cost report settlements payable and valuation allowances	(24)	(39)
	1,336	1,246
Discontinued operations:		
Patient accounts receivable	11	46
Allowance for doubtful accounts	(5)	(15)
Estimated future recoveries from accounts assigned to our Conifer subsidiary	2	2
Net cost report settlements receivable (payable) and valuation allowances	1	(1)
	9	32
Accounts receivable, net	**$ 1,345**	**$ 1,278**

Our self-pay collection rate, which is the blended collection rate for uninsured and balance after insurance accounts receivable, was approximately 28.9% and 27.7% as of December 31, 2012 and 2011, respectively. These self-pay collection rates include payments made by patients, including co-payments and deductibles paid by patients with insurance. Our estimated collection rate from managed care payers was approximately 98.0% and 98.2% at December 31, 2012 and 2011, respectively. As of December 31, 2012 and 2011, our allowance for doubtful accounts for self-pay uninsured accounts was 87.3% and 88.4%, respectively, of our self-pay uninsured patient accounts receivable. As of December 31, 2012 and 2011, our allowance for doubtful accounts for self-pay balance after insurance accounts was 54.5% and 57.5%, respectively, of our self-pay balance after insurance patient accounts receivable, consisting primarily of co-pays and deductibles owed by patients with insurance. Our self-pay write-offs, including uninsured and balance after insurance accounts, increased approximately $36 million from $182 million in the year ended December 31, 2011 to $218 million in the year ended December 31, 2012 primarily due to an increase in patient account assignments to our Conifer subsidiary. The increase in provision for doubtful accounts primarily related to the increase in uninsured patient volumes in the year ended December 31, 2012 compared to the year ended December 31, 2011, partially offset by the impact of a 120 basis point improvement in our collection rate on self-pay accounts.

Accounts that are pursued for collection through the regional business offices of Conifer are maintained on our hospitals' books and reflected in patient accounts receivable with an allowance for doubtful accounts established to reduce the carrying value of such receivables to their estimated net realizable value. We estimate this allowance based on the aging of our accounts receivable by hospital, our historical collection experience by hospital and for each type of payer over an 18-month look-back period, and other relevant factors. As of December 31, 2012 and 2011, our allowance for doubtful accounts for self-pay was 73.8% and 76.5%, respectively, of our self-pay patient accounts receivable, including co-pays and deductibles owed by patients with insurance. As of December 31, 2012 and 2011, our allowance for doubtful accounts for managed care was 9.4% and 8.8%, respectively, of our managed care patient accounts receivable.

Accounts assigned to our Conifer subsidiary are written off and excluded from patient accounts receivable and allowance for doubtful accounts; however, an estimate of future recoveries from all accounts at our Conifer subsidiary is determined based on historical experience and recorded on our hospitals' books as a component of accounts receivable in the accompanying Consolidated Balance Sheets.

The estimated costs (based on selected operating expenses, which include salaries, wages and benefits, supplies and other operating expenses) of caring for our self-pay patients for the years ended December 31, 2012, 2011 and 2010 were approximately $437 million, $395 million and $368 million, respectively. Our estimated costs (based on the selected operating expenses described above) of caring for charity care patients for the years ended December 31, 2012, 2011 and 2010 were approximately $133 million, $117 million, and $113 million, respectively. Most states include an estimate of the cost of charity care in the determination of a hospital's eligibility for Medicaid disproportionate share hospital ("DSH") payments. Revenues attributable to DSH payments and other state-funded subsidy payments for the years ended December 31, 2012, 2011 and 2010 were approximately $283 million, $255 million and $178 million, respectively. These payments are intended to mitigate our cost of uncompensated care, as well as reduced Medicaid funding levels. Our method of measuring the estimated costs uses adjusted self-pay/charity patient days multiplied by selected operating expenses per adjusted patient day. The adjusted self-pay/charity patient days represents actual self-pay/charity patient days adjusted to include self-pay/charity outpatient services by multiplying actual

self-pay/charity patient days by the sum of gross self-pay/charity inpatient revenues and gross self-pay/charity outpatient revenues and dividing the results by gross self-pay/charity inpatient revenues.

NOTE 4. DISCONTINUED OPERATIONS

In the three months ended June 30, 2012, our Creighton University Medical Center hospital ("CUMC") in Nebraska was reclassified into discontinued operations based on the guidance in the Financial Accounting Standards Board's Accounting Standards Codification ("ASC") 360, "Property, Plant and Equipment," as a result of our plan to sell CUMC. We recorded an impairment charge in discontinued operations of $100 million, consisting of $98 million for the write-down of CUMC's long-lived assets to their estimated fair values, less estimated costs to sell, and a $2 million charge for the write-down of goodwill related to CUMC in the three months ended June 30, 2012. We completed the sale of CUMC on August 31, 2012 at a transaction price of $40 million, excluding working capital, and recognized a loss on sale of approximately $1 million in discontinued operations. Because we did not sell the accounts receivable of CUMC, net receivables of approximately $9 million are included in our accounts receivable in the accompanying Consolidated Balance Sheet at December 31, 2012.

In May 2012, we completed the sale of Diagnostic Imaging Services, Inc. ("DIS"), our former diagnostic imaging center business in Louisiana, for net proceeds of approximately $10 million. As a result of the sale, DIS was reclassified into discontinued operations in the three months ended June 30, 2012, and a gain on sale of approximately $2 million was recognized in discontinued operations.

We recorded a $6 million impairment charge in discontinued operations during the year ended December 31, 2011 for the write-down of goodwill related to DIS. Material adverse trends in our estimates of future operating results of the centers at that time, primarily due to our limited market presence, indicated that the carrying value of the goodwill exceeded its fair value. As a result, we reduced the carrying value of the goodwill to its fair value as determined based on an appraisal.

Effective April 1, 2010, we completed the sale of certain of our owned assets at NorthShore Regional Medical Center ("NorthShore"), located in Slidell, Louisiana, for approximately $16 million of cash proceeds. At that time, we also terminated our operating lease agreement for the hospital. We recorded $1 million of net impairment and restructuring charges in discontinued operations during the year ended December 31, 2010, consisting of a $3 million write-down of land to expected sales proceeds related to a previously divested hospital, partially offset by $1 million in impairment credits to discontinued operations relating to an increase in the estimated fair values of NorthShore's long-lived assets, less estimated costs to sell, and $1 million for a reduction in reserves recorded in previous periods.

Net operating revenues and income (loss) before income taxes reported in discontinued operations are as follows:

	Years Ended December 31,		
	2012	2011	2010
Net operating revenues	$ 154	$ 216	$ 240
Income (loss) before income taxes	(101)	(41)	10

Included in loss before income taxes from discontinued operations in the year ended December 31, 2011 is approximately $14 million of expense related to the settlement of two Hurricane Katrina-related class action lawsuits, which amount is net of approximately $10 million of recoveries from our reinsurance carriers in connection with the settlement. We had previously recorded a $5 million reserve for this matter as of December 31, 2010. Also included in loss before income taxes from discontinued operations in the year ended December 31, 2011 is approximately $17 million of expense recorded in litigation and investigation costs allocable to certain of our previously divested hospitals related to changes in the reserve estimate established in connection with a governmental review and an accrual for a hospital-related tort claim.

Should we dispose of additional hospitals or other assets in the future, we may incur additional asset impairment and restructuring charges in future periods.

NOTE 5. IMPAIRMENT AND RESTRUCTURING CHARGES

We recognized impairment charges on long-lived assets in 2012, 2011 and 2010 because the fair values of those assets or groups of assets indicated that the carrying amount was not recoverable. The fair value estimates were derived from appraisals, established market values of comparable assets, or internal estimates of future net cash flows. These fair value estimates can change by material amounts in subsequent periods. Many factors and assumptions can impact the estimates, including the future financial results of the hospitals, how the hospitals are operated in the future, changes in health care industry trends and regulations, and the nature of the ultimate disposition of the assets. In certain cases, these fair value estimates assume the highest and best use of hospital assets in the future to a market place participant is other than as a hospital. In these cases, the estimates are

based on the fair value of the real property and equipment if utilized other than as a hospital. The impairment recognized does not include the costs of closing the hospitals or other future operating costs, which could be substantial. Accordingly, the ultimate net cash realized from the hospitals, should we choose to sell them, could be significantly less than their impaired value.

Our impairment tests presume stable, improving or, in some cases, declining operating results in our hospitals, which are based on programs and initiatives being implemented that are designed to achieve the hospital's most recent projections. If these projections are not met, or if in the future negative trends occur that impact our future outlook, impairments of long-lived assets and goodwill may occur, and we may incur additional restructuring charges, which could be material.

As of December 31, 2012, our continuing operations consisted of two operating segments, our Conifer subsidiary and our hospital and other operations. Our hospital and other operations are structured as follows:

- Our California region included all of our hospitals in California;
- Our Central region included all of our hospitals in Missouri, Tennessee and Texas;
- Our Florida region included all of our hospitals in Florida; and
- Our Southern States region included all of our hospitals in Alabama, Georgia, North Carolina, Pennsylvania and South Carolina.

Year Ended December 31, 2012

During the year ended December 31, 2012, we recorded net impairment and restructuring charges of $19 million, consisting of $3 million relating to the impairment of obsolete assets, $2 million relating to other impairment charges, $8 million of employee severance costs and $6 million of other related costs.

Year Ended December 31, 2011

During the year ended December 31, 2011, we recorded net impairment and restructuring charges of $20 million. This amount included a $6 million impairment charge for the write-down of buildings and equipment of one of our previously impaired hospitals to their estimated fair values, primarily due to a decline in the fair value of real estate in the market in which the hospital operates and a decline in the estimated fair value of equipment. Material adverse trends in our estimates of future undiscounted cash flows of the hospital at that time, consistent with our previous estimates in prior years when impairment charges were recorded at this hospital, indicated the carrying value of the hospital's long-lived assets was not recoverable from the estimated future cash flows. We believed the most significant factors contributing to the adverse financial trends at that time included reductions in volumes of insured patients, shifts in payer mix from commercial to governmental payers combined with reductions in reimbursement rates from governmental payers, and high levels of uninsured patients. As a result, we updated the estimate of the fair value of the hospital's long-lived assets and compared the fair value estimate to the carrying value of the hospital's long-lived assets. Because the fair value estimate was lower than the carrying value of the hospital's long-lived assets, an impairment charge was recorded for the difference in the amounts. The aggregate carrying value of assets held and used of the hospital for which an impairment charge was recorded was $20 million as of December 31, 2011 after recording the impairment charge. In addition, we also recorded impairment charges of $1 million in connection with the sale of seven medical office buildings in Texas, $1 million related to a cost basis investment, $7 million in employee severance costs, $3 million in lease termination costs, $1 million of acceleration of stock-based compensation costs and $1 million of other related costs.

Year Ended December 31, 2010

During the year ended December 31, 2010, we recorded net impairment and restructuring charges of $10 million. This amount included a $5 million net impairment charge for the write-down of buildings, equipment and other long-lived assets, primarily capitalized software costs classified in other intangible assets, of one of our previously impaired hospitals to their estimated fair values primarily due to a decline in the fair value of real estate in the market in which the hospital operates and a decline in the estimated fair value of equipment. The aggregate carrying value of assets held and used of the hospital for which an impairment charge was recorded was $25 million as of December 31, 2010 after recording the impairment charge. In addition, we recorded a $5 million net impairment charge in connection with the sale of nine medical office buildings in Florida and $2 million in employee severance and other related costs. These charges were partially offset by a $2 million credit related to the collection of a note receivable due from a buyer of one of our previously divested hospitals, which had been fully reserved in a prior year.

Accrued Restructuring Charges

The tables below are reconciliations of beginning and ending liability balances in connection with restructuring charges recorded during the years ended December 31, 2012, 2011 and 2010 in continuing and discontinued operations:

	Balances at Beginning of Period	Restructuring Charges, Net	Cash Payments	Other	Balances at End of Period
Year Ended December 31, 2012					
Continuing operations:					
Lease and other costs, and employee severance-related costs in connection with hospital cost-control programs and general overhead-reduction plans	$ 6	$ 14	$(12)	$ 0	$ 8
Discontinued operations:					
Employee severance-related costs, and other estimated costs associated with the sale or closure of hospitals and other facilities	5	0	(1)	0	4
	$ 11	**$ 14**	**$(13)**	**$ 0**	**$ 12**
Year Ended December 31, 2011					
Continuing operations:					
Lease and other costs, and employee severance-related costs in connection with hospital cost-control programs and general overhead-reduction plans	$ 4	$ 12	$(10)	$ 0	$ 6
Discontinued operations:					
Employee severance-related costs, and other estimated costs associated with the sale or closure of hospitals and other facilities	6	1	(1)	(1)	5
	$ 10	**$ 13**	**$(11)**	**$ (1)**	**$ 11**
Year Ended December 31, 2010					
Continuing operations:					
Lease and other costs, and employee severance-related costs in connection with hospital cost-control programs and general overhead-reduction plans	$ 6	$ 2	$ (4)	$ 0	$ 4
Discontinued operations:					
Employee severance-related costs, and other estimated costs associated with the sale or closure of hospitals and other facilities	8	(1)	(1)	0	6
	$ 14	**$ 1**	**$ (5)**	**$ 0**	**$ 10**

The above liability balances at December 31, 2012 and 2011 are included in other current liabilities and other long-term liabilities in the accompanying Consolidated Balance Sheets. Cash payments to be applied against these accruals at December 31, 2012 are expected to be approximately $7 million in 2013 and $5 million thereafter. The column labeled "Other" above represents charges recorded in restructuring expense that are not recorded in the liability account, such as the acceleration of stock-based compensation expense related to severance agreements.

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NOTE 6. LONG-TERM DEBT AND LEASE OBLIGATIONS

The table below shows our long-term debt as of December 31, 2012 and 2011:

	December 31, 2012	December 31, 2011
Senior notes:		
6½%, due 2012	$ 0	$ 57
7⅜%, due 2013	55	216
9⅞%, due 2014	60	60
9¼%, due 2015	474	474
6¾%, due 2020	300	0
8%, due 2020	750	600
6⅞%, due 2031	430	430
Senior secured notes:		
9%, due 2015	0	1
6¼%, due 2018	1,041	900
10%, due 2018	714	714
8⅞%, due 2019	925	925
4¾%, due 2020	500	0
Credit facility due 2016	0	80
Capital leases and mortgage notes	119	32
Unamortized note discounts and premium	(116)	(129)
Total long-term debt	**5,252**	**4,360**
Less current portion	94	66
Long-term debt, net of current portion	**$ 5,158**	**$ 4,294**

Credit Agreement

We have a senior secured revolving credit facility, as amended November 29, 2011 ("Credit Agreement"), that provides, subject to borrowing availability, for revolving loans in an aggregate principal amount of up to $800 million, with a $300 million subfacility for standby letters of credit. The Credit Agreement has a scheduled maturity date of November 29, 2016, subject to our repayment or refinancing on or before December 3, 2014 of approximately $238 million of the aggregate outstanding principal amount of our 9¼% senior notes due 2015 (approximately $474 million of which was outstanding at December 31, 2012). If such repayment or refinancing does not occur, borrowings under the Credit Agreement will be due December 3, 2014. The revolving credit facility is collateralized by patient accounts receivable of all of our wholly owned acute care and specialty hospitals. In addition, borrowings under the Credit Agreement are guaranteed by our wholly owned hospital subsidiaries. Outstanding revolving loans accrued interest during a six-month initial period that ended in May 2012 at the rate of either (i) a base rate plus a margin of 1.25% or (ii) the London Interbank Offered Rate ("LIBOR") plus a margin of 2.25% per annum. Outstanding revolving loans now accrue interest at a base rate plus a margin ranging from 1.00% to 1.50% or LIBOR plus a margin ranging from 2.00% to 2.50% per annum based on available credit. An unused commitment fee was payable on the undrawn portion of the revolving loans at a six-month initial rate that ended in May 2012 of 0.438% per annum. The unused commitment fee now ranges from 0.375% to 0.500% per annum based on available credit. Our borrowing availability is based on a specified percentage of eligible accounts receivable, including self-pay accounts. At December 31, 2012, we had no borrowings outstanding under the revolving credit facility, and we had approximately $154 million of standby letters of credit outstanding. Based on our eligible receivables, approximately $646 million was available for borrowing under the revolving credit facility at December 31, 2012.

Senior Notes and Senior Secured Notes

In October 2012, we sold $500 million aggregate principal amount of 4¾% senior secured notes due 2020 and $300 million aggregate principal amount of 6¾% senior notes due 2020. The 4¾% senior secured notes will mature on June 1, 2020, and the 6¾% senior notes will mature on February 1, 2020. We will pay interest on the 4¾% senior secured notes semi-annually in arrears on June 1 and December 1 of each year, commencing on June 1, 2013. We will pay interest on the 6¾% senior notes semi-annually in arrears on February 1 and August 1 of each year; payments commenced on February 1, 2013. We used a portion of the proceeds from the sale of the notes to purchase $161 million aggregate principal amount outstanding of our 7⅜% senior notes due 2013 in a tender offer. In connection with the purchase, we recorded a loss from early extinguishment of debt of approximately $4 million primarily related to the difference between the purchase prices and the par values of the purchased notes.

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In April 2012, we issued an additional $141 million aggregate principal amount of our 6¼% senior secured notes due 2018 at a premium for $142 million of cash proceeds and an additional $150 million aggregate principal amount of our 8% senior notes due 2020 in a private financing related to our repurchase and subsequent retirement of 298,700 shares of our 7% mandatory convertible preferred stock.

In November 2011, we sold $900 million aggregate principal amount of 6¼% senior secured notes due 2018. The notes will mature on November 1, 2018. We will pay interest on the 6¼% senior secured notes semi-annually in arrears on May 1 and November 1 of each year; payments commenced on May 1, 2012.

Also in November 2011, we purchased approximately $713 million aggregate principal amount of our 9% senior secured notes due 2015 for total cash of approximately $776 million, including approximately $4 million in accrued and unpaid interest through the dates of purchase. We purchased the senior secured notes with a portion of the proceeds from our sale of new 6¼% senior secured notes due 2018, as described above. In connection with the purchase, we recorded a loss from early extinguishment of debt of approximately $117 million related to the difference between the purchase prices and the par values of the purchased notes, as well as the write-off of unamortized note discounts and issuance costs associated with the notes.

All of our senior notes are general unsecured senior debt obligations that rank equally in right of payment with all of our other unsecured senior indebtedness, but are effectively subordinated to our senior secured notes described below, the obligations of our subsidiaries and any obligations under our Credit Agreement to the extent of the collateral. We may redeem any series of our senior notes, in whole or in part, at any time at a redemption price equal to 100% of the principal amount of the notes redeemed, plus a make-whole premium specified in the applicable indenture, together with accrued and unpaid interest to the redemption date.

All of our senior secured notes are guaranteed by and secured by a first-priority pledge of the capital stock and other ownership interests of certain of our subsidiaries. All of our senior secured notes and the related subsidiary guarantees are our and the subsidiary guarantors' senior secured obligations. All of our senior secured notes rank equally in right of payment with all of our other senior secured indebtedness. Our senior secured notes rank senior to any subordinated indebtedness that we or such subsidiary guarantors may incur; they are effectively senior to our and such subsidiary guarantors' existing and future unsecured indebtedness and other liabilities to the extent of the value of the collateral securing the notes and the subsidiary guarantees; they are effectively subordinated to our and such subsidiary guarantors' obligations under our Credit Agreement to the extent of the value of the collateral securing borrowings thereunder; and they are structurally subordinated to all obligations of our non-guarantor subsidiaries.

The indentures setting forth the terms of our senior secured notes contain provisions governing our ability to redeem the notes and the terms by which we may do so. At our option, we may redeem our 4¾% senior secured notes and our 6¼% senior secured notes, in whole or in part, at any time at a redemption price equal to 100% of the principal amount of the notes redeemed plus the make-whole premium set forth in the related indenture, together with accrued and unpaid interest thereon, if any, to the redemption date. In addition, we, at our option, may redeem our 8⅞% and 10% senior secured notes, in whole or in part, or on or prior to July 1, 2014 in the case of the 8⅞% senior secured notes and May 1, 2014 in the case of the 10% senior secured notes, at a redemption price equal to 100% of the principal amount of the notes redeemed plus the applicable make-whole premium set forth in the applicable indenture, together with accrued and unpaid interest thereon, if any, to the redemption date. At any time or from time to time after July 1, 2014 in the case of the 8⅞% senior secured notes and May 1, 2014 in the case of the 10% senior secured notes, we, at our option, may redeem the notes, in whole or in part, at the redemption prices set forth in the applicable indenture, together with accrued and unpaid interest thereon, if any, to the redemption date.

In addition, we may be required to purchase for cash all or any part of each series of our senior secured notes upon the occurrence of a change of control (as defined in the applicable indentures) for a cash purchase price of 101% of the aggregate principal amount of the notes, plus accrued and unpaid interest.

Covenants

Our Credit Agreement contains customary covenants for an asset-backed facility, including a minimum fixed charge coverage ratio to be met when the available credit under the revolving credit facility falls below $80 million, as well as limits on debt, asset sales and prepayments of senior debt. The Credit Agreement also includes a provision, which we believe is customary in receivables-backed credit facilities, that gives our banks the right to require that proceeds of collections of substantially all of our consolidated accounts receivable be applied directly to repay outstanding loans and other amounts that are due and payable under the Credit Agreement at any time that unused borrowing availability under the revolving credit facility is less than $100 million or if an event of default has occurred and is continuing thereunder. In that event, we would seek to re-borrow under

the Credit Agreement to satisfy our operating cash requirements. Our ability to borrow under the Credit Agreement is subject to conditions that we believe are customary in revolving credit facilities, including that no events of default then exist.

The indentures governing our senior notes contain covenants and conditions that have, among other requirements, limitations on (1) liens on principal properties and (2) sale and lease-back transactions with respect to principal properties. A principal property is defined in the indentures as a hospital that has an asset value on our books in excess of 5% of our consolidated net tangible assets, as defined. The above limitations do not apply, however, to (1) debt that is not secured by principal properties or (2) debt that is secured by principal properties if the aggregate of such secured debt does not exceed 15% of our consolidated net tangible assets, as further described in the indentures. The indentures also prohibit the consolidation, merger or sale of all or substantially all assets unless no event of default would result after giving effect to such transaction.

The indentures governing our senior secured notes contain covenants that, among other things, restrict our ability and the ability of our subsidiaries to incur liens, consummate asset sales, enter into sale and lease-back transactions or consolidate, merge or sell all or substantially all of our or their assets, other than in certain transactions between one or more of our wholly owned subsidiaries. These restrictions, however, are subject to a number of important exceptions and qualifications. In particular, there are no restrictions on our ability or the ability of our subsidiaries to incur additional indebtedness, make restricted payments, pay dividends or make distributions in respect of capital stock, purchase or redeem capital stock, enter into transactions with affiliates or make advances to, or invest in, other entities (including unaffiliated entities). In addition, the indentures governing our senior secured notes contain a covenant that neither we nor any of our subsidiaries will incur secured debt, unless at the time of and after giving effect to the incurrence of such debt, the aggregate amount of all such secured debt (including the aggregate principal amount of senior secured notes outstanding at such time) does not exceed the greater of (i) $3.2 billion or (ii) the amount that would cause the secured debt ratio (as defined in the indentures) to exceed 4.0 to 1.0; provided that the aggregate amount of all such debt secured by a lien on par to the lien securing the senior secured notes may not exceed the greater of (a) $2.6 billion or (b) the amount that would cause the secured debt ratio to exceed 3.0 to 1.0.

Interest Rate Swap and LIBOR Cap Agreements

We were party to an interest rate swap agreement for an aggregate notional amount of $600 million from February 14, 2011 through August 2, 2011. The interest rate swap agreement was designated as a fair value hedge and was being used to manage our exposure to future changes in interest rates. It had the effect of converting our 10% senior secured notes due 2018 from a fixed interest rate paid semi-annually to a variable interest rate paid semi-annually based on the six-month LIBOR plus a floating rate spread of 6.60%. During the term of the interest rate swap agreement, changes in the fair value of the interest rate swap agreement and changes in the fair value of the 10% senior secured notes, which we expected to substantially offset each other, were recorded in interest expense. During the year ended December 31, 2011, our interest rate swap agreement generated approximately $8 million of cash interest savings and a $22 million gain on the settlement of the agreement.

The fair value of the LIBOR cap agreement included in investments and other assets in the accompanying Consolidated Balance Sheets totaled less than $1 million at both December 31, 2012 and 2011. In addition, see Note 18 for additional disclosure regarding the fair value of the LIBOR cap agreement.

Future Maturities

Future long-term debt maturities and minimum operating lease payments as of December 31, 2012 are as follows:

		Years Ending December 31,					
	Total	2013	2014	2015	2016	2017	Later Years
Long-term debt, including capital lease obligations	$ 5,368	$ 94	$104	$ 497	$ 3	$ 3	$ 4,667
Long-term non-cancelable operating leases	$ 439	$118	$ 77	$ 58	$ 48	$ 35	$ 103

Rental expense under operating leases, including short-term leases, was $156 million, $143 million and $134 million in the years ended December 31, 2012, 2011 and 2010, respectively. Included in rental expense for these periods was sublease income of $8 million, $8 million and $12 million, respectively, which was recorded as a reduction to rental expense.

NOTE 7. GUARANTEES

Consistent with our policy on physician relocation and recruitment, we provide income guarantee agreements to certain physicians who agree to relocate to fill a community need in the service area of one of our hospitals and commit to remain in practice in the area for a specified period of time. Under such agreements, we are required to make payments to the physicians in excess of the amounts they earn in their practices up to the amount of the income guarantee. The income guarantee periods are typically 12 months. If a physician does not fulfill his or her commitment period to the community, which is typically three years

subsequent to the guarantee period, we seek recovery of the income guarantee payments from the physician on a prorated basis. We also provide revenue collection guarantees to hospital-based physician groups providing certain services at our hospitals with terms generally ranging from one to three years.

At December 31, 2012, the maximum potential amount of future payments under our income guarantees to certain physicians who agree to relocate and revenue collection guarantees to hospital-based physician groups providing certain services at our hospitals was $120 million. We had a liability of $81 million recorded for these guarantees included in other current liabilities at December 31, 2012.

We have also guaranteed minimum rent revenue to certain landlords who built medical office buildings on or near our hospital campuses. The maximum potential amount of future payments under these guarantees at December 31, 2012 was $4 million. We had a liability of $2 million recorded for these guarantees at December 31, 2012, of which $1 million was included in other current liabilities and $1 million was included in other long-term liabilities.

NOTE 8. EMPLOYEE BENEFIT PLANS

Share-Based Compensation Plans

We currently grant stock-based awards to our directors and key employees pursuant to our 2008 Stock Incentive Plan, which was approved by our shareholders at their 2008 annual meeting. At December 31, 2012, approximately four million shares of common stock were available under our 2008 Stock Incentive Plan for future stock option grants and other incentive awards, including restricted stock units. Options have an exercise price equal to the fair market value of the shares on the date of grant and generally expire 10 years from the date of grant. A restricted stock unit is a contractual right to receive one share of our common stock or the equivalent value in cash in the future. Options and restricted stock units typically vest one-third on each of the first three anniversary dates of the grant; however, from time to time, we grant performance-based options and restricted stock units that vest subject to the achievement of specified performance goals within a specified timeframe.

All amounts related to shares, share prices and earnings per share have been restated to give retrospective presentation for the reverse stock split described in Note 2.

Our income from continuing operations for the years ended December 31, 2012, 2011 and 2010 includes $33 million, $25 million and $22 million, respectively, of pretax compensation costs related to our stock-based compensation arrangements ($21 million, $15 million and $14 million, respectively, after-tax, excluding the impact of the deferred tax valuation allowance). The table below shows the stock option and restricted stock unit grants and other awards that comprise the $33 million of stock-based compensation expense recorded in salaries, wages and benefits in the year ended December 31, 2012. Compensation cost is measured by the fair value of the awards on their grant dates and is recognized over the requisite service period of the awards, whether or not the awards had any intrinsic value during the period.

Grant Date	Awards	Exercise Price Per Share	Fair Value Per Share at Grant Date	Stock-Based Compensation Expense for Year Ended December 31, 2012
	(In Thousands)			(In Millions)
Stock Options:				
February 29, 2012	379	$22.60	$11.96	$1
February 25, 2010	232	20.12	11.56	1
February 26, 2009	2,746	4.56	2.84	1
Restricted Stock Units:				
May 11, 2012	67		20.28(1)	2
February 29, 2012	1,019		22.60	7
November 4, 2011	60		19.44(1)	1
February 23, 2011	935		27.60	9
February 25, 2010	1,065		20.12	8
Other grants				3
				$33

(1) End of month fair market value was used for this grant to calculate compensation expense.

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Prior to our shareholders approving the 2008 Stock Incentive Plan, we granted stock-based awards to our directors and employees pursuant to other plans. Stock options remain outstanding under those other plans, but no additional stock-based awards will be granted under them.

Pursuant to the terms of our stock-based compensation plans, awards granted under the plans vest and may be exercised as determined by the compensation committee of our board of directors. In the event of a change in control, the compensation committee may, at its sole discretion without obtaining shareholder approval, accelerate the vesting or performance periods of the awards.

Stock Options

The following table summarizes stock option activity during the years ended December 31, 2012, 2011 and 2010:

	Options	Weighted Average Exercise Price Per Share	Aggregate Intrinsic Value (In Millions)	Weighted Average Remaining Life
Outstanding as of December 31, 2009	12,079,314	$ 42.32		
Granted	241,002	20.12		
Exercised	(520,495)	4.84		
Forfeited/Expired	(1,010,934)	82.48		
Outstanding as of December 31, 2010	10,788,887	39.88		
Granted	0			
Exercised	(629,021)	5.24		
Forfeited/Expired	(1,661,473)	128.92		
Outstanding as of December 31, 2011	8,498,393	25.04		
Granted	477,500	22.79		
Exercised	(3,657,127)	5.77		
Forfeited/Expired	(1,029,574)	69.72		
Outstanding as of December 31, 2012	**4,289,192**	**$ 30.49**	**$ 34**	**4.1 years**
Vested and expected to vest at December 31, 2012	**4,284,062**	**$ 30.50**	**$ 34**	**4.1 years**
Exercisable as of December 31, 2012	**3,815,870**	**$ 31.47**	**$ 29**	**3.5 years**

There were 3,657,127 stock options exercised during the year ended December 31, 2012 with a $71 million aggregate intrinsic value, and 629,021 stock options exercised in 2011 with a $14 million aggregate intrinsic value.

As of December 31, 2012, there were $4 million of total unrecognized compensation costs related to stock options. These costs are expected to be recognized over a weighted average period of 2.1 years.

In the year ended December 31, 2012, we granted an aggregate of 477,500 stock options under our 2008 Stock Incentive Plan to certain of our senior officers; 257,500 of these stock options are subject to time-vesting and 220,000 of these stock options were granted subject to performance-based vesting. If all conditions are met, the performance-based options will vest and be settled ratably over a three-year period from the date of the grant. In the year ended December 31, 2011, there were no stock options granted.

The weighted average estimated fair value of stock options we granted in the year ended December 31, 2012 was $12.05 per share. This fair value was calculated based on the grant date using a binomial lattice model with the following assumptions:

	Year Ended December 31, 2012
Expected volatility	52%
Expected dividend yield	0%
Expected life	6.9 years
Expected forfeiture rate	2%
Risk-free interest rate	1.06%-1.41%
Early exercise threshold	70% gain
Early exercise rate	20% per year

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The expected volatility used in the binomial lattice model incorporated historical and implied share-price volatility and was based on an analysis of historical prices of our stock and open-market exchanged options. The expected volatility reflects the historical volatility for a duration consistent with the contractual life of the options, and the volatility implied by the trading of options to purchase our stock on open-market exchanges. The historical share-price volatility excludes the movements in our stock price during the period October 1, 2002 through December 31, 2002 due to unique events occurring during that time, which caused extreme volatility in our stock price, and two dates (one in 2010 and one in 2011) with unusual volatility due to an unsolicited acquisition proposal. The expected life of options granted is derived from the output of the binomial lattice model and represents the period of time that the options are expected to be outstanding. This model incorporates an early exercise assumption in the event of a significant increase in stock price. The risk-free interest rates are based on zero-coupon United States Treasury yields in effect at the date of grant consistent with the expected exercise timeframes.

The following table summarizes information about our outstanding stock options at December 31, 2012:

	Options Outstanding			Options Exercisable	
Range of Exercise Prices	Number of Options	Weighted Average Remaining Contractual Life	Weighted Average Exercise Price	Number of Options	Weighted Average Exercise Price
$0.00 to $4.569	615,138	6.1 years	$ 4.56	615,138	$ 4.56
$4.57 to $25.089	1,254,167	6.9 years	20.85	780,845	19.84
$25.09 to $32.569	758,531	3.5 years	30.01	758,531	30.01
$32.57 to $42.529	738,289	2.1 years	42.14	738,289	42.14
$42.53 to $55.129	700,317	1.2 years	48.44	700,317	48.14
$55.13 to $70.249	222,750	0.5 years	62.88	222,750	62.88
	4,289,192	**4.1 years**	**$30.49**	**3,815,870**	**$31.47**

As of December 31, 2012, approximately 75.0% of our outstanding options were held by current employees and approximately 25.0% were held by former employees. Approximately 61.1% of our outstanding options were in-the-money, that is, they had an exercise price less than the $32.47 market price of our common stock on December 31, 2012, and approximately 38.9% were out-of-the-money, that is, they had an exercise price of more than $32.47 as shown in the table below:

	In-the-Money Options		Out-of-the-Money Options		All Options	
	Outstanding	% of Total	Outstanding	% of Total	Outstanding	% of Total
Current employees	2,213,930	84.4%	1,004,781	60.3%	3,218,711	75.0%
Former employees	408,906	15.6%	661,575	39.7%	1,070,481	25.0%
Totals	2,622,836	100.0%	1,666,356	100.0%	4,289,192	100.0%
% of all outstanding options	61.1%		38.9%		100.0%	

Restricted Stock Units

The following table summarizes restricted stock unit activity during the years ended December 31, 2012, 2011 and 2010:

	Restricted Stock Units	Weighted Average Grant Date Fair Value Per Unit
Unvested as of December 31, 2009	1,201,610	$ 23.28
Granted	1,284,825	20.12
Vested	(625,213)	22.80
Forfeited	(280,904)	25.04
Unvested as of December 31, 2010	1,580,318	20.56
Granted	1,138,350	27.04
Vested	(722,471)	19.92
Forfeited	(68,890)	23.72
Unvested as of December 31, 2011	1,927,307	24.52
Granted	1,654,337	22.18
Vested	(1,033,632)	23.51
Forfeited	(252,070)	23.39
Unvested as of December 31, 2012	**2,295,942**	**$ 23.40**

In the year ended December 31, 2012, we granted 1,468,403 restricted stock units subject to time-vesting. In addition, we granted 116,255 performance-based restricted stock units certain of our senior officers. Because all conditions were met, the

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performance-based restricted stock units will vest and be settled ratably over a three-year period from the date of the grant. We also granted 69,679 restricted stock units to our directors, which vested immediately on the grant date and may be settled in cash, shares of our common stock or a combination of cash and stock. The fair value of restricted stock units granted to directors will be adjusted based on our share price at the end of each calendar quarter. Annual grants of restricted stock units to our directors settle on the earlier of the third anniversary of the date of the grant or termination of board service, unless settlement has been deferred by the director. Initial grants of restricted stock units to newly appointed directors are settled only upon termination of board service.

In the year ended December 31, 2011, we granted 882,362 restricted stock units subject to time-vesting. In addition, we granted 188,859 performance-based restricted stock units to certain of our senior officers. Because all conditions were met, the performance-based restricted stock units will vest and be settled ratably over a three-year period from the date of the grant. In the year ended December 31, 2011, we also granted 67,129 restricted stock units to our directors, which vested immediately on the grant date and may be settled in cash, shares of our common stock or a combination of cash and stock.

As of December 31, 2012 and 2011, there were $33 million and $29 million, respectively, of total unrecognized compensation costs related to restricted stock units. These costs are expected to be recognized over a weighted average period of 2.2 years.

Employee Stock Purchase Plan

We have an employee stock purchase plan under which we are currently authorized to issue up to 5,062,500 shares of common stock to our eligible employees. As of December 31, 2012, there were approximately 502,900 shares available for issuance under our employee stock purchase plan. Under the terms of the plan, eligible employees may elect to have between 1% and 10% of their base earnings withheld each quarter to purchase shares of our common stock. Shares are purchased at a price equal to 95% of the closing price on the last day of the quarter. The plan requires a one-year holding period for all shares issued. The holding period does not apply upon termination of employment. Under the plan, no individual may purchase, in any year, shares with a fair market value in excess of $25,000. The plan is currently not considered to be compensatory.

We sold the following numbers of shares under our employee stock purchase plan in the years ended December 31, 2012, 2011 and 2010:

	Years Ended December 31,		
	2012	2011	2010
Number of shares	144,021	187,409	192,830
Weighted average price	$22.81	$21.44	$19.72

Employee Retirement Plans

Substantially all of our employees, upon qualification, are eligible to participate in a defined contribution 401(k) plan. Under the plan, employees may contribute 1% to 75% of their eligible compensation, and we match such contributions annually up to a maximum percentage for participants actively employed as of December 31. During the years ended December 31, 2012, 2011 and 2010, the employer match was discretionary, employees were required to work 1,000 hours or more during the plan year to be eligible to receive any match and the matching percentage was 1.5%. Plan expenses, primarily related to our contributions to the plan, were approximately $32 million, $32 million and $26 million for the years ended December 31, 2012, 2011 and 2010, respectively. Such amounts are reflected in salaries, wages and benefits in the accompanying Consolidated Statements of Operations.

We maintain one active and two frozen non-qualified defined benefit pension plans ("SERPs") that provide supplemental retirement benefits to certain of our current and former executives. The plans are not funded, and plan obligations are paid from our working capital. Pension benefits are generally based on years of service and compensation. The following tables summarize the balance sheet impact, as well as the benefit obligations, funded status and rate assumptions associated with the SERPs based on actuarial valuations prepared as of December 31, 2012 and 2011:

Reconciliation of funded status of plans and the amounts included in the Consolidated Balance Sheets:	December 31, 2012	December 31, 2011
Projected benefit obligations(1)		
Beginning obligations	$ (285)	$ (268)
Service cost	(2)	(2)
Interest cost	(14)	(14)
Actuarial loss	(30)	(19)
Benefits paid	19	18
Ending obligations	(312)	(285)
Fair value of plans' assets	0	0
Funded status of plans	$ (312)	$ (285)
Amounts recognized in the Consolidated Balance Sheets consist of:		
Other current liability	$ (20)	$ (20)
Other long-term liability	(292)	(265)
Accumulated other comprehensive loss	90	65
	$ (222)	$ (220)
Assumptions:		
Discount rate	4.00%	5.00%
Compensation increase rate	3.00%	3.00%
Measurement date	December 31, 2012	December 31, 2011

(1) The accumulated benefit obligation at December 31, 2012 and 2011 was approximately $308 million and $280 million, respectively.

The components of net periodic benefit costs and related assumptions are as follows:

	Years Ended December 31, 2012	2011	2010
Service costs	$ 2	$ 2	$ 2
Interest costs	14	14	14
Amortization of prior-year service costs	0	0	0
Amortization of net actuarial loss	5	3	1
Net periodic benefit cost	$ 21	$ 19	$ 17
Assumptions:			
Discount rate	5.00%	5.50%	5.75%
Long-term rate of return on assets	n/a	n/a	n/a
Compensation increase rate	3.00%	3.00%	3.00%
Measurement date	January 1, 2012	January 1, 2011	January 1, 2010
Census date	January 1, 2012	January 1, 2011	January 1, 2010

Net periodic benefit costs for the current year are based on assumptions determined at the valuation date of the prior year.

We recorded loss adjustments of $25 million, $16 million and $20 million in other comprehensive income (loss) in the years ended December 31, 2012, 2011 and 2010, respectively, to recognize changes in the funded status of our SERPs. Changes in the funded status are recorded as a direct increase or decrease to shareholders' equity through accumulated other comprehensive loss. Net actuarial losses of $30 million, $19 million and $21 million during the years ended December 31, 2012, 2011 and 2010, respectively, and the amortization of net prior service costs of less than $1 million for the years ended December 31, 2012, 2011 and 2010 were recognized in other comprehensive income (loss). Cumulative net actuarial losses of $90 million, $65 million and $49 million as of December 31, 2012, 2011 and 2010, respectively, and unrecognized prior service costs of less than $1 million as of each of the years ended December 31, 2012, 2011 and 2010, have not yet been recognized as components of net periodic benefit costs. During the year ending December 31, 2013, no net prior service costs are expected to be recognized as components of net periodic benefit costs.

The following table presents our estimated future benefit payments for the next five years and in the aggregate for the five years thereafter:

	Total	Years Ending December 31, 2013	2014	2015	2016	2017	Five Years Thereafter
SERP benefit payments	$ 202	$20	$20	$20	$21	$20	$101

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The SERP obligations of $312 million at December 31, 2012 are classified in the accompanying Consolidated Balance Sheet as an other current liability ($20 million) and an other noncurrent liability ($292 million) based on an estimate of the expected payment patterns.

NOTE 9. OTHER CURRENT ASSETS

The principal components of other current assets are shown in the table below:

	December 31,	
	2012	2011
Prepaid expenses	$ 76	$ 73
Physician receivables and relocation agreements	57	58
Physician and group coverage guarantees	80	104
Disproportionate share hospital revenue receivables	47	27
Vendor and other nonpatient receivables	74	47
Grant receivable related to medical residency program	2	2
Electronic health record incentives receivable	8	13
Supplemental California Medi-Cal payment receivable	33	16
Sublease receivables	1	2
Other, net	80	36
Other current assets	**$ 458**	**$ 378**

Of the total amounts in other current assets, $53 million and $38 million was past due more than 90 days as of December 31, 2012 and 2011, respectively, primarily related to disproportionate share hospital revenue receivables and vendor and other nonpatient receivables.

NOTE 10. PROPERTY AND EQUIPMENT

The principal components of property and equipment are shown in the table below:

	December 31,	
	2012	2011
Land	$ 341	$ 350
Buildings and improvements	4,087	4,102
Construction in progress	140	236
Equipment	3,219	3,048
	7,787	7,736
Accumulated depreciation and amortization	(3,494)	(3,386)
Net property and equipment	**$ 4,293**	**$ 4,350**

Property and equipment is stated at cost, less accumulated depreciation and amortization and impairment write-downs related to assets held and used. At December 31, 2012 and 2011, we had $98 million and $109 million, respectively, of property and equipment purchases accrued for items received but not yet paid. Of these amounts, $93 million and $104 million, respectively, were included in accounts payable.

NOTE 11. GOODWILL AND OTHER INTANGIBLE ASSETS

The following table provides information on changes in the carrying amount of goodwill, which is included in the accompanying Consolidated Balance Sheets as of December 31, 2012 and 2011:

Hospital Operations and other	2012	2011
As of January 1:		
Goodwill	$ 3,166	$ 3,076
Accumulated impairment losses	(2,430)	(2,424)
Total	736	652
Goodwill acquired during the year	104	90
Goodwill allocated to hospital sold	(2)	0
Impairment of goodwill	0	(6)
Total	**$ 838**	**$ 736**

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Hospital Operations and other	2012	2011
As of December 31:		
Goodwill	$ 3,268	$ 3,166
Accumulated impairment losses	(2,430)	(2,430)
Total	**$ 838**	**$ 736**

Conifer	2012	2011
As of January 1:		
Goodwill	$ 0	$ 0
Accumulated impairment losses	0	0
Total	0	0
Goodwill acquired during the year	78	0
Total	**$ 78**	**$ 0**
As of December 31:		
Goodwill	$ 78	$ 0
Accumulated impairment losses	0	0
Total	**$ 78**	**$ 0**

The following table provides information regarding other intangible assets, which are included in the accompanying Consolidated Balance Sheets as of December 31, 2012 and 2011:

	Gross Carrying Amount	Accumulated Amortization	Net Book Value
As of December 31, 2012:			
Capitalized software costs	$927	$(399)	$528
Long-term debt issuance costs	106	(25)	81
Other	43	(2)	41
Total	**$1,076**	**$(426)**	**$650**
As of December 31, 2011:			
Capitalized software costs	$756	$(344)	$412
Long-term debt issuance costs	88	(15)	73
Other	5	(1)	4
Total	**$849**	**$(360)**	**$489**

Estimated future amortization of intangibles with finite useful lives as of December 31, 2012 is as follows:

		Years Ending December 31,					
	Total	2013	2014	2015	2016	2017	Later Years
Amortization of intangible assets	$ 650	$106	$ 95	$79	$71	$57	$242

NOTE 12. INVESTMENTS AND OTHER ASSETS

The principal components of investments and other assets in our accompanying Consolidated Balance Sheets are as follows:

	December 31,	
	2012	2011
Marketable debt securities	$ 15	$ 22
Equity investments in unconsolidated health care entities(1)	22	23
Total investments	37	45
Cash surrender value of life insurance policies	21	18
Long-term deposits	16	47
Land held for expansion, long-term receivables and other assets	88	46
Investments and other assets	**$162**	**$156**

(1) Equity earnings of unconsolidated affiliates are included in net operating revenues in the accompanying Consolidated Statements of Operations and were $8 million in each of the years ended December 31, 2012 and 2011.

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Our policy is to classify investments that may be needed for cash requirements as "available-for-sale." In doing so, the carrying values of the shares and debt instruments are adjusted at the end of each accounting period to their market values through a credit or charge to other comprehensive income (loss), net of taxes. At both December 31, 2012 and 2011, there were less than $1 million of accumulated unrealized gains on these investments.

NOTE 13. ACCUMULATED OTHER COMPREHENSIVE LOSS

Our accumulated other comprehensive loss is comprised of the following:

	December 31,	
	2012	2011
Unamortized realized losses from interest rate lock derivatives	$ (1)	$ (1)
Adjustments for supplemental executive retirement plans	(67)	(51)
Accumulated other comprehensive loss	**$ (68)**	**$ (52)**

There was a tax effect allocated to the adjustments for supplemental executive retirement plans for the years ended December 31, 2012 and 2011 of $9 million and $7 million, respectively.

NOTE 14. PROPERTY AND PROFESSIONAL AND GENERAL LIABILITY INSURANCE

Property Insurance

We have property, business interruption and related insurance coverage to mitigate the financial impact of catastrophic events or perils that is subject to deductible provisions based on the terms of the policies. These policies are on an occurrence basis. For the annual policy periods April 1, 2010 through March 31, 2013, we have coverage totaling $600 million per occurrence, after deductibles and exclusions, with annual aggregate sub-limits of $100 million each for floods and earthquakes and a per-occurrence sub-limit of $100 million for windstorms with no annual aggregate. With respect to fires and other perils, excluding floods, earthquakes and windstorms, the total $600 million limit of coverage per occurrence applies. Deductibles are 5% of insured values up to a maximum of $25 million for floods, California earthquakes and wind-related claims, and 2% of insured values for New Madrid fault earthquakes, with a maximum per claim deductible of $25 million. Other covered losses, including fires and other perils, have a minimum deductible of $1 million.

Professional and General Liability Insurance

At December 31, 2012 and 2011, the aggregate current and long-term professional and general liability reserves in our accompanying Consolidated Balance Sheets were approximately $356 million and $412 million, respectively. These reserves include the reserves recorded by our captive insurance subsidiaries and our self-insured retention reserves recorded based on actuarial estimates for the portion of our professional and general liability risks, including incurred but not reported claims, for which we do not have insurance coverage. We estimated the reserves for losses and related expenses using expected loss-reporting patterns discounted to their present value under a risk-free rate approach using a Federal Reserve seven-year maturity rate of 1.18%, 1.35% and 2.71% at December 31, 2012, 2011 and 2010, respectively.

Self-insured retentions are determined for each claim period based on the following insurance policies in effect:

- *Policy period June 1, 2012 through May 31, 2013*—Our hospitals generally have a self-insurance retention of $5 million per occurrence for all claims incurred. Our captive insurance company, The Healthcare Insurance Corporation ("THINC"), retains $10 million per occurrence coverage above our hospitals' $5 million self-insurance retention level. The next $10 million of claims in excess of these aggregate self-insurance retentions of $15 million per occurrence are 80% reinsured by THINC with independent reinsurance companies, with THINC retaining 20% or a maximum of $2 million. Claims in excess of $25 million are covered by our excess professional and general liability insurance policies with major independent insurance companies, on a claims-made basis, subject to an aggregate limit of $175 million.

- *Policy period June 1, 2011 through May 31, 2012*—Our hospitals generally have a self-insurance retention of $5 million per occurrence for all claims incurred. THINC retains $10 million per occurrence coverage above our hospitals' $5 million self-insurance retention level. The next $10 million of claims in excess of these aggregate self-insurance retentions of $15 million per occurrence are 65% reinsured by THINC with independent reinsurance companies, with THINC retaining 35% or a maximum of $3.5 million. Claims in excess of $25 million are covered

by our excess professional and general liability insurance policies with major independent insurance companies, on a claims-made basis, subject to an aggregate limit of $175 million.

- *Policy period June 1, 2010 through May 31, 2011*—Our hospitals generally have a self-insurance retention of $5 million per occurrence for all claims incurred. THINC retains $10 million per occurrence coverage above our hospitals' $5 million self-insurance retention level. The next $10 million of claims in excess of these aggregate self-insurance retentions of $15 million per occurrence are 55% reinsured by THINC with independent reinsurance companies, with THINC retaining 45% or a maximum of $4.5 million. Claims in excess of $25 million are covered by our excess professional and general liability insurance policies with major independent insurance companies, on a claims-made basis, subject to an aggregate limit of $175 million.

- *Policy period June 1, 2009 through May 31, 2010*—Our hospitals generally have a self-insurance retention of $5 million per occurrence for all claims incurred. THINC retains $10 million per occurrence above our hospitals' $5 million self-insurance retention level. The next $10 million of claims in excess of these aggregate self-insurance retentions of $15 million per occurrence are 65% reinsured by THINC with independent reinsurance companies, with THINC retaining 35% or a maximum of $3.5 million. Claims in excess of $25 million are covered by our excess professional and general liability insurance policies with major independent insurance companies, on a claims-made basis, subject to an aggregate limit of $175 million, with Tenet retaining 20% of the initial $50 million layer in excess of $25 million per claim or a maximum of $10 million.

If the aggregate limit of any of our professional and general liability policies is exhausted, in whole or in part, it could deplete or reduce the limits available to pay any other material claims applicable to that policy period.

Included in other operating expenses, net, in the accompanying Consolidated Statements of Operations is malpractice expense of $92 million, $108 million and $56 million for the years ended December 31, 2012, 2011 and 2010, respectively.

NOTE 15. CLAIMS AND LAWSUITS

We operate in a highly regulated and litigious industry. As a result, various lawsuits, claims, and legal and regulatory proceedings have been and can be expected to continue to be instituted or asserted against us. The resolution of any of these matters could have a material adverse effect on our results of operations, financial condition or cash flows in a given period.

In accordance with ASC 450, "Contingencies," and related guidance, we record accruals for estimated losses relating to claims and lawsuits when available information indicates that a loss is probable and the amount of the loss, or range of loss, can be reasonably estimated. Where a loss on a material matter is reasonably possible and estimable, we disclose an estimate of the loss or a range of loss. In cases where we have not disclosed an estimate, we have concluded that the loss is either not reasonably possible or the loss, or a range of loss, is not reasonably estimable, based on available information.

1. Governmental Reviews—Health care companies are subject to numerous investigations by various governmental agencies. Further, private parties have the right to bring qui tam or "whistleblower" lawsuits against companies that allegedly submit false claims for payments to, or improperly retain overpayments from, the government and, in some states, private payers. Certain of our individual facilities have received inquiries from government agencies, and our facilities may receive such inquiries in future periods. The following material governmental reviews are currently pending.

    - *Review of Billing Practices for Kyphoplasty Procedures.* The U.S. Department of Justice ("DOJ"), in coordination with the Office of Inspector General ("OIG") of the U.S. Department of Health and Human Services ("HHS"), has contacted a number of hospitals nationwide requesting information regarding their billing practices in connection with kyphoplasty procedures. More specifically, the government is investigating the appropriateness of Medicare patients receiving kyphoplasty – which is a surgical procedure used to treat pain and related conditions associated with certain vertebrae injuries – on an inpatient as opposed to an outpatient basis. In March 2009, one of our hospitals received an information request from the DOJ regarding these procedures and, in July 2010, we were notified that seven additional hospitals were also under review. Following a chart review by our external clinical expert and non-binding discussions with the government, we entered into an agreement with the DOJ in January 2013 for approximately $900,000 (which was previously reserved) to settle claims relating to the first hospital to receive an information request. In September 2012, we reached agreement with the DOJ on the appropriate methodology to review the billing practices of a second hospital, and our expert has completed the chart review for that hospital. As a result, in the three months ended December 31, 2012, management established a reserve, as described below, to reflect the current estimate of probable liability for that second hospital. Because we have not reached agreement with the DOJ on the

appropriate methodology to review the billing practices of the remaining five hospitals under review, we are unable to calculate an estimate of loss or range of loss with respect to those hospitals.

- *Review of Billing Practices for Cardiac Defibrillator Implantation Procedures.* The DOJ has contacted a number of hospitals nationwide requesting information regarding their Medicare billing practices in connection with the implantation of cardiac defibrillators. As previously reported, in March 2010, the DOJ issued a civil investigative demand to one of our hospitals pursuant to the federal False Claims Act seeking information to determine if procedures to implant cardiac defibrillators at that hospital from 2002 to 2010 were performed in accordance with Medicare coverage requirements. Also as previously reported, in September 2010, the DOJ notified us that its review may extend to billing procedures at 32 of our other hospitals in addition to the hospital that received the original information request. The number of hospitals under review may increase or decrease depending on the timeframe of the government's examination.

- *Review of Arrangements with Local Service Provider.* We received a subpoena from the OIG in Atlanta seeking documents from January 2004 through May 2012 related to the relationship that Atlanta Medical Center, North Fulton Regional Hospital, South Fulton Medical Center and Spalding Regional Hospital (all located in Georgia) and Hilton Head Hospital (located in South Carolina) had with Hispanic Medical Management, Inc. ("HMM"). HMM is an unaffiliated entity that owns and operates clinics that provide, among other things, prenatal care predominately to Hispanic women. The hospitals contracted with HMM for translation services, marketing services and Medicaid eligibility assistance. The investigation is being conducted by the U.S. Attorney's Office for the Middle District of Georgia along with the Civil Division of the DOJ. We understand the government's review focuses on whether the arrangements violated the federal Anti-kickback Statute and False Claims Act. We have produced documents and information responsive to the subpoena and are cooperating with the government's review. At this time, we are unable to determine the potential impact, if any, that will result from the final resolution of this investigation.

Except with respect to the recently settled matter involving one hospital discussed above, our analysis of these pending reviews is still ongoing, and we are unable to predict with any certainty the progress or final outcome of any discussions with government agencies at this time. Based on currently available information, as of December 31, 2012, we had recorded reserves of approximately $3 million in the aggregate with respect to three hospitals under review in the foregoing governmental proceedings. Changes in the reserves may be required in the future as additional information becomes available. We cannot predict the ultimate resolution of any governmental review, and the final amounts paid in settlement or otherwise, if any, could differ materially from our currently recorded reserves.

2. Hospital-Related Tort Claim—As previously reported, in May 2012, the Superior Court in Los Angeles County, California reduced punitive damages awarded in connection with an alleged April 2006 assault at Tarzana Regional Medical Center (a hospital we divested in 2008) from $65 million to $5 million. (The plaintiff was also previously awarded compensatory damages of approximately $2.4 million in the lawsuit – which is captioned *Rosenberg v. Encino-Tarzana Regional Medical Center and Tenet Healthcare Corporation.*) The plaintiff subsequently filed a motion seeking attorneys' fees in the amount of $6 million; however, the judge instead awarded attorneys' fees of $1.5 million. Both parties have filed notices appealing all aspects of the final judgment.

   In the three months ended December 31, 2011, the Company recorded a reserve of approximately $6 million in discontinued operations for this matter. For purposes of computing the reserve, management estimated that the probable range of loss would be between approximately $6 million and $25 million (including approximately $1 million in attorneys' fees) based on our expectation, after analysis of relevant case law, that a California court would apply U.S. Supreme Court opinions that generally limit, as a matter of constitutional law, the amount of a punitive award to be no more than a multiple of nine times the compensatory award and, in the case of a substantial compensatory award, to be no more than a multiple of one times that award. At that time, management concluded that no amount within this range is any more likely than any other; therefore, in accordance with ASC 450, the accrual was recorded at the low end of the estimated range.

   Although we are unable to predict the ultimate resolution of this lawsuit at this time, we continue to believe that the current reserve, recorded at the low end of the estimated range, reflects our probable liability. We intend to continue to vigorously defend ourselves in this matter.

3. Ordinary Course Matters—Also, as previously reported, we are defendants in a class action lawsuit in which the plaintiffs claim that in April 1996 patient identifying records from a psychiatric hospital that we closed in 1995 were temporarily placed in an unsecure location while the hospital was undergoing renovations. The lawsuit, *Doe, et al. v. Jo Ellen Smith Medical Foundation,* was filed in the Civil District Court for the Parish of Orleans in Louisiana in March 1997 and is currently pending. The plaintiffs' claims include allegations of tortious invasion of privacy and negligent infliction of emotional distress. The plaintiffs contend that the class consists of approximately 5,000 persons;

however, only eight individuals have been identified to date in the class certification process. The plaintiffs have asserted each member of the class is entitled to common damages under a theory of presumed "common damage" regardless of whether or not any members of the class were actually harmed or even aware of the incident. We believe there is no authority for an award of common damages under Louisiana law. In addition, we believe that there is no basis for the certification of this proceeding as a class action under applicable federal and Louisiana law precedents. However, the trial court has denied our motions for summary judgment and our motion to decertify the class. In March 2012, the Louisiana Supreme Court denied our interlocutory appeal of the trial court's decision on summary judgment based on procedural grounds, noting that we retain an adequate remedy to appeal any adverse judgment that might be rendered by the trial court. In April 2012, we filed a notice of appeal of the trial court's denial of our motion to decertify the proceeding as a class action. The notice of appeal was granted, and the trial has been stayed pending the outcome of the appeal. At this time, we are not able to estimate the reasonably possible loss or reasonably possible range of loss given: the small number of class members that have been identified or otherwise responded to the class certification process; the novel theories asserted by plaintiffs, including their assertion that a theory of presumed common damage exists under Louisiana law; uncertainties as to the timing and outcome of the appeals process; and the failure of the plaintiffs to provide any evidence of damages. We intend to vigorously contest the plaintiffs' claims.

In addition to the matters described above, our hospitals are subject to investigations, claims and legal proceedings in the ordinary course of our business. Most of these matters involve allegations of medical malpractice or other injuries suffered at our hospitals. We are also party in the normal course of business to regulatory proceedings and private litigation concerning the terms of our union agreements and the application of various federal and state labor laws, rules and regulations governing, among other things, a variety of workplace wage and hour issues. Furthermore, our hospitals are routinely subject to sales and use tax audits and personal property tax audits by the state and local government jurisdictions in which they do business. The results of the audits are frequently disputed, and such disputes are ordinarily resolved by administrative appeals or litigation. It is management's opinion that the ultimate resolution of these ordinary course investigations, claims and legal proceedings will not have a material adverse effect on our business, financial condition, results of operations or cash flows.

New claims or inquiries may be initiated against us from time to time. These matters could (1) require us to pay substantial damages or amounts in judgments or settlements, which individually or in the aggregate could exceed amounts, if any, that may be recovered under our insurance policies where coverage applies and is available, (2) cause us to incur substantial expenses, (3) require significant time and attention from our management, and (4) cause us to close or sell hospitals or otherwise modify the way we conduct business.

The table below presents reconciliations of the beginning and ending liability balances in connection with legal settlements and related costs recorded during the years ended December 31, 2012, 2011 and 2010:

	Balances at Beginning of Period	Litigation and Investigation Costs	Cash Payments	Other	Balances at End of Period
Year Ended December 31, 2012					
Continuing operations	$ 49	$ 5	$ (49)	$ 0	$ 5
Discontinued operations	17	0	(12)	0	5
	$ 66	**$ 5**	**$ (61)**	**$ 0**	**$ 10**
Year Ended December 31, 2011					
Continuing operations	$ 30	$ 55	$ (36)	$ 0	$ 49
Discontinued operations	0	17	0	0	17
	$ 30	**$ 72**	**$ (36)**	**$ 0**	**$ 66**
Year Ended December 31, 2010					
Continuing operations	$ 95	$ 12	$ (78)	$ 1	$ 30
Discontinued operations	0	0	0	0	0
	$ 95	**$ 12**	**$ (78)**	**$ 1**	**$ 30**

For the years ended December 31, 2012, 2011 and 2010, we recorded net costs of $5 million, $72 million and $12 million, respectively, in connection with significant legal proceedings and investigations. The 2012 amount primarily related to costs associated with various legal proceedings and governmental reviews. The 2011 amount primarily related to costs associated with our evaluation of an unsolicited acquisition proposal received in November 2010 (which was subsequently withdrawn), changes in reserve estimates established in connection with certain governmental reviews described above, accruals for a physician privileges case and certain hospital-related tort claims, the settlement of a union arbitration claim, and costs to defend the Company in various matters. The 2010 costs primarily related to costs to defend the Company in various matters and changes in reserve estimates established in connection with certain governmental reviews, as well as costs associated with our

evaluation of the unsolicited acquisition proposal received in November 2010. The amount for 2010 in the column entitled "Other" above related to the reclassification of previously recorded reserves associated with certain of the matters described above to the accrued legal settlement costs caption in the accompanying Consolidated Balance Sheets.

NOTE 16. INCOME TAXES

The provision for income taxes for continuing operations for the years ended December 31, 2012, 2011 and 2010 consists of the following:

	Years Ended December 31,		
	2012	2011	2010
Current tax expense (benefit):			
Federal	$ (3)	$ 0	$ 6
State	11	(6)	0
	8	(6)	6
Deferred tax expense (benefit):			
Federal	117	62	(929)
State	0	5	(54)
	117	67	(983)
	$ 125	**$ 61**	**$(977)**

A reconciliation between the amount of reported income tax expense (benefit) and the amount computed by multiplying income (loss) from continuing operations before income taxes by the statutory federal income tax rate is shown below:

	Years Ended December 31,		
	2012	2011	2010
Tax expense at statutory federal rate of 35%	$ 117	$ 57	$ 55
State income taxes, net of federal income tax benefit	13	10	10
Tax attributable to noncontrolling interests	(4)	(4)	(3)
Other changes in valuation allowance	(5)	(2)	(1,054)
Change in tax contingency reserves, including interest	(1)	(12)	16
Prior-year provision to return adjustment and other changes in deferred taxes, net of valuation allowance	3	7	(3)
Other items	2	5	2
	$ 125	**$ 61**	**$(977)**

Deferred income taxes reflect the tax effects of temporary differences between the carrying amount of assets and liabilities for financial reporting purposes and the amount used for income tax purposes. The following table discloses those significant components of our deferred tax assets and liabilities, including any valuation allowance:

	December 31, 2012		December 31, 2011	
	Assets	Liabilities	Assets	Liabilities
Depreciation and fixed-asset differences	$ 0	$375	$ 0	$418
Reserves related to discontinued operations and restructuring charges	5	0	5	0
Receivables (doubtful accounts and adjustments)	173	0	178	0
Deferred gain on debt exchanges	0	53	0	53
Accruals for retained insurance risks	182	0	197	0
Intangible assets	0	122	0	115
Other long-term liabilities	55	0	53	0
Benefit plans	214	0	190	0
Other accrued liabilities	11	0	31	0
Investments and other assets	6	0	5	0
Net operating loss carryforwards	588	0	695	0
Stock-based compensation	32	0	44	0
Other items	36	0	41	0
	1,302	**550**	**1,439**	**586**
Valuation allowance	(56)	0	(61)	0
	$ 1,246	**$550**	**$ 1,378**	**$586**

Below is a reconciliation of the deferred tax assets and liabilities and the corresponding amounts reported in the accompanying Consolidated Balance Sheets.

	December 31,	
	2012	2011
Current portion of deferred income taxes	$ 354	$ 418
Deferred income taxes, net of current portion	342	374
Noncurrent deferred income tax liability	0	0
Net deferred tax asset	$ 696	$ 792

The provision for income taxes in the year ended December 31, 2010 included an income tax benefit of $998 million in continuing operations related to a decrease in the valuation allowance for our deferred tax assets and other tax adjustments. The net decrease in the valuation allowance during the year ended December 31, 2010 is primarily attributable to the estimated realization of deferred tax assets resulting from the utilization of net operating loss carryforwards against projected future years' taxable income. After considering all available evidence, both positive (including cumulative profits, carryforward periods for utilization of federal net operating loss carryovers and other factors) and negative (including cumulative losses in past years and other factors), we concluded that the valuation allowance against our deferred tax assets should be reduced by approximately $1.06 billion. The remaining $66 million balance in the valuation allowance as of December 31, 2010 was primarily attributable to certain state net operating loss carryovers and federal tax credits that, more likely than not, will expire unutilized. Based on the improvement of our operating results in 2009 and 2010 and our assessment of projected future results of operations, we determined that realization of the deferred income tax benefit was more likely than not. As a result, our judgment about the need for this valuation allowance changed and the reduction in the valuation allowance was recorded as a benefit in the provision for income taxes.

Effective January 1, 2007, we adopted ASC 740-10-25, which prescribes a comprehensive model for the financial statement recognition, measurement, presentation and disclosure of uncertain tax positions taken or expected to be taken in income tax returns. The table below summarizes the total changes in unrecognized tax benefits during the years ended December 31, 2012, 2011 and 2010. The additions and reductions for tax positions include the impact of items for which the ultimate deductibility is highly certain, but for which there is uncertainty about the timing of such deductions. Such amounts include unrecognized tax benefits that have impacted deferred tax assets and liabilities at December 31, 2012, 2011 and 2010.

	Continuing Operations	Discontinued Operations	Total
Balance at December 31, 2009	$ 34	$ 12	$ 46
Additions for prior-year tax positions	12	0	12
Reductions for tax positions of prior years	(12)	(11)	(23)
Additions for current-year tax positions	1	0	1
Reductions for current-year tax positions	0	0	0
Reductions due to settlements with taxing authorities	0	0	0
Reductions due to a lapse of statute of limitations	(1)	0	(1)
Balance at December 31, 2010	34	1	35
Additions for prior-year tax positions	15	0	15
Reductions for tax positions of prior years	(2)	0	(2)
Additions for current-year tax positions	3	0	3
Reductions for current-year tax positions	0	0	0
Reductions due to settlements with taxing authorities	(12)	0	(12)
Reductions due to a lapse of statute of limitations	(4)	0	(4)
Balance at December 31, 2011	34	1	35
Additions for prior-year tax positions	0	0	0
Reductions for tax positions of prior years	(2)	0	(2)
Additions for current-year tax positions	2	0	2
Reductions for current-year tax positions	0	0	0
Reductions due to settlements with taxing authorities	(3)	0	(3)
Reductions due to a lapse of statute of limitations	(0)	0	(0)
Balance at December 31, 2012	$ 31	$ 1	$ 32

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The total amount of unrecognized tax benefits as of December 31, 2012 was $32 million, which, if recognized, would affect our effective tax rate and income tax expense (benefit) from continuing and discontinued operations. Income tax expense in the year ended December 31, 2012 includes expense of $3 million in continuing operations attributable to an increase in our estimated liabilities for uncertain tax positions, net of related deferred tax effects. The total amount of unrecognized tax benefits as of December 31, 2011 was $35 million, which, if recognized, would impact our effective tax rate and income tax expense (benefit) from continuing and discontinued operations. Income tax expense in the year ended December 31, 2011 includes a benefit of $21 million ($2 million related to continuing operations and $19 million related to discontinued operations) attributable to a reduction in our estimated liabilities for uncertain tax positions, net of related deferred tax effects. The total amount of unrecognized tax benefits as of December 31, 2010 was $35 million of which $23 million, if recognized, would affect our effective tax rate and income tax expense (benefit) from continuing and discontinued operations. Income tax expense in the year ended December 31, 2010 includes a benefit of $58 million ($45 million related to continuing operations and $13 million related to discontinued operations) attributable to a reduction in our estimated liabilities for uncertain tax positions, net of related deferred tax effects, primarily as a result of audit settlements and the expiration of statutes of limitation.

Our practice is to recognize interest and/or penalties related to income tax matters in income tax expense in our consolidated statements of operations. Approximately $1 million of interest and penalties related to accrued liabilities for uncertain tax positions related to continuing operations are included in the accompanying Consolidated Statement of Operations for the year ended December 31, 2012. Total accrued interest and penalties on unrecognized tax benefits as of December 31, 2012 were $8 million, all of which related to continuing operations.

The Internal Revenue Service ("IRS") has completed the audits of our tax returns for all tax years ending on or before December 31, 2007. All disputed issues with respect to these audits have been resolved and all related tax assessments (including interest) have been paid. Tax returns for years ended after December 31, 2007 are not currently under examination by the IRS. During 2011, the resolution of tax and interest computations by the IRS resulted in a net refund of tax and interest of $18 million with respect to the tax years ended May 31, 1998 through December 31, 2003, and payment of $15 million of tax and interest with respect to the tax years ended December 31, 2006 and 2007.

As of December 31, 2012, approximately $8 million of unrecognized federal and state tax benefits, as well as reserves for interest and penalties, may decrease in the next 12 months as a result of the settlement of audits, the filing of amended tax returns or the expiration of statutes of limitations.

At December 31, 2012, our carryforwards available to offset future taxable income consisted of (1) federal net operating loss ("NOL") carryforwards of approximately $1.5 billion pretax expiring in 2024 to 2029, (2) approximately $19 million in alternative minimum tax credits with no expiration, (3) general business credit carryforwards of approximately $14 million expiring in 2023 through 2032, and (4) state NOL carryforwards of $3.2 billion expiring in 2012 through 2032 for which the associated deferred tax benefit, net of valuation allowance and federal tax impact, is $34 million. Our ability to utilize NOL carryforwards to reduce future taxable income may be limited under Section 382 of the Internal Revenue Code if certain ownership changes in our company occur during a rolling three-year period. These ownership changes include purchases of common stock under share repurchase programs (see Note 2), the offering of stock by us, the purchase or sale of our stock by 5% shareholders, as defined in the Treasury regulations, or the issuance or exercise of rights to acquire our stock. If such ownership changes by 5% shareholders result in aggregate increases that exceed 50 percentage points during the three-year period, then Section 382 imposes an annual limitation on the amount of our taxable income that may be offset by the NOL carryforwards or tax credit carryforwards at the time of ownership change.

NOTE 17. EARNINGS PER COMMON SHARE

The table below is a reconciliation of the numerators and denominators of our basic and diluted earnings (loss) per common share calculations for income from continuing operations for the years ended December 31, 2012, 2011 and 2010. Income is expressed in millions and weighted average shares are expressed in thousands.

	Income (Numerator)	Weighted Average Shares (Denominator)	Per-Share Amount
Year Ended December 31, 2012			
Income available to Tenet Healthcare Corporation common shareholders for basic earnings per share	$ 185	104,200	$ 1.77
Effect of dilutive stock options and restricted stock units	0	4,726	(0.07)
Income available to Tenet Healthcare Corporation common shareholders for diluted earnings per share	**$ 185**	**108,926**	**$ 1.70**

	Income (Numerator)	Weighted Average Shares (Denominator)	Per-Share Amount
Year Ended December 31, 2011			
Income available to Tenet Healthcare Corporation common shareholders for basic earnings per share	$ 68	117,182	$ 0.58
Effect of dilutive stock options and restricted stock units	0	4,113	(0.02)
Income available to Tenet Healthcare Corporation common shareholders for diluted earnings per share	**$ 68**	**121,295**	**$ 0.56**
Year Ended December 31, 2010			
Income available to Tenet Healthcare Corporation common shareholders for basic earnings per share	$1,101	121,080	$ 9.09
Effect of dilutive stock options, restricted stock units and mandatory convertible preferred stock	24	19,078	(1.06)
Income available to Tenet Healthcare Corporation common shareholders for diluted earnings per share	**$1,125**	**140,158**	**$ 8.03**

Stock options (in thousands) whose exercise price exceeded the average market price of our common stock and, therefore, were not included in the computation of diluted shares for the years ended December 31, 2012, 2011 and 2010 were 2,876, 3,421 and 5,043 shares, respectively.

NOTE 18. FAIR VALUE MEASUREMENTS

Our financial assets and liabilities recorded at fair value on a recurring basis primarily relate to investments in available-for-sale securities held by our captive insurance subsidiaries and our derivative contracts. The following tables present information about our assets and liabilities that are measured at fair value on a recurring basis as of December 31, 2012 and 2011. The following tables also indicate the fair value hierarchy of the valuation techniques we utilized to determine such fair values. In general, fair values determined by Level 1 inputs utilize quoted prices (unadjusted) in active markets for identical assets or liabilities. We consider a security that trades at least weekly to have an active market. Fair values determined by Level 2 inputs utilize data points that are observable, such as quoted prices, interest rates and yield curves. Fair values determined by Level 3 inputs are unobservable data points for the asset or liability, and include situations where there is little, if any, market activity for the asset or liability.

Investments:	December 31, 2012	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Marketable securities – current	$ 4	$ 4	$ 0	$ 0
Investments in Reserve Yield Plus Fund	2	0	2	0
Marketable debt securities – noncurrent	14	2	11	1
	$ 20	**$ 6**	**$ 13**	**$ 1**
Derivative Contracts (see Note 6):				
LIBOR cap agreement asset	**$ 0**	**$ 0**	**$ 0**	**$ 0**

Investments:	December 31, 2011	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Investments in Reserve Yield Plus Fund	$ 2	$ 0	$ 2	$ 0
Marketable debt securities – noncurrent	22	6	15	1
	$ 24	**$ 6**	**$ 17**	**$ 1**
Derivative Contracts (see Note 6):				
LIBOR cap agreement asset	**$ 0**	**$ 0**	**$ 0**	**$ 0**

There was no change in the fair value of our auction rate securities valued using significant unobservable inputs during the years ended December 31, 2012 or 2011.

At December 31, 2012, one of our captive insurance subsidiaries held $1 million of preferred stock and other securities that were distributed from auction rate securities whose auctions have failed due to sell orders exceeding buy orders. We were not required to record an other-than-temporary impairment of these securities during the years ended December 31, 2012 or 2011.

Our non-financial assets and liabilities not permitted or required to be measured at fair value on a recurring basis typically relate to long-lived assets held and used, long-lived assets held for sale and goodwill. We are required to provide additional disclosures about fair value measurements as part of our financial statements for each major category of assets and liabilities measured at fair value on a non-recurring basis. The following table presents this information and indicates the fair value hierarchy of the valuation techniques we utilized to determine such fair values. In general, fair values determined by Level 1 inputs utilize quoted prices (unadjusted) in active markets for identical assets or liabilities, which generally are not applicable to non-financial assets and liabilities. Fair values determined by Level 2 inputs utilize data points that are observable, such as definitive sales agreements, appraisals or established market values of comparable assets. Fair values determined by Level 3 inputs are unobservable data points for the asset or liability and include situations where there is little, if any, market activity for the asset or liability, such as internal estimates of future cash flows.

	December 31, 2011	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Long-lived assets held and used	$ 20	$ 0	$ 20	$ 0
Goodwill	$ 0	$ 0	$ 0	$ 0

As described in Notes 4 and 5, we recorded $12 million in impairment charges in the year ended December 31, 2011 consisting of (i) $6 million in continuing operations for the write-down of buildings and equipment of one of our previously impaired hospitals to their estimated fair values of $20 million primarily due to a decline in the fair value of real estate in the market in which the hospital operates and a decline in the estimated fair value of equipment and (ii) $6 million in discontinued operations for the write-off of goodwill associated with our diagnostic imaging center business in Louisiana to its implied fair value of $0.

The fair value of our long-term debt is based on quoted market prices (Level 1). At December 31, 2012 and 2011, the estimated fair value of our long-term debt was approximately 108.2% and 104.9%, respectively, of the carrying value of the debt.

NOTE 19. ACQUISITIONS

During the year ended December 31, 2012, we acquired a diagnostic imaging center, an oncology center, an urgent care center, a health plan, a cyberknife center in which we previously held a noncontrolling interest, a majority interest in nine ambulatory surgery centers (in one of which we had previously held a noncontrolling interest), as well as 20 physician practice entities and a physician practice management company in which we had previously held a noncontrolling interest as part of our Hospital Operations and other segment. Also during the year ended December 31, 2012, our Conifer segment acquired an information management and services company and a hospital revenue cycle management business. The fair value of the consideration conveyed in the acquisitions (the "purchase price") was $211 million.

We are required to allocate the purchase prices of the acquired businesses to assets acquired or liabilities assumed and, if applicable, noncontrolling interests based on their fair values. The excess of the purchase price allocation over those fair values is recorded as goodwill. We are in process of finalizing the purchase price allocations, including valuations of the acquired property and equipment, for several recently acquired outpatient centers; therefore, the purchase price allocations for those centers are subject to adjustment once the valuations are completed. We are also in process of finalizing the purchase price allocations, including valuations of the acquired identifiable intangible assets, for the recent acquisitions made by our Conifer subsidiary; therefore, the purchase price allocations for those acquisitions are subject to adjustment once the valuations are completed. During the year ended December 31, 2012, we finalized the purchase price allocations for various outpatient centers acquired in 2011, which resulted in an increase in goodwill of $1 million with a corresponding decrease in property and equipment.

During the year ended December 31, 2011, we acquired 15 outpatient centers – four diagnostic imaging centers, a majority interest in one other diagnostic imaging center, three oncology centers, an urgent care center, a majority interest in five ambulatory surgery centers, and a majority interest in one other ambulatory surgery center in which we previously held a minority interest. In 2011, we also acquired 26 physician practice entities. The fair value of the consideration conveyed in the acquisitions (the "purchase price") was $84 million.

	Year Ended December 31,		
	2012	2011	2010
Capital expenditures:			
Hospital Operations and other	$ 495	$ 461	$ 465
Conifer	13	14	11
Total	**$ 508**	**$ 475**	**$ 476**
Net operating revenues:			
Hospital Operations and other	$ 9,002	$ 8,575	$ 8,216
Conifer			
Tenet	371	261	206
Other customers	117	79	49
	9,490	8,915	8,471
Intercompany eliminations	(371)	(261)	(206)
Total	**$ 9,119**	**$ 8,654**	**$ 8,265**
Adjusted EBITDA:			
Hospital Operations and other	$ 1,098	$ 1,083	$ 1,021
Conifer	105	43	15
Total	**$ 1,203**	**$ 1,126**	**$ 1,036**
Depreciation and amortization:			
Hospital Operations and other	$ 420	$ 389	$ 372
Conifer	10	9	8
Total	**$ 430**	**$ 398**	**$ 380**
Adjusted EBITDA	**$ 1,203**	**$ 1,126**	**$ 1,036**
Depreciation and amortization	(430)	(398)	(380)
Interest expense	(412)	(375)	(424)
Loss from early extinguishment of debt	(4)	(117)	(57)
Litigation and investigation costs	(5)	(55)	(12)
Impairment of long-lived assets and goodwill, and restructuring charges, net	(19)	(20)	(10)
Investment earnings	1	3	5
Income before income taxes	**$ 334**	**$ 164**	**$ 158**

Due to the fact that Conifer's revenues from providing services to Tenet's hospitals are based on estimated third-party billing terms in 2012 but not in 2011 or 2010, the following supplemental table presents 2012 Adjusted EBITDA on a comparable basis to the 2011 and 2010 presentation.

	Year Ended December 31,		
	2012	2011	2010
Adjusted supplemental EBITDA:			
Hospital Operations and other	$ 1,167	$ 1,083	$ 1,021
Conifer	36	43	15
Total	**$ 1,203**	**$ 1,126**	**$ 1,036**

NOTE 21. RECENT ACCOUNTING STANDARDS

Changes in Accounting Principle

Effective January 1, 2011, we adopted ASU 2010-24, "Health Care Entities (Topic 954): Presentation of Insurance Claims and Related Insurance Recoveries," which clarifies that a health care entity should not net insurance recoveries against a related claim liability. The adoption had no impact on our financial condition, results of operations or cash flows.

Effective January 1, 2011, we adopted ASU 2010-23, "Health Care Entities (Topic 954): Measuring Charity Care for Disclosure," which prescribes a specific measurement basis of charity care for disclosure. The adoption had no impact on our financial condition, results of operations or cash flows.

ATTACHMENT 39

Effective December 31, 2011, we adopted ASU 2011-07, "Health Care Entities (Topic 954): Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities," which requires health care entities to present the provision for doubtful accounts relating to patient service revenue as a deduction from patient service revenue in the statement of operations rather than as an operating expense. Additional disclosures relating to sources of patient revenue and the allowance for doubtful accounts related to patient accounts receivable are also required. Such additional disclosures are included in Notes 1 and 3. The adoption of this ASU had no impact on our financial condition, results of operations or cash flows.

Recently Issued Accounting Standards

In July 2012, the Financial Accounting Standards Board issued ASU 2012-02, "Intangibles—Goodwill and Other (Topic 350): Testing Indefinite-Lived Intangible Assets for Impairment," which permits an entity to first assess qualitative factors to determine whether it is more likely than not that an indefinite-lived intangible asset is impaired as a basis for determining whether it is necessary to perform the quantitative impairment test as described in Topic 350. The guidance provided in the ASU is effective for annual and interim impairment testing performed for fiscal years beginning after September 15, 2012. The adoption of this standard is not expected to have any impact on our financial condition, results of operations or cash flows.

NOTE 22. SUBSEQUENT EVENT

Issuance of New Notes; Repurchase of Outstanding Notes

In February 2013, we sold $850 million aggregate principal amount of 4½% senior secured notes, which will mature on April, 1 2021. We will pay interest on the 4½% senior secured notes semi-annually in arrears on April 1 and October 1 of each year, commencing on October 1, 2013. We used a portion of the proceeds from the sale of the notes to purchase approximately $645 million aggregate principal amount outstanding of our 10% senior secured notes due 2018 in a tender offer and to call approximately $69 million of the remaining aggregate principal amount outstanding of those notes. In connection with the purchase, we expect to record a loss from early extinguishment of debt of approximately $179 million primarily related to the difference between the purchase prices and the par values of the purchased notes, as well as the write-off of unamortized note discounts and issuance costs. The remaining net proceeds will be used for purchases of our other outstanding senior secured notes through public or privately negotiated transactions and for general corporate purposes, including strategic acquisitions and the repayment of indebtedness and drawings under our senior secured revolving credit facility.

Daniel Cancelmi
Chief Financial Officer
Tel: 469-893-2246
Fax: 469-893-3246
daniel.cancelmi@tenethealth.com

July 10, 2013

Ms. Courtney Avery
Illinois Health Facilities
And Services Review Board
525 West Jefferson
Springfield, IL 62761

Dear Ms. Avery:

On June 24, 2013, Vanguard Health Systems, Inc. ("Vanguard") entered into an Agreement and Plan of Merger to sell 100% of its stock (by way of merger) to Tenet Healthcare Corporation ("Tenet"). Both Vanguard and Tenet are publicly traded companies. The shares of both companies are traded on the New York Stock Exchange.

Vanguard through its wholly owned subsidiaries has an ownership interest in each of the following Illinois hospitals ("Illinois Hospitals"):

- VHS - West Suburban Medical Center
- VHS - Westlake Hospital
- VHS - MacNeal Hospital
- VHS - Weiss Memorial Hospital

In accordance with the requirements of Review Criteria 1120.120 and 1120.130, and as represented in the respective Certificate of Need Applications for each hospital, Tenet confirms it will fund all project capital expenditures (i.e., the imputed purchase price attributable to the Illinois Hospitals) entirely through available/internal resources (cash and cash equivalents), the availability of which is documented, as provided under Review Criterion 1120.130, in Tenet's most recent audited financial statements, which are on file with the U.S. Securities and Exchange Commission. These financial resources as shown in the most recent audited financial statements are in excess of the amount necessary to fund the imputed cash purchase price attributed to the Illinois hospitals. Tenet will maintain sufficient available financial resources to fund the imputed cash purchase price attributed to the Illinois Hospitals and will use these resources to complete such acquisition.

Very truly yours,

Daniel J. Cancelmi
Chief Financial Officer

KATHLEEN M. KENNEDY
Notary Public, State of Texas
My Commission Expires
September 30, 2015

Notarized: Kathleen M. Kennedy
Dallas County, TX
7/10/13

PROJECTED OPERATING CAPITAL
COSTS per ADJUSTED PATIENT DAY

VHS-Weiss Memorial Hospital

Projected Operating Costs, 2014

Projected Adjusted
Patient Days: 19,100

	Hospital	M/S	OB	ICU	AMI	Rehab	SNF	Cath	OH Surg
salaries & benefits:	$ 62,053,064	$ 10,458,228		$ 2,977,002	$ 1,001,381	$ 1,274,211		$ 532,343	n/a
medical supplies*	$ 14,388,892	$ 418,000		$ 252,818	$ 7,170	$ 21,073		$ 966,403	
	$ 76,441,956	$ 10,876,228		$ 3,229,820	$ 1,008,551	$ 1,295,284		$ 1,498,746	
Projected Operating Cost per Adjusted Patient Day	$ 4,002	$ 569.44		$ 169.10	$ 52.80	$ 67.82		$ 78.47	

Projected Capital Costs, 2014

depreciation	$ 6,236,583
amortization	$ 134,747
Projected Capital Cost per Adjusted Patient Day	$ 333.58

*excludes medications

ATTACHMENT 42

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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