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E-041-17

RECEIVED
SEP 01 2017
HEALTH FACILITIES &
SERVICES REVIEW BOARD

August 31, 2017

VIA FEDEX

Courtney Avery
Administrator
Illinois Health Facilities & Services Review Board
525 W. Jefferson Street, 2nd Floor
Springfield, IL. 62761

Re: Vista West Medical Center – Exemption to Discontinue Rehabilitation Unit

Dear Ms. Avery:

Enclosed is an application for an exemption to discontinue the 25 bed rehabilitation unit at Vista West Medical Center. Also enclosed is a check for the \$2,500.00 filing fee.

As always, thank you.

Very truly yours,


Clare E. Connor

DM_US 84472542-1.100513.0024

E-041-17

ORIGINAL

**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR EXEMPTION PERMIT**

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION**RECEIVED****This Section must be completed for all projects.**

SEP 01 2017

Facility/Project Identification

Facility Name: Vista Medical Center West – Discontinue Rehabilitation Unit	HEALTH FACILITIES & SERVICES REVIEW BOARD
Street Address: 2615 W. Washington	
City and Zip Code: Waukegan 60085	
County: Lake	Health Service Area 8 Health Planning Area: A-09

Applicant(s) [Provide for each applicant (refer to Part 1130.220)]

Exact Legal Name: Waukegan Illinois Hospital Company, LLC
Street Address: 1573 Mallory Lane, Suite 100
City and Zip Code: Brentwood, TN 37027
Name of Registered Agent: CT Corporation System
Registered Agent Street Address: 208 S. LaSalle Street
Registered Agent City and Zip Code: Chicago, IL 60604
Name of Chief Executive Officer: Mike Cullota
CEO Street Address: 1573 Mallory Lane, Suite 100
CEO City and Zip Code: Brentwood, TN 37027
CEO Telephone Number:

Type of Ownership of Applicants

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

☐ Corporations and limited liability companies must provide an **Illinois certificate of good standing**.
☐ Partnerships must provide the name of the state in which they are 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]

Name: Clare E. Connor
Title: Partner
Company Name: McDermott Will & Emery LLP
Address: 444 W. Lake Street, Suite 4000 Chicago, IL 60606
Telephone Number: (312) 984-3365
E-mail Address: Cconnor@mwe.com
Fax Number: (312) 277-2964

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

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

**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR EXEMPTION PERMIT****SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION****This Section must be completed for all projects.****Facility/Project Identification**

Facility Name: Vista Medical Center West – Discontinue Rehabilitation Unit		
Street Address: 2615 W. Washington		
City and Zip Code: Waukegan 60085		
County: Lake	Health Service Area: 8	Health Planning Area: A-09

Applicant(s) [Provide for each applicant (refer to Part 1130.220)]

Exact Legal Name: Quorum Health Corporation		
Street Address: 1573 Mallory Lane, Suite 100		
City and Zip Code: Brentwood, TN 37027		
Name of Registered Agent: CT Corporation System		
Registered Agent Street Address: 208 S. LaSalle Street		
Registered Agent City and Zip Code: Chicago, IL 60604		
Name of Chief Executive Officer: Tom Miller		
CEO Street Address: 1573 Mallory Lane, Suite 100		
CEO City and Zip Code: Brentwood, TN 37027		
CEO Telephone Number: 615-221-1400		

Type of Ownership of Applicants

☐ Non-profit Corporation	☐ Partnership	
☒ For-profit Corporation	☐ Governmental	
☐ Limited Liability Company	☐ Sole Proprietorship	☐ Other
- o Corporations and limited liability companies must provide an Illinois certificate of good standing. - o Partnerships must provide the name of the state in which they are 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.		

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Telephone Number: (312) 984-3365
E-mail Address: Cconnor@mwe.com
Fax Number: (312) 277-2964

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

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

Post Exemption 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: Norman Stephens
Title: CEO
Company Name: Vista West Medical Center
Address: 1324 N. Sheridan Road, Waukegan, IL 60085
Telephone Number: 847-360-4001
E-mail Address: Norman_Stephens@QuorumHealth.com
Fax Number: 847-360-4109

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Waukegan Illinois Hospital Company, LLC
Address of Site Owner: 1573 Mallory Lane, Suite 100, Brentwood, TN 37027
Street Address or Legal Description of the Site:
Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statements, 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: Vista Medical Center West	
Address: 2615 W. Washington, Waukegan, IL 60085	
☐ Non-profit Corporation ☐ For-profit Corporation ☒ Limited Liability Company	☐ Partnership ☐ Governmental ☐ Sole Proprietorship
☐ Other	
- o Corporations and limited liability companies must provide an Illinois Certificate of Good Standing. - o 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. - o 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 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**N/A - Discontinuation**

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2006-5 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 #2006-5 ([http:// www.illinois.gov/sites/hfsrb](http://www.illinois.gov/sites/hfsrb)).

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

Historic Resources Preservation Act Requirements**N/A - Discontinuation**

[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:

- ☐ Change of Ownership
- ☒ Discontinuation of an Existing Health Care Facility or of a category of service
- ☐ Establishment or expansion of a neonatal intensive care or beds

2. Narrative Description

In the space below, provide 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.

Waukegan Illinois Hospital Company, LLC d/b/a Vista Medical Center West ("Vista West") proposes discontinuation of its 25-bed rehabilitation unit. The permanent discontinuation will be effective after approval by the Illinois Health Facilities and Services Review Board and will likely occur contemporaneously with the closing of the sale of the hospital (described below). The unit was temporarily discontinued in latter August (with notice to the HFSRB as required) due to lack of utilization and concerns regarding staffing availability. The area where the unit is located will be used for expansion of the facility's psychiatric beds. In the near future a Certificate of Exemption application requesting approval for the change of ownership of Vista Medical Center West will be filed, and contemporaneously a Certificate of Need application by the proposed new owner to modernize and expand the Vista West's physical plant and psychiatric bed capacity.

This project does not include the construction, demolition, or modernization of any existing buildings and there are no project costs.

This is a substantive project because it proposes the discontinuation of a designated category of service.

Project Costs and Sources of Funds (Neonatal Intensive Care Services only)

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 be equal.

Project Costs and Sources of Funds			
USE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Preplanning Costs	N/A	N/A	
Site Survey and Soil Investigation	N/A	N/A	N/A
Site Preparation	N/A	N/A	N/A
Off Site Work	N/A	N/A	N/A
New Construction Contracts	N/A	N/A	N/A
Modernization Contracts	N/A	N/A	N/A
Contingencies	N/A	N/A	N/A
Architectural/Engineering Fees	N/A	N/A	N/A
Consulting and Other Fees	N/A	N/A	N/A
Movable or Other Equipment (not in construction contracts)	N/A	N/A	N/A
Bond Issuance Expense (project related)	N/A	N/A	N/A
Net Interest Expense During Construction (project related)	N/A	N/A	N/A
Fair Market Value of Leased Space or Equipment	N/A	N/A	N/A
Other Costs To Be Capitalized	N/A	N/A	N/A
Acquisition of Building or Other Property (excluding land)	N/A	N/A	N/A
TOTAL USES OF FUNDS	N/A	N/A	N/A
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities	N/A	N/A	N/A
Pledges	N/A	N/A	N/A
Gifts and Bequests	N/A	N/A	N/A
Bond Issues (project related)	N/A	N/A	N/A
Mortgages	N/A	N/A	N/A
Leases (fair market value)	N/A	N/A	N/A
Governmental Appropriations	N/A	N/A	N/A
Grants	N/A	N/A	N/A
Other Funds and Sources	N/A	N/A	N/A
TOTAL SOURCES OF FUNDS	N/A	NA	N/A
NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT 7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

Related Project Costs

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

Land acquisition is related to project	☐ Yes	☒ No
Purchase Price: \$	_____	
Fair Market Value: \$	_____	
The project involves the establishment of a new facility or a new category of service		
☐ Yes ☒ No		
If yes, provide the dollar amount of all non-capitalized operating start-up costs (including operating deficits through the first full fiscal year when the project achieves or exceeds the target utilization specified in Part 1100.		
Estimated start-up costs and operating deficit cost is \$ <u>N/A</u>		

Project Status and Completion Schedules

For facilities in which prior permits have been issued please provide the permit numbers.	
Indicate the stage of the project's architectural drawings:	
☒ None or not applicable	☐ Preliminary
☐ Schematics	☐ Final Working
Anticipated project completion date (refer to Part 1130.140): <u>Shortly before the proposed change of ownership to US Healthvest</u>	
Indicate the following with respect to project expenditures or to financial commitments (refer to Part 1130.140): <u>N/A</u>	
☐ Purchase orders, leases or contracts pertaining to the project have been executed.	
☐ Financial commitment is contingent upon permit issuance. Provide a copy of the contingent "certification of financial commitment" document, highlighting any language related to CON Contingencies	
☐ Financial Commitment 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 [Section 1130.620(c)]

Are the following submittals up to date as applicable:
☒ Cancer Registry
☒ APORS
☒ All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
☒ All reports regarding outstanding permits
Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.

CERTIFICATION

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives are:

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

This Application is filed on the behalf of Waukegan Illinois Hospital Company, LLC
d/b/a Vista Medical Center West *

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 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 fee required for this application is sent herewith or will be paid upon request.

SIGNATURE

PRINTED NAME

Hal McCord
Sr. VP and Assistant Secretary

PRINTED TITLE

SIGNATURE

PRINTED NAME

Martin Smith
Director

PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 18th day of August, 2017

Signature of Notary

Seal

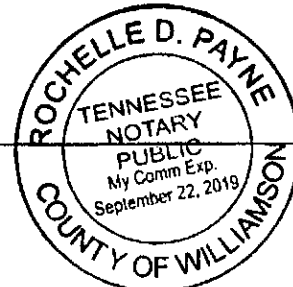


Notarization:

Subscribed and sworn to before me
this 18th day of August, 2017

Signature of Notary

Seal



*Insert the EXACT legal name of the applicant
Notary

CERTIFICATION

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives are:

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

This Application is filed on the behalf of Quorum Health 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 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 fee required for this application is sent herewith or will be paid upon request.

SIGNATURE

PRINTED NAME

Hal McCard
Sr. VP and Assistant Secretary

PRINTED TITLE

SIGNATURE

PRINTED NAME

MARTIN SMITH
DIRECTOR

PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 18th day of August, 2017

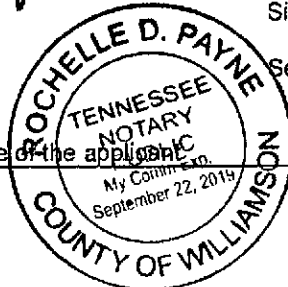
Notarization:

Subscribed and sworn to before me
this 18th day of August, 2017

Signature of Notary

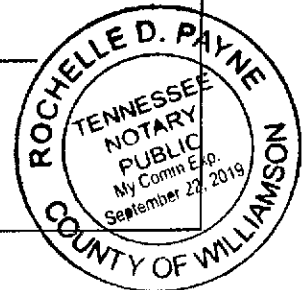
Seal

*Insert the EXACT legal name of the applicant



Signature of Notary

Seal



SECTION II. DISCONTINUATION

This Section is applicable to the discontinuation of a health care facility maintained by a State agency. **NOTE:** If the project is solely for discontinuation and if there is no project cost, the remaining Sections of the application are not applicable.

Type of Discontinuation

- | | |
|-------------------------------------|---|
| ☐ | Discontinuation of an Existing Health Care Facility |
| ☒ | Discontinuation of a category of service |

Criterion 1110.130 - Discontinuation

READ THE REVIEW CRITERION and provide the following information:

GENERAL INFORMATION REQUIREMENTS

1. Identify the categories of service and the number of beds, if any, that are to be discontinued.
2. Identify all of the other clinical services that are to be discontinued.
3. Provide the anticipated date of discontinuation for each identified service or for the entire facility.
4. Provide the anticipated use of the physical plant and equipment after the discontinuation occurs.
5. Provide the anticipated disposition and location of all medical records pertaining to the services being discontinued, and the length of time the records will be maintained.
6. For applications involving the discontinuation of an entire facility, provide certification by an authorized representative that all questionnaires and data required by HFSRB or DPH (e.g., annual questionnaires, capital expenditures surveys, etc.) will be provided through the date of discontinuation, and that the required information will be submitted no later than 90 days following the date of discontinuation.
7. Upon a finding that an application to close a health care facility is complete, the State Board shall publish a legal notice on 3 consecutive days in a newspaper of general circulation in the area or community to be affected and afford the public an opportunity to request a hearing. If the application is for a facility located in a Metropolitan Statistical Area, an additional legal notice shall be published in a newspaper of limited circulation, if one exists, in the area in which the facility is located. If the newspaper of limited circulation is published on a daily basis, the additional legal notice shall be published on 3 consecutive days. The legal notice shall also be posted on the Health Facilities and Services Review Board's web site and sent to the State Representative and State Senator of the district in which the health care facility is located. In addition, the health care facility shall provide notice of closure to the local media that the health care facility would routinely notify about facility events.
8. Provide attestation that the facility provided the required notice of the facility or category of service closure to local media that the health care facility would routinely notify about facility events. The supporting documentation shall include a copy of the notice, the name of the local media outlet, the date the notice was given, and the result of the notice, e.g., number of times broadcasted, written,

or published. Only notice that is given to a local television station, local radio station, or local newspaper will be accepted.

REASONS FOR DISCONTINUATION

The applicant shall state the reasons for the discontinuation and provide data that verifies the need for the proposed action. See criterion 1110.130(b) for examples.

IMPACT ON ACCESS

1. Document that the discontinuation of each service or of the entire facility and whether or not it will have an adverse effect upon access to care for residents of the facility's market area.
2. Document that a written request for an impact statement was received by all existing or approved health care facilities (that provide the same services as those being discontinued) located within 45 minutes travel time of the applicant facility.

APPEND DOCUMENTATION AS ATTACHMENT 10, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

**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. **N/A - Discontinuation**

Background

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 that the information was 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.

Criterion 1110.230 – Purpose of the Project, and Alternatives (Not applicable to Change of Ownership) **N/A - Discontinuation**

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 relevant area, per the applicant's definition.
3. Identify the existing problems or issues that need to be addressed as applicable and appropriate for the project.
4. Cite the sources of the 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 the age and condition of the project site, as well as 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 Board 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**N/A – Discontinuation**

- 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.

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	Mod.	Gross Sq. Ft. New	Circ.*	Gross Sq. Ft. Mod.	Circ.*	Const. \$ (A x C)	Mod. \$ (B x E)	
Contingency			N	/	A				
TOTALS									
* Include the percentage (%) of space for circulation									

D. Projected Operating Costs

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

E. Total Effect of the Project on Capital Costs

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

APPEND DOCUMENTATION AS ATTACHMENT 37, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

APPEND DOCUMENTATION AS ATTACHMENT 37, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION IX. SAFETY NET IMPACT STATEMENT (DISCONTINUATION ONLY)

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for ALL SUBSTANTIVE PROJECTS AND PROJECTS TO DISCONTINUE STATE-OWNED HEALTH CARE FACILITIES [20 ILCS 3960/5.4]:

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 Medicaid patients. 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 40.

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

SECTION X. CHARITY CARE INFORMATION (CHOW ONLY)

Charity Care information **MUST** be furnished for **ALL** projects [1120.20(c)].

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 41.

CHARITY CARE			
	Year	Year	Year
Net Patient Revenue			
Amount of Charity Care (charges)			
Cost of Charity Care			

APPEND DOCUMENTATION AS **ATTACHMENT 21**, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

After paginating the entire completed application indicate, in the chart below, the page numbers for the included attachments:

INDEX OF ATTACHMENTS		
ATTACHMENT NO.		PAGES
1	Applicant Identification including Certificate of Good Standing	
2	Site Ownership	
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	
5	Flood Plain Requirements	
6	Historic Preservation Act Requirements	
7	Project and Sources of Funds Itemization	
8	Financial Commitment Document if required	
9	Cost Space Requirements	
10	Discontinuation	
11	Background of the Applicant	
12	Purpose of the Project	
13	Alternatives to the Project	
	Service Specific:	
14	Neonatal Intensive Care Services	
15	Change of Ownership	
	Financial and Economic Feasibility:	
16	Availability of Funds	
17	Financial Waiver	
18	Financial Viability	
19	Economic Feasibility	
20	Safety Net Impact Statement	
21	Charity Care Information	

Certificates of Good Standing - Applicants



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

WAUKEGAN ILLINOIS HOSPITAL COMPANY, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON DECEMBER 20, 2005, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.



***In Testimony Whereof, I hereto set
my hand and cause to be affixed the Great Seal of
the State of Illinois, this 17TH
day of AUGUST A.D. 2017 .***

Jesse White

SECRETARY OF STATE

Delaware

The First State

Page 1

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "QUORUM HEALTH CORPORATION" IS DULY INCORPORATED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL CORPORATE EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE SEVENTEENTH DAY OF AUGUST, A.D. 2017.

AND I DO HEREBY FURTHER CERTIFY THAT THE ANNUAL REPORTS HAVE BEEN FILED TO DATE.

AND I DO HEREBY FURTHER CERTIFY THAT THE FRANCHISE TAXES HAVE BEEN PAID TO DATE.



5792308 8300

SR# 20175778517

You may verify this certificate online at corp.delaware.gov/authver.shtml

A handwritten signature in black ink, appearing to read "JB", is written over a horizontal line. Below the line, the text "Jeffrey W. Bullock, Secretary of State" is printed.

Authentication: 203078404

Date: 08-17-17

Proof of Site Ownership

See attached

This instrument prepared by:
Kris E. Curran, Esq.
Ungaretti & Harris LLP
3500 Three First National Plaza
Chicago, Illinois 60602

When recorded return to:
David C. Dillender, Esq.
Boult Cummings Conners & Berry PLC
1600 Division Street, Suite 700
Nashville, Tennessee 37203

SPECIAL WARRANTY DEED

This **SPECIAL WARRANTY DEED** is made as of the 27th day of June, 2006, by **VISTA HEALTH (f/k/a Victory/St. Therese Enterprises, Inc.)**, a not-for-profit corporation, created and existing under and by virtue of the laws of the State of Illinois and duly authorized to transact business in the State of Illinois ("Grantor"), whose address is 1324 North Sheridan Road, Waukegan, Illinois 60085, to **WAUKEGAN ILLINOIS HOSPITAL COMPANY, LLC**, an Illinois limited liability company ("Grantee"), whose address is c/o Community Health Systems, 7100 Commerce Way, Suite 100, Brentwood, Tennessee 37027.

WITNESSETH:

That Grantor, in consideration of Ten Dollars (\$10.00) in hand paid by Grantee, for other valuable consideration, receipt of which is hereby acknowledged, **DOES HEREBY CONVEY, GRANT, BARGAIN AND SELL UNTO GRANTEE**, its successors and assigns, **FOREVER**, the real property situated in the County of Lake, State of Illinois, legally described on Exhibit A attached hereto and incorporated herein by this reference, together with all buildings, structures, fixtures and other improvements located thereon, and all and singular the hereditaments and appurtenances thereunto belonging, or in anywise appertaining, and the reversion or reversions, remainder or remainders, rents, issues and profits thereof, and all the estate, right, title, interest, claim or demand whatsoever, of the Grantor, either in law or equity of, in and to the above described premises, with the hereditaments and appurtenances:

TO HAVE AND TO HOLD the said premises as above described, with the appurtenances, unto the Grantee, its successors and assigns, forever.

And the Grantor, for itself and its successors, does covenant, promise and agree to and with the Grantee and its successors and assigns, that Grantor has not done or suffered to be done, anything whereby the said premises hereby granted are, or may be, in any manner encumbered or charged except as herein recited; and that Grantor will **WARRANT AND DEFEND**, the said premises against all persons claiming, or to claim the same, by, through or under Grantor, subject only to the permitted encumbrances set forth on Exhibit B attached hereto and incorporated herein by this reference.

IN WITNESS WHEREOF, Grantor has executed this Special Warranty Deed as of the day and year first above written.

VISTA HEALTH,
an Illinois not-for-profit corporation

By: *Barbara J. Martin*
Barbara J. Martin, President and
Chief Operating Officer

**THIS TRANSACTION IS EXEMPT FROM TRANSFER TAX UNDER THE
PROVISIONS OF SECTION 45 (b) OF THE ILLINOIS REAL ESTATE TRANSFER
TAX LAW (35 ILCS 200/31-45(B)).**

Dated this 27th day of June, 2006

Barbara J. Martin
Transferor or representative

ACKNOWLEDGEMENT

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

I, VICTORIA MCELROY, a Notary Public in and for the said County, in the State aforesaid, DO HEREBY CERTIFY that Barbara J. Martin, President and Chief Operating Officer of **VISTA HEALTH**, an Illinois not-for-profit corporation, personally known to me to be the same person whose name is subscribed to the foregoing instrument, as such officer, appeared before me this day in person, and acknowledged that she signed and delivered such instrument as her free and voluntary acts and as the free and voluntary act of said corporation, and for the uses and purposes therein set forth.

GIVEN under my hand and official seal, this 27th day of JUNE, 2006.

{Seal}

Victoria McElroy
Notary Public

My Commission expires _____

Vista Health Deed
749001

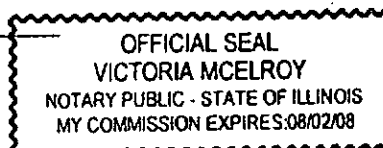


EXHIBIT A
LEGAL DESCRIPTION

THE PROPERTY CONVEYED HEREBY CONSISTS OF THREE (3) TRACTS;
THE LEGAL DESCRIPTIONS, COMMON ADDRESSES AND PIN NUMBERS FOR
THE THREE (3) TRACTS ARE SET FORTH ON THE THREE (3) FOLLOWING
PAGES: THE LEGAL DESCRIPTIONS FOR TRACTS 1, 2 AND 3 CONSIST OF ONE (1)
PAGE EACH

EXHIBIT A
LEGAL DESCRIPTION

TRACT 1: St. Therese Hospital Campus

PARCEL 1:

THAT PART OF THE SOUTH EAST 1/4 OF THE SOUTH EAST 1/4 OF SECTION 19, TOWNSHIP 45 NORTH, RANGE 12, EAST OF THE THIRD PRINCIPAL MERIDIAN, LYING SOUTH OF THE HIGHWAY (COMMONLY CALLED WASHINGTON STREET) AND EAST OF THE EAST LINE OF PRAIRIE AVENUE AS SHOWN ON THE PLAT OF USSATT'S SUBDIVISION RECORDED AS DOCUMENT 325908, IN BOOK "T" OF PLATS, PAGE 29, IN LAKE COUNTY, ILLINOIS.

PARCEL 2:

THAT PART OF THE SOUTHWEST 1/4 OF THE SOUTHWEST 1/4 OF SECTION 20, TOWNSHIP 45 NORTH, RANGE 12, EAST OF THE THIRD PRINCIPAL MERIDIAN, BOUNDED AND DESCRIBED AS FOLLOWS, TO-WIT: COMMENCING AT THE NORTHWEST CORNER OF THE SOUTHWEST 1/4 OF THE SOUTHWEST 1/4 OF SAID SECTION 20; THENCE SOUTH ALONG THE WEST LINE OF SAID SECTION, 80 RODS, MORE OR LESS, TO THE SOUTHWEST CORNER OF SAID SECTION; THENCE EAST ALONG THE SOUTH LINE OF SAID SECTION 20, 8 RODS; THENCE NORTH PARALLEL WITH THE WEST LINE OF SECTION 20, 80 RODS, MORE OR LESS, TO THE NORTH LINE OF SAID QUARTER QUARTER SECTION; THENCE WEST 8 RODS TO THE POINT OF BEGINNING, IN LAKE COUNTY, ILLINOIS.

PARCEL 3:

LOT 8 IN WOLANSER'S SUBDIVISION OF THE EAST 10 RODS OF THE WEST 18 RODS OF THE SOUTHWEST 1/4 OF THE SOUTHWEST 1/4 OF SECTION 20, TOWNSHIP 45 NORTH, RANGE 12, EAST OF THE THIRD PRINCIPAL MERIDIAN, ACCORDING TO THE PLAT THEREOF RECORDED APRIL 29, 1926 AS DOCUMENT 277899, IN BOOK "P" OF PLATS, PAGE 29, IN LAKE COUNTY ILLINOIS.

Permanent Index Number: 08-19-400-039; 08-20-300-007; 08-20-309-010; 08-19-400-040
Commonly known as: 2615 and 2645 West Washington Street, Waukegan, Illinois

EXHIBIT A
LEGAL DESCRIPTION

TRACT 2: MRI Institute Parcel

LOT 5 IN SULLIVANS SUBDIVISION BEING A SUBDIVISION OF PARTS OF THE SOUTHWEST 1/4 OF THE SOUTHWEST 1/4 OF SECTION 24, TOWNSHIP 45 NORTH, RANGE 11, EAST OF THE THIRD PRINCIPAL MERIDIAN, ACCORDING TO THE PLAT THEREOF RECORDED SEPTEMBER 21, 1979, AS DOCUMENT 2023106 IN BOOK 72 OF PLATS, PAGE 21, IN LAKE COUNTY, ILLINOIS

Permanent Index Number: 07-24-305-005-0000

Commonly known as: 60 South Greenleaf, Waukegan, Illinois

Vista Health Deed

EXHIBIT A
LEGAL DESCRIPTION

TRACT 3: Vacant Parcel

BEGINNING AT THE SOUTHEAST CORNER OF THE RESUBDIVISION OF LOT "A" IN GRANDWOOD PARK UNIT NO. 1, BEING A RESUBDIVISION OF PART OF THE SOUTH EAST 1/4 OF SECTION 7, TOWNSHIP 45 NORTH, RANGE 11, EAST OF THE THIRD PRINCIPAL MERIDIAN, ACCORDING TO THE PLAT THEREOF RECORDED JULY 14, 1970 AS DOCUMENT 1465828, IN BOOK 48 OF PLATS, PAGE 17, THENCE NORTHERLY ALONG THE EAST LINE OF SAID RESUBDIVISION OF LOT "A", SAID LINE BEING THE EAST LINE OF THE WEST 1/2 OF THE SOUTH EAST 1/4 OF SAID SECTION 7, A DISTANCE OF 429.75 FEET RECORD (MEASURED 429.64 FEET BEARING NORTH 00 DEGREES 15 MINUTES 09 SECONDS WEST) TO THE SOUTHEAST CORNER OF WOODLAND TERRACE RIGHT OF WAY AS SHOWN ON THE PLAT OF SUBDIVISION OF GRANDWOOD PARK UNIT NO. 1, RECORDED AS DOCUMENT 1058518, ON JANUARY 1, 1960, IN BOOK 35 OF PLATS, PAGE 7; THENCE EASTERLY ALONG THE SOUTH RIGHT OF WAY LINE OF WOODLAND TERRACE AS DEDICATED AND SHOWN IN THE BLAZEVOICH SUBDIVISION, AS RECORDED ON NOVEMBER 21, 1986 AS DOCUMENT 2507792, A DISTANCE OF 233.00 FEET BEARING NORTH 89 DEGREES 44 MINUTES 34 SECONDS EAST; THENCE SOUTHERLY ALONG A LINE, 233.00 FEET DISTANT FROM AND PARALLEL TO THE EAST LINE OF THE WEST 1/2 OF THE SOUTH EAST 1/4 OF SAID SECTION 7, A DISTANCE OF 417.40 FEET BEARING SOUTH 00 DEGREES 15 MINUTES 09 SECONDS EAST TO A POINT ON THE NORTH RIGHT OF WAY LINE OF GRAND AVENUE (F. A. S. ROUTE 3), ACCORDING TO THE PLAT OF SURVEY RECORDED ON FEBRUARY 24, 1969 AS DOCUMENT 1411767; THENCE WESTERLY ALONG THE NORTH RIGHT OF WAY LINE OF GRAND AVENUE (F. A. S. ROUTE 3), SAID NORTH RIGHT OF WAY LINE BEING ALONG A CURVE TO THE SOUTH HAVING A RADIUS OF 16,455.22 FEET AND A DELTA ANGLE OF 1 DEGREE 36 MINUTES 29 SECONDS, A DISTANCE OF 171.56 FEET (CHORD DISTANCE 171.56 FEET BEARING SOUTH 86 DEGREES 45 MINUTES 19 SECONDS WEST) TO A POINT OF TANGENCY; THENCE CONTINUING WESTERLY ALONG SAID NORTH RIGHT OF WAY LINE, A DISTANCE OF 61.78 FEET RECORD (MEASURED 61.76 FEET BEARING SOUTH 86 DEGREES 40 MINUTES 54 SECONDS WEST) TO THE POINT OF BEGINNING, ALL IN LAKE COUNTY, ILLINOIS.

Permanent Index Number: 07-07-400-010-0000

Commonly known as: 18824 W. Grand, Gurnee, Illinois

EXHIBIT B

PERMITTED ENCUMBRANCES

**THE PERMITTED ENCUMBRANCES ARE SET FORTH BY TRACT ON THE
FOLLOWING FOUR (4) PAGES; THE PERMITTED ENCUMBRANCES
APPLICABLE TO TRACT 1 CONSISTS OF TWO (2) PAGES; THE PERMITTED
ENCUMBRANCES FOR EACH OF TRACTS 2 AND 3 CONSIST OF ONE (1) PAGE.**

PERMITTED ENCUMBRANCES APPLICABLE TO TRACT 1

1. TAXES FOR THE YEAR 2006 AND SUBSEQUENT YEARS.

2. RIGHT OF THE CITY OF WAUKEGAN TO CONSTRUCT, OPERATE AND MAINTAIN A STORM SEWER OVER, ALONG AND UNDER A 10 FEET STRIP OF LAND, THE CENTER LINE OF WHICH IS DESCRIBED AS FOLLOWS: COMMENCING 24 FEET SOUTH OF THE NORTH LINE OF CATALPA AVENUE AND 140 FEET WEST OF THE WEST LINE OF KELLER AVENUE; THENCE NORTH 70 DEGREES WEST TO A PART IN THE WEST LINE OF THE SOUTHWEST 1/4 OF THE SOUTHWEST 1/4 OF SECTION 20, AS GRANTED BY INSTRUMENT DATED MARCH 27, 1928 AND RECORDED SEPTEMBER 24, 1929 AS DOCUMENT 34374B.
(AFFECTS PARCEL 2)

AS SHOWN ON THAT CERTAIN SURVEY PREPARED BY WEBSTER, MCGRATH & AHLBERG, LTD., JOB NUMBER 41529, DATED APRIL 10, 2006 AND LAST REVISED ON JUNE 29, 2006.

3. EASEMENT IN FAVOR OF THE NORTH SHORE GAS COMPANY TO CONSTRUCT, MAINTAIN, ETC., A PIPELINE OR PIPELINES AND APPURTENANT EQUIPMENT OVER, THROUGH, UNDER, ALONG, AND ACROSS THE NORTH 10 FEET OF THE WEST 70 FEET OF THE EAST 102 FEET OF PARCEL 2, TOGETHER WITH THE RIGHT TO USE ADJOINING LAND WHEN REASONABLY REQUIRED TO PERFORM SAID FUNCTIONS, AS GRANTED BY INSTRUMENT DATED AUGUST 6, 1979 AND RECORDED AUGUST 14, 1979 AS DOCUMENT 2014014 AND SHOWN ON EXHIBIT "A" ATTACHED THERETO.

(AFFECTS PARCEL 2)

AS SHOWN ON THAT CERTAIN SURVEY PREPARED BY WEBSTER, MCGRATH & AHLBERG, LTD., JOB NUMBER 41529, DATED APRIL 10, 2006 AND LAST REVISED ON JUNE 29, 2006.

4. RIGHT OF THE COMMONWEALTH EDISON COMPANY, ITS SUCCESSORS AND ASSIGNS, TO CONSTRUCT, LAY, MAINTAIN, ETC., UNDERGROUND CONDUITS, CABLES, ETC., WITH RIGHT OF ACCESS THERETO FOR THE MAINTENANCE THEREOF, IN, UPON, UNDER AND ALONG A PORTION OF THE NORTHERLY 20 FEET OF THE LAND AS GRANTED BY INSTRUMENT DATED MAY 30, 1980 AND RECORDED JULY 7, 1980 AS DOCUMENT 2067138 AS SHOWN AND DESCRIBED ON EXHIBIT "A" ATTACHED TO SAID INSTRUMENT.
(AFFECTS PARCELS 1 AND 2)

AS SHOWN ON THAT CERTAIN SURVEY PREPARED BY WEBSTER, MCGRATH & AHLBERG, LTD., JOB NUMBER 41529, DATED APRIL 10, 2006 AND LAST REVISED ON JUNE 29, 2006.

5. RIGHT OF THE COMMONWEALTH EDISON COMPANY, ITS SUCCESSORS AND ASSIGNS, TO CONSTRUCT, LAY, MAINTAIN, ETC., UNDERGROUND CONDUITS, CABLES, ETC., WITH RIGHT OF ACCESS THERETO FOR THE MAINTENANCE THEREOF, IN, UPON, UNDER AND ALONG THAT PART OF THE LAND AS SHOWN ON EXHIBIT "A" ATTACHED THERETO AS GRANTED BY INSTRUMENT DATED SEPTEMBER 8, 1980 AND RECORDED OCTOBER 2, 1980 AS DOCUMENT 2081415.
(AFFECTS PARCELS 1 AND 2)

AS SHOWN ON THAT CERTAIN SURVEY PREPARED BY WEBSTER, MCGRATH & AHLBERG, LTD., JOB NUMBER 41529, DATED APRIL 10, 2006 AND LAST REVISED ON JUNE 29, 2006.

6. RIGHTS OF THE CITY OF WAUKEGAN IN AND TO THE SOUTH 30 FEET OF THE LAND DEDICATED FOR STREET PURPOSES BY INSTRUMENT DATED FEBRUARY 2, 1956 AND RECORDED APRIL 3, 1956 AS DOCUMENT 903026.
(AFFECTS THAT PART OF PARCELS 1 AND 2 FALLING WITHIN DEDICATED MELROSE STREET)

AS SHOWN ON THAT CERTAIN SURVEY PREPARED BY WEBSTER, MCGRATH & AHLBERG, LTD., JOB NUMBER 41529, DATED APRIL 10, 2006 AND LAST REVISED ON JUNE 29, 2006.

PERMITTED ENCUMBRANCES APPLICABLE TO TRACT 2.

1. TAXES FOR THE YEAR 2006 AND SUBSEQUENT YEARS.

2. NOTATION CONTAINED ON THE PLAT OF SAID SUBDIVISION AS FOLLOWS:

3. EASEMENT FOR UTILITIES OVER THE SOUTH 10 FEET, THE WEST 5 FEET AND 5 FEET OVER THE NORTHWEST CORNER OF LOT 5 AS SHOWN ON PLAT OF SAID SUBDIVISION.

AS SHOWN ON PLAT OF SURVEY PREPARED BY WEBSTER, MCGRATH & AHLBERG, LTD. JOB NO. 41530 AND DATED APRIL 7, 2006 AND LAST REVISED JUNE 26, 2006.

4. EASEMENT FOR SANITARY SEWER, WATER AND UTILITIES TO THE VILLAGE OF GURNEE OVER THE NORTH 25 FEET OF LOT 5 AS SHOWN ON PLAT OF SAID SUBDIVISION.

AS SHOWN ON PLAT OF SURVEY PREPARED BY WEBSTER, MCGRATH & AHLBERG, LTD. JOB NO. 41530 AND DATED APRIL 7, 2006 AND LAST REVISED JUNE 26, 2006.

5. TERMS AND PROVISIONS CONTAINED IN PRE ANNEXATION AGREEMENT RECORDED MARCH 27, 1987 AS DOCUMENT NUMBER 2549373 AND ANNEXATION AGREEMENT RECORDED AS DOCUMENT NUMBER 2555129.

TERMS AND PROVISIONS CONTAINED IN ORDINANCE RECORDED AUGUST 8, 1989 AS DOCUMENT NUMBER 2818529 REGARDING WATER MAIN AND SANITARY SEWER.

6. DRIVEWAY AGREEMENT MADE BY AND BETWEEN CHICAGO TITLE AND TRUST COMPANY, AS TRUSTEE UNDER TRUST AGREEMENT DATED DECEMBER 12, 1986 AND KNOWN AS TRUST NUMBER 1089302 AND VICTORY MEMORIAL HOSPITAL ASSOCIATION AND THE FRANCISCAN SISTERS HEALTHCARE CORPORATION, AS ESTABLISHED BY AGREEMENT RECORDED/FILED OCTOBER 23, 1991, AS DOCUMENT NO. 3076341; AND THE PROVISIONS CONTAINED THEREIN, AFFECTING LOTS 4 AND 5.

AS SHOWN ON PLAT OF SURVEY PREPARED BY WEBSTER, MCGRATH & AHLBERG, LTD. JOB NO. 41530 AND DATED APRIL 7, 2006 AND LAST REVISED JUNE 26, 2006.

7. EASEMENT OVER THE LAND FOR THE PURPOSE OF INSTALLING AND MAINTAINING ALL EQUIPMENT NECESSARY TO SERVE THE SUBDIVISION AND OTHER LAND WITH TELEPHONE AND ELECTRICAL SERVICE, TOGETHER WITH THE RIGHT TO OVERHAND ARIEL SERVICE WIRES AND THE RIGHT OF ACCESS TO SUCH WIRES, AS CREATED BY GRANT TO ILLINOIS BELL TELEPHONE COMPANY AND THE COMMONWEALTH EDISON COMPANY AND THEIR RESPECTIVE SUCCESSORS AND ASSIGNS AND AS SHOWN ON THE PLAT OF SUBDIVISION RECORDED SEPTEMBER 21, 1979 AS DOCUMENT 2023106, AS SHOWN ON PLAT OF SURVEY PREPARED BY WEBSTER, MCGRATH & AHLBERG, LTD. JOB NO. 41530 AND DATED 7, 2006 AND LAST REVISED JUNE 26, 2006.

PERMITTED ENCUMBRANCES APPLICABLE TO TRACT 3

1. TAXES FOR THE YEAR 2006 AND SUBSEQUENT YEARS.
2. GRANT BY THE BOARD OF SUPERVISORS OF LAKE COUNTY, ILLINOIS, TO THE POSTAL TELEGRAPH COMPANY, ITS SUCCESSORS AND ASSIGNS, OF THE RIGHT, PERMISSION AND AUTHORITY TO CONSTRUCT AND MAINTAIN A LINE OF TELEGRAPH ON AND ALONG THE HWYS OF WARREN AND OTHER TOWNS, DATED MARCH 14, 1887 AND RECORDED DECEMBER 3, 1901 IN BOOK "B" OF INCORPORATIONS, PAGE 233, AS DOCUMENT 84029.

b6
b7c



Plat Act Affidavit

18 N County St - 2nd Floor
Waukegan, IL 60085-4358
Phone: (847) 377-2575
FAX: (847) 625-7200

STATE OF ILLINOIS

COUNTY OF LAKE

SS

DOCUMENT NUMBER _____

I, (name) Barbara J. Martin, President of VISTA HEALTH, being duly sworn on oath, state that I reside at 1324 N. Sheridan Road, Waukegan, Illinois 60085, and that the attached deed is not in violation of the Plat Act, Ch. 765 ILCS 205/1.1(b), as the provisions of this Act do not apply and no plat is required due to the following allowed exception (Circle the number applicable to the attached deed):

1. The division or subdivision of land into parcels or tracts of 5 acres or more in size which does not involve any new streets or easements of access;
2. The division of lots or blocks of less than 1 acre in any recorded subdivision which does not involve any new streets or easements of access;
3. The sale or exchange of parcels of land between owners of adjoining and contiguous land;
4. The conveyance of parcels of land or interests therein for use as a right of way for railroads or other public utility facilities and other pipe lines which does not involve any new streets or easements of access;
5. The conveyance of land owned by a railroad or other public utility which does not involve any new streets or easements of access;
6. The conveyance of land for highway or other public purposes or grants or conveyances relating to the dedication of land for public use or instruments relating to the vacation of land impressed with a public use;
7. Conveyances made to correct descriptions in prior conveyances;
8. The sale or exchange of parcels or tracts of land following the division into no more than 2 parts of a particular parcel or tract of land existing on July 17, 1959, and not involving any new streets or easements of access;
9. The sale of a single lot of less than 5 acres from a larger tract when a survey is made by an Illinois Registered Land Surveyor; provided, that this exemption shall not apply to the sale of any subsequent lots from the same larger tract of land, as determined by the dimensions and configuration of the larger tract on October 1, 1973, and provided also that this exemption does not invalidate any local requirements applicable to the subdivision of land;
10. The conveyance of land does not involve any land division and is described in the same manner as title was taken by grantor(s).

AFFIANT further states that this affidavit is made for the purpose of inducing the RECORDER OF LAKE COUNTY, ILLINOIS to accept the attached deed for recording. (This affidavit is not applicable to Facsimile Assignment of Beneficial Interest.)

VISTA HEALTH,
an Illinois not for profit corporation

By: Barbara J. Martin

(Signature)

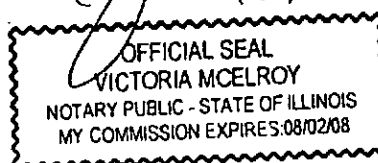
Barbara J. Martin, President

Revised: June 13, 2001 10:15 AM

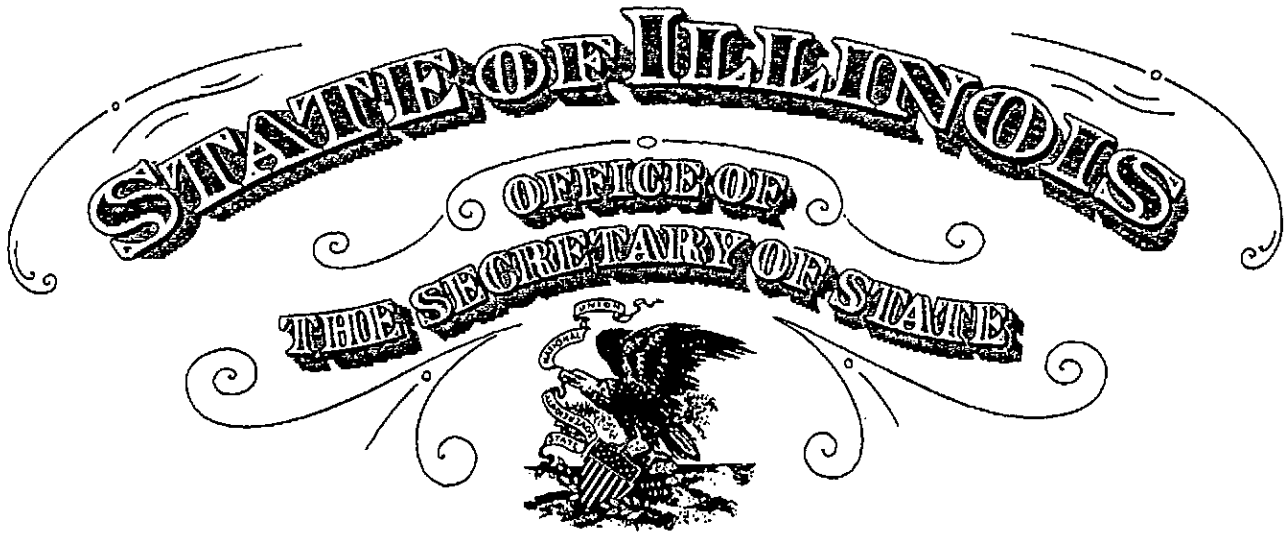
SUBSCRIBED and SWORN to before me this 27th day of JUNE, 2006

Notary: Victoria Mcelroy

(seal)



Operating Entity Certificate of Good Standing



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

WAUKEGAN ILLINOIS HOSPITAL COMPANY, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON DECEMBER 20, 2005, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.



***In Testimony Whereof, I hereto set
my hand and cause to be affixed the Great Seal of
the State of Illinois, this 17TH
day of AUGUST A.D. 2017 .***

Jesse White

SECRETARY OF STATE

Attachment 10 - Discontinuation

GENERAL INFORMATION REQUIREMENTS

1. Identify the categories of service and the number of beds, if any, that are to be discontinued.

Acute Rehabilitation beds – 25 beds.

2. Identify all of the other clinical services that are to be discontinued.

No other clinical services will be discontinued.

3. Provide the anticipated date of discontinuation for each identified service or for the entire facility.

Shortly before the proposed change of ownership to Healthvest HFSRB and IDPH will be notified of the exact date of discontinuation. We anticipate this will be in the first quarter of 2018.

4. Provide the anticipated use of the physical plant and equipment after the discontinuation occurs.

The space may be used by US Healthvest for future expansion of psychiatric licensed bed capacity, if approved by the Board.

5. Provide the anticipated disposition and location of all medical records pertaining to the services being discontinued, and the length of time the records will be maintained.

The medical records will be maintained by Vista West.

6. For applications involving the discontinuation of an entire facility, provide certification by an authorized representative that all questionnaires and data required by HFSRB or DPH (e.g., annual questionnaires, capital expenditures surveys, etc.) will be provided through the date of discontinuation, and that the required information will be submitted no later than 90 days following the date of discontinuation. **N/A**

7. Upon a finding that an application to close a health care facility is complete, the State Board shall publish a legal notice on 3 consecutive days in a newspaper of general circulation in the area or community to be affected and afford the public an opportunity to request a hearing. If the application is for a facility located in a Metropolitan Statistical Area, an additional legal notice shall be published in a newspaper of limited circulation, if one exists, in the area in which the facility is located. If the newspaper of limited circulation is published on a daily basis, the additional legal notice shall be published on 3 consecutive days. The legal notice shall also be posted on the Health Facilities and Services Review Board's web site and sent to the State Representative and State Senator of the district in which the health care facility is located. In addition, the health care facility shall provide notice of closure to the local media that the health care facility would routinely notify about facility events. **N/A**

8. Provide attestation that the facility provided the required notice of the facility or category of service closure to local media that the health care facility would routinely notify about facility events. The supporting documentation shall include a copy of the notice, the name of the local media outlet, the date the notice was given, and the result of the notice, e.g., number of times broadcasted, written, or published. Only notice that is given to a local television station, local radio station, or local newspaper will be accepted.

See Appendix A.

Attachment 10 – Discontinuation (Continued)**REASONS FOR DISCONTINUATION**

The applicant shall state the reasons for the discontinuation and provide data that verifies the need for the proposed action. See criterion 1110.130(b) for examples.

Vista West has provided quality inpatient rehabilitation services to its patients for many years. However, over the past few years the utilization of those services has declined steadily to the point that keeping the Unit open in a hospital-based setting no longer appears to be necessary. There are three hospital providers that offer acute rehabilitation services within a 45-minute radius of the hospital, with a total of 132 beds. In addition, many long term care facilities offer the short term rehabilitation services currently offered at Vista West (the Units average daily census is eleven days). With the discontinuation of the Unit, Vista West will be better able to focus its resources on psychiatric care services. These services will in fact be modernized and expanded should a proposed change of ownership and modernization/expansion project be approved by the Board. It is anticipated these applications will be filed in the near future. However, regardless of the foregoing, Vista West would likely discontinue the Unit due to lack of utilization.

IMPACT ON ACCESS

1. Document that the discontinuation of each service or of the entire facility and whether or not it will have an adverse effect upon access to care for residents of the facility's market area.

Given the low volume of the service and the other area providers of acute rehabilitation, we do not believe there will be any impact on the availability of the service to area residents.

2. Document that a written request for an impact statement was received by all existing or approved health care facilities (that provide the same services as those being discontinued) located within 45 minutes travel time of the applicant facility.

See Appendix A.

Attachment 20 - Safety Net Impact Statement

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.

Vista West believes that there is an abundant supply of rehabilitation beds in the service area. The abundance of beds is sufficient enough to ensure that this project will not have a material impact on essential safety net services in the community.

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.

Vista West believes that this project will not materially impact the ability of other providers or health care systems to subsidize safety net services.

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.

Vista West believes that this discontinuation will have no impact on the remaining safety net providers.

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.

See attached table below. Note that the table in this attachment indicates the amount of Charity Care provided by Vista West relating to the rehabilitation unit that is the subject of this discontinuation project.

2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. 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.

See attached table below. Note that the table in this attachment indicates the amount of care provided to Medicaid patients by Vista West relating to the rehabilitation unit that is the subject of this discontinuation project.

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

The utilization of the Unit has been declining, and Vista West believes that that there are many acute rehab care providers in the area and that residents will continue to have access to acute rehabilitation services.

A table in the following format must be provided as part of Attachment 40.

Vista West

Safety Net Information per PA 96--031			
CHARITY CARE			
Charity (# of patients)	Year 2014	Year 2015	Year 2016
Inpatient	18	3	2
Outpatient	146	67	81
Total	164	70	83
Charity (cost in dollars)			
Inpatient	\$ 41,333	\$ 11,864	\$ 7,506
Outpatient	\$ 103,048	\$ 103,152	\$ 96,695
Total	\$ 144,381	\$ 115,016	\$ 104,201
MEDICAID			
Medicaid (# of patients)	Year 2014	Year 2015	Year 2016
Inpatient	539	928	922
Outpatient	6,966	7,916	7,712
Total	7,505	8,844	8,634
Medicaid (gross revenue)			
Inpatient	\$ 20,666,636	\$ 21,814,888	\$ 23,635,148
Outpatient	\$ 22,324,700	\$ 27,744,334	\$ 31,436,129
Total	\$ 42,991,336	\$ 49,559,222	\$ 55,071,277

Attachment 21 – Charity Care Information

Charity Care Information MUST be furnished for ALL projects [1120.20(c)].

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.

See table below. This table reflects charity care provided by Quorum Health. For charity care information for Vista West, please see the attachment.

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 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.

See table below. This table reflects charity care provided by the co-applicant Quorum Health (Illinois only). Apart from Vista West, other facilities under Quorum Health are neither involved nor relevant to this discontinuation. For charity care information for Vista West, please see the previous attachment.

4. 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.

N/A-Existing

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 41.

Quorum Health Corporation*

CHARITY CARE			
	Year 2014	Year 2015	Year 2016
Net Patient Revenue	\$	\$	\$
Amount of Charity Care (charges)	\$	\$	\$
Cost of Charity Care	\$	\$	\$

*Illinois Hospitals Only – See Attached

VISTA WEST CHARITY, FREE & DISCOUNTED CARE			
	2014	2015	2016
Net Patient Revenue	\$ 20,375,045	\$ 20,817,752	\$ 20,936,392
Cost of Free and Discounted Care	\$ 326,282	\$ 908,633	\$ 691,326
Gross Free and Discounted Care	\$ 3,879,431	\$ 5,288,207	\$ 4,023,489
Cost of Charity Care Only	\$ 144,381	\$ 115,016	\$ 104,201
Gross Charity Care Only	\$ 840,289	\$ 669,391	\$ 606,447

ALL QUORUM ILLINOIS HOSPITALS CHARITY, FREE & DISCOUNTED CARE			
	2014	2015	2016
Net Patient Revenue	\$ 757,665,196	\$ 727,342,100	\$ 736,508,515
Cost of Free and Discounted Care	\$ 5,439,882	\$ 18,676,331	\$ 13,972,505
Gross Free and Discounted Care	\$ 39,093,303	\$ 132,415,526	\$ 102,940,642
Cost of Charity Care Only	\$ 3,426,401	\$ 1,850,279	\$ 2,592,355
Gross Charity Care Only	\$ 25,172,675	\$ 14,716,403	\$ 19,947,199

APPENDIX A



August 23, 2017

**VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED**

Centegra Hospital - McHenry
4201 Medical Center Drive
McHenry, IL 60050

Re: Discontinuation of 25 Acute Rehabilitation Beds

Dear Director:

I am writing to request an impact statement from you concerning the planned discontinuation of our twenty-five (25) bed licensed acute rehabilitation unit (the "Unit"). We anticipate closing the Unit after approval by the Illinois Health Facilities and Services Review Board, and hope we will receive such approval on or before the end of 2017. In 2017 to date, average daily census has been 8.9 inpatients.

We are interested in your facility's ability to accommodate a portion or all of our previous patients and whether your facility has any restrictions or limitations which would preclude it from providing the service to our patients in the area. If you do not respond, we will assume the discontinuation has no impact on your facility.

Thank you.

Sincerely,

A handwritten signature in black ink, appearing to read "Norman Stephens", followed by a horizontal line.

Norman Stephens, CEO
Vista Health System



August 23, 2017

**VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED**

Resurrection Medical Center
7435 W. Talcott Ave.
Chicago, IL 60631

Re: Discontinuation of 25 Acute Rehabilitation Beds

Dear Director:

I am writing to request an impact statement from you concerning the planned discontinuation of our twenty-five (25) bed licensed acute rehabilitation unit (the "Unit"). We anticipate closing the Unit after approval by the Illinois Health Facilities and Services Review Board, and hope we will receive such approval on or before the end of 2017. In 2017 to date, average daily census has been 8.9 inpatients.

We are interested in your facility's ability to accommodate a portion or all of our previous patients and whether your facility has any restrictions or limitations which would preclude it from providing the service to our patients in the area. If you do not respond, we will assume the discontinuation has no impact on your facility.

Thank you.

Sincerely,

A handwritten signature in black ink, appearing to read "Norman Stephens", with a long horizontal flourish extending to the right.

Norman Stephens, CEO
Vista Health System



August 23, 2017

**VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED**

Advocate Lutheran General
1775 Dempster Street
Park Ridge, IL 60068

Re: Discontinuation of 25 Acute Rehabilitation Beds

Dear Director:

I am writing to request an impact statement from you concerning the planned discontinuation of our twenty-five (25) bed licensed acute rehabilitation unit (the "Unit"). We anticipate closing the Unit after approval by the Illinois Health Facilities and Services Review Board, and hope we will receive such approval on or before the end of 2017. In 2017 to date, average daily census has been 8.9 inpatients.

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Thank you.

Sincerely,

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Norman Stephens, CEO
Vista Health System

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City, State, ZIP+4 Park Ridge, IL 60068	
PS Form 3800, August 2006 See Reverse for Instructions	

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Sent To: Centegra Hospital - Mokena	
Street, Apt. No., or PO Box No. 4201 Medical Center Drive	
City, State, ZIP+4 Mokena, IL 60050	
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Sent To: Resurrection Medical Center	
Street, Apt. No., or PO Box No. 7435 W. Talcott Ave.	
City, State, ZIP+4 Chicago, IL 60631	
PS Form 3800, August 2006 See Reverse for Instructions	

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