E-051-18

[ORIGINAL

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
CHANGE OF OWNERSHIP APPLICATION FOR EXEMPTION- 08/2018 Edition

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR CHANGE OF OWNERSHIP EXEMPTION

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

RECEIVED
SEP 06 2018
HEALTH FACILITIES & SERVICES REVIEW BOARD

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: VHS West Suburban Medical Center			
Street Address: 3 Erie Court			
City and Zip Code: Oak Park 60302			
County: Suburban Cook	Health Service Area:	7	Health Planning Area: A-06

Legislators

State Senator Name: Don Harmon
State Representative Name: Camille Lilly

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

Exact Legal Name: SRC Hospital Investments II, LLC
Street Address: 898 N. Sepulveda Boulevard, Suite 500
City and Zip Code: El Seguendo, CA 90245
Name of Registered Agent: Registered Agent Solutions, Inc.
Registered Agent Street Address: 9 E. Loockerman Street, Suite 311
Registered Agent City and Zip Code: Dover, DE 19901
Name of Chief Executive Officer: Nicholas Orzano
CEO Street Address: 898 N. Sepulveda Boulevard, Suite 500
CEO City and Zip Code: El Seguendo, CA 90245
CEO Telephone Number: (213) 694-4861

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: Anne M. Murphy, Esq.
Title: Attorney
Company Name: Hinckley, Allen & Snyder LLP
Address: 28 State Street, Boston, MA 02109
Telephone Number: (617) 378-4368
E-mail Address: amurphy@hinckleyallen.com
Fax Number: (617) 345-9020

Facility/Project Identification

Facility Name: VHS West Suburban Medical Center			
Street Address: 3 Erie Court			
City and Zip Code: Oak Park 60302			
County: Suburban Cook	Health Service Area:	7	Health Planning Area: A-06

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

Exact Legal Name: Pipeline – West Suburban Medical Center, LLC
Street Address: 898 N. Sepulveda Boulevard, Suite 500
City and Zip Code: El Seguendo, CA 90245
Name of Registered Agent: Registered Agent Solutions, Inc.
Registered Agent Street Address: 9 E. Loockerman Street, Suite 311
Registered Agent City and Zip Code: Dover, DE 19901
Name of Chief Executive Officer: Nicholas Orzano
CEO Street Address: 898 N. Sepulveda Boulevard, Suite 500
CEO City and Zip Code: El Seguendo, CA 90245
CEO Telephone Number: (213) 694-4861

Type of Ownership of Applicants

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E-mail Address: amurphy@hinckleyallen.com
Fax Number: (617) 345-9020

Facility/Project Identification

Facility Name: VHS West Suburban Medical Center		
Street Address: 3 Erie Court		
City and Zip Code: Oak Park 60302		
County: Suburban Cook	Health Service Area 7	Health Planning Area: A-06

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

Exact Legal Name: VHS West Suburban Medical Center, Inc.
Street Address: 1445 Ross Avenue, Suite 1400
City and Zip Code: Dallas, TX 75202
Name of Registered Agent: The Corporation Trust Company
Registered Agent Street Address: Corporation Trust Center, 1209 Orange Street
Registered Agent City and Zip Code: Wilmington, DE 19801
Name of Chief Executive Officer: Joseph Ottolino
CEO Street Address: 3 Erie Court
CEO City and Zip Code: Oak Park, IL 60302
CEO Telephone Number: (708) 763-2983

Type of Ownership of Applicants

☐	Non-profit Corporation	☐	Partnership		
☒	For-profit Corporation	☐	Governmental		
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E-mail Address: amurphy@hinckleyallen.com
Fax Number: (617) 345-9020

Facility/Project Identification

Facility Name: VHS West Suburban Medical Center		
Street Address: 3 Erie Court		
City and Zip Code: Oak Park 60302		
County: Suburban Cook	Health Service Area 7	Health Planning Area: A-06

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

Exact Legal Name: Tenet Healthcare Corporation
Street Address: 1445 Ross Avenue, Suite 1400
City and Zip Code: Dallas, TX 75202
Name of Registered Agent: CT Corporation
Registered Agent Street Address:
Registered Agent City and Zip Code:
Name of Chief Executive Officer: Ronald A. Rittenmeyer
CEO Street Address: 1445 Ross Avenue
CEO City and Zip Code: Dallas, TX 75202
CEO Telephone Number: (469) 893-2000

Type of Ownership of Applicants

☐	Non-profit Corporation	☐	Partnership		
☒	For-profit Corporation	☐	Governmental		
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Telephone Number: (617) 378-4368
E-mail Address: amurphy@hinckleyallen.com
Fax Number: (617) 345-9020

Post Exemption Contact

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

Name: Richard McKellar
Title: Senior Associate
Company Name: SRC Hospital Investments II, LLC
Address: 222 Sutter Street, San Francisco, CA 94108
Telephone Number: 213.694.4866
E-mail Address: rmckellar@stantonroadcapital.com
Fax Number:

Site Ownership after the Project is Complete

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: West Suburban Property Holdings, LLC
Address of Site Owner: 898 N. Sepulveda Boulevard, Suite 500, El Seguendo, CA 90245
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 after the Project is Complete

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

Exact Legal Name: Pipeline – West Suburban Medical Center, LLC
Address: 898 N. Sepulveda Boulevard, Suite 500, El Seguendo, CA 90245

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

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

Narrative Description

In the space below, provide a brief narrative description of the change of ownership. 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.

Tenet Healthcare Corporation ("Tenet"), VHS West Suburban Medical Center, Inc. ("VHS"), SRC Hospital Investments II, LLC ("SRC"), and Pipeline – West Suburban Medical Center, LLC ("WSMC OpCo"), hereby seek a Certificate of Exemption ("COE") from the Illinois Health Facilities and Services Review Board (the "Review Board") to allow consummation of a proposed transaction (the "Transaction") between Tenet and VHS, on the one hand, and SRC, on the other hand.

The Transaction contemplates a one hundred percent (100%) change in the ownership of VHS West Suburban Medical Center ("WSMC"), a 234 bed general acute care hospital located at 3 Erie Court, Oak Park, Illinois, 60302, pursuant to that certain Asset Purchase Agreement, dated July 17, 2018 (the "Purchase Agreement"). Under the terms of the Purchase Agreement, SRC will be acquiring WSMC, VHS Westlake Hospital ("Westlake"), Louis B. Weiss Memorial Hospital ("Weiss," and together with WSMC and Westlake, the "Hospitals"), and certain assets used in connection with the operation of the Hospitals, from Tenet, VHS, and related entities, for Seventy Million Dollars ($70,000,000.00), subject to adjustments for working capital and capital expenditures.

VHS presently owns the real property and assets constituting WSMC. Upon completion of the Transaction (i) the real property and buildings on which WSMC is situated will be owned by West Suburban Property Holdings, LLC ("WSMC PropCo"), a Delaware limited liability company, and (ii) all other assets previously owned by VHS and used in connection with the operation of WSMC will be owned by WSMC OpCo, a Delaware limited liability company. Weiss PropCo will not be involved in operations or delivery of care at WSMC. Each of WSMC PropCo and WSMC OpCo are wholly-owned subsidiaries of SRC. WSMC PropCo and WSMC OpCo will enter into a multi-year lease pursuant to which WSMC OpCo will pay fair market value rent and will be responsible for all of the costs and expenses associated with the land, buildings, and other real estate comprising the campus of WSMC. WSMC OpCo will be the hospital licensee of WSMC, and will be submitting its application for licensure upon approval of this COE application.

WSMC OpCo will enter into a Management Services Agreement with Pipeline Healthcare Management - Illinois, LLC ("Pipeline Illinois"), pursuant to which Pipeline Illinois will provide certain operations and administrative management services to the Hospitals. Pipeline Illinois will be eighty percent (80%) owned and controlled by Pipeline Healthcare Management, LLC ("Pipeline"). Pipeline has experience managing academic medical centers and community hospitals in California, Texas, Nevada, and New Mexico, including management and operation of the largest emergency room management company on the West Coast. Pipeline's national experience also includes management of (i) a network of urgent care clinics, (ii) the nation's largest telemedicine platform, and (iii) a hospitalist staffing company. In addition to its business ventures, Pipeline has a track record of implementing programs and coordinating outreach with the community-at-large. TWG Partners, LLC ("TWG") will own the remaining twenty percent (20%) of Pipeline Illinois. TWG brings to Pipeline Illinois experience in founding and developing a range of health care companies in the areas of health care technology, Medicaid-managed care, and Medicare Part D insurance operating in Illinois and other numerous other States, and a local understanding of the Chicago-area health care market and clinical operations, as well as Illinois policy, which will complement Pipeline's national health system management experience.

VHS is a Delaware for-profit corporation. Vanguard Health Financial Company, LLC, a Delaware limited liability company, is the sole shareholder of VHS. VHS is a wholly-owned subsidiary of Vanguard Health Systems, Inc., a Delaware corporation ("Vanguard"). Tenet, a Nevada corporation, is the sole shareholder of Vanguard. Accordingly, Tenet has "final control" of VHS and is a co-Applicant on this COE application. Based in Dallas, Texas, Tenet operates 68 acute-care hospitals and 470 outpatient centers in forty seven states. Employing more than 115,000 individuals (including 32,000 physicians and 33,000 nurses), Tenet reported $19.2 billion in operating revenues in fiscal year 2017. Through its subsidiaries, partnerships, and joint ventures, Tenet operates general acute care and specialty hospitals, ambulatory surgical centers, urgent care centers, and other outpatient facilities in the United States and United Kingdom.

SRC is a Delaware limited liability company. As reflected on Attachment III of Section I, various individuals and entities hold an ownership interest in SRC (collectively, the "SRC Owners"). None of the SRC Owners holds a 50% or greater ownership interest in SRC. Simultaneous with this application, SRC is submitting COE applications to the Review Board in connection with its acquisition of Westlake and WSMC.

The Transaction is contingent upon the approval of the Review Board. The Transaction is currently scheduled to close on November 1, 2018, subject to the Review Board granting this COE and the COEs for Westlake and WSMC. If the Transaction closes, Weiss, Westlake, and WSMC will be the first Illinois health care facilities owned or operated by SRC or its affiliated entities.

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 (***Note: not applicable***)

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

CERTIFICATION

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives 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 manager 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 is filed on the behalf of SRC Hospital Investments II, LLC

*

in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this Application 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	SIGNATURE
Nicholas Orzano PRINTED NAME	Mark Bell PRINTED NAME
Managing Partner, on behalf of SRC I Healthcare Investments I, LLC (its Member) PRINTED TITLE	Managing Partner, on behalf of Mokuleia, LLC (its Member) PRINTED TITLE
Notarization: Subscribed and sworn to before me this _____ day of _____	Notarization: Subscribed and sworn to before me this _____ day of _____
Signature of Notary	Signature of Notary
Seal	Seal

Please see attached

*Insert the EXACT legal name of the applicant

CALIFORNIA JURAT CERTIFICATE

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California

County of Los Angeles

Subscribed and sworn to (or affirmed) before me on this 28th day of August 20 18 , by Nicholas Orzano

proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

WITNESS MY HAND AND OFFICIAL SEAL.

Signature of Notary Public

MIN YOUNG PARK
Commission No. 2092038
NOTARY PUBLIC-CALIFORNIA
LOS ANGELES COUNTY
My Comm. Expires DECEMBER 30, 2018

(Notary Seal)

OPTIONAL INFORMATION

The jurat contained within this document is in accordance with California law. Any affidavit subscribed and sworn to before a notary shall use the preceding wording or substantially similar wording pursuant to Civil Code sections 1189 and 8202. ***A jurat certificate cannot be affixed to a document sent by mail or otherwise delivered to a notary public, including electronic means, whereby the signer did not personally appear before the notary public, even if the signer is known by the notary public. The seal and signature cannot be affixed to a document without the correct notarial wording. As an additional option an affiant can produce an affidavit on the same document as the notarial certificate wording to eliminate the use of additional documentation.***

DESCRIPTION OF ATTACHED DOCUMENT

Certificaiton
(Title of document)

Number of Pages 1 (Including jurat)

Document Date August 28, 2018

SRC Hospital Investments II, LLC
(Additional Information)

CAPACITY CLAIMED BY SIGNER

X Individual
____ Corporate Officer
____ Partner
____ Attorney-In-Fact
____ Trustee
____ Other: ____

63-6

CERTIFICATION

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives 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 manager 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 is filed on the behalf of SRC Hospital Investments II, LLC*

in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this Application 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	SIGNATURE
Nicholas Orzano PRINTED NAME	Mark Bell PRINTED NAME
Managing Partner, on behalf of SRC I Healthcare Investments I, LLC (its Member) PRINTED TITLE	Managing Partner, on behalf of Mokuleia, LLC (its Member) PRINTED TITLE
Notarization: Subscribed and sworn to before me this _____ day of _____	Notarization: Subscribed and sworn to before me this 29 day of August 2018
Signature of Notary	Signature of Notary
Seal	Seal

DORENE LYNN CRIST
Commission # 2100203
Notary Public - California
Los Angeles County
My Comm. Expires Feb 15, 2019

*Insert the EXACT legal name of the applicant

CERTIFICATION

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

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- in the case of a sole proprietor, the individual that is the proprietor.

This Application is filed on the behalf of Pipeline – West Suburban Medical Center, LLC*

in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this Application 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	SIGNATURE
Nicholas Orzano PRINTED NAME	PRINTED NAME
Chief Executive Officer, SRC Hospital Investments II, LLC (its sole Member) PRINTED TITLE	PRINTED TITLE
Notarization: Subscribed and sworn to before me this _____ day of _____	Notarization: Subscribed and sworn to before me this _____ day of _____
Signature of Notary	Signature of Notary
Seal	Seal

Please see attached

*Insert the EXACT legal name of the applicant

CERTIFICATION

CALIFORNIA JURAT CERTIFICATE

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

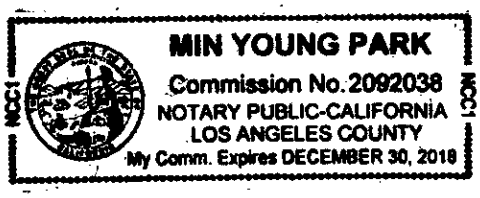
State of California

County of Los Angeles

Subscribed and sworn to (or affirmed) before me on this 28th day of August 20 18, by Nicholas Orzano

proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

WITNESS MY HAND AND OFFICIAL SEAL.



Signature of Notary Public

(Notary Seal)

OPTIONAL INFORMATION

The jurat contained within this document is in accordance with California law. Any affidavit subscribed and sworn to before a notary shall use the preceding wording or substantially similar wording pursuant to Civil Code sections 1189 and 8202. ***A jurat certificate cannot be affixed to a document sent by mail or otherwise delivered to a notary public, including electronic means, whereby the signer did not personally appear before the notary public, even if the signer is known by the notary public. The seal and signature cannot be affixed to a document without the correct notarial wording. As an additional option an affiant can produce an affidavit on the same document as the notarial certificate wording to eliminate the use of additional documentation.***

DESCRIPTION OF ATTACHED DOCUMENT

Certificaiton
(Title of document)

Number of Pages 1 (Including jurat)

Document Date August 28, 2018

Pipeline - West Suburban Medical Center, LLC
(Additional Information)

CAPACITY CLAIMED BY SIGNER

X Individual
____ Corporate Officer
____ Partner
____ Attorney-In-Fact
____ Trustee
____ Other: ____

63-2

0014

CERTIFICATION

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives 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 manager 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 is filed on the behalf of VHS West Suburban Medical Center, 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 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

Douglas E. Rabe
PRINTED NAME

Vice President
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 29 day of August 2018

Signature of Notary

Seal

NOTARY PUBLIC STATE OF TEXAS
GIGI ALDRETE
My Commission Expires
April 04, 2019

SIGNATURE

Michael T. Maloney
PRINTED NAME

Vice President
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 29 day of August 2018

Signature of Notary

Seal

NOTARY PUBLIC STATE OF TEXAS
GIGI ALDRETE
My Commission Expires
April 04, 2019

*Insert the EXACT legal name of the applicant

CERTIFICATION

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

This Application 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 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

Douglas E. Rabe
PRINTED NAME

Vice President
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 29 day of August 2018

Signature of Notary

Seal

GIGI ALDRETE
My Commission Expires
April 04, 2019

SIGNATURE

Michael T. Maloney
PRINTED NAME

Senior Vice President, Acquisitions & Development
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 29 day of August 2018

Signature of Notary

Seal

GIGI ALDRETE
My Commission Expires
April 04, 2019

*Insert the EXACT legal name of the applicant

SECTION II. BACKGROUND.

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, 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 5, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-4) MUST BE IDENTIFIED IN ATTACHMENT 5.

SECTION III. CHANGE OF OWNERSHIP (CHOW)

Transaction Type. Check the Following that Applies to the Transaction:

- [X] Purchase resulting in the issuance of a license to an entity different from current licensee.
- [ ] Lease resulting in the issuance of a license to an entity different from current licensee.
- [ ] Stock transfer resulting in the issuance of a license to a different entity from current licensee.
- [ ] Stock transfer resulting in no change from current licensee.
- [ ] Assignment or transfer of assets resulting in the issuance of a license to an entity different from the current licensee.
- [ ] Assignment or transfer of assets nopt resulting in the issuance of a license to an entity different from the current licensee.
- [ ] Change in membership or sponsorship of a not-for-profit corporation that is the licensed entity.
- [ ] Change of 50% or more of the voting members of a not-for-profit corporation's board of directors that controls a health care facility's operations, license, certification or physical plant and assets.
- [ ] Change in the sponsorship or control of the person who is licensed, certified or owns the physical plant and assets of a governmental health care facility.
- [ ] Sale or transfer of the physical plant and related assets of a health care facility not resulting in a change of current licensee.
- [ ] Any other transaction that results in a person obtaining control of a health care facility's operation or physical plant and assets and explain in "Narrative Description."

1130.520 Requirements for Exemptions Involving the Change of Ownership of a Health Care Facility

1. Prior to acquiring or entering into a contract to acquire an existing health care facility, a person shall submit an application for exemption to HFSRB, submit the required application-processing fee (see Section 1130.230) and receive approval from HFSRB.

2. If the transaction is not completed according to the key terms submitted in the exemption application, a new application is required.

3. READ the applicable review criteria outlined below and **submit the required documentation (key terms) for the criteria:**

APPLICABLE REVIEW CRITERIA	CHOW
1130.520(b)(1)(A) - Names of the parties	X
1130.520(b)(1)(B) - Background of the parties, which shall include proof that the applicant is fit, willing, able, and has the qualifications, background and character to adequately provide a proper standard of health service for the community by certifying that no adverse action has been taken against the applicant by the federal government, licensing or certifying bodies, or any other agency of the State of Illinois against any health care facility owned or operated by the applicant, directly or indirectly, within three years preceding the filing of the application.	X
1130.520(b)(1)(C) - Structure of the transaction	X
1130.520(b)(1)(D) - Name of the person who will be licensed or certified entity after the transaction	X
1130.520(b)(1)(E) - List of the ownership or membership interests in such licensed or certified entity both prior to and after the transaction, including a description of the applicant's organizational structure with a listing of controlling or subsidiary persons.	X
1130.520(b)(1)(F) - Fair market value of assets to be transferred.	X
1130.520(b)(1)(G) - The purchase price or other forms of consideration to be provided for those assets. [20 ILCS 3960/8.5(a)]	X
1130.520(b)(2) - Affirmation that any projects for which permits have been issued have been completed or will be completed or altered in accordance with the provisions of this Section	X
1130.520(b)(3) - If the ownership change is for a hospital, affirmation that the facility will not adopt a more restrictive charity care policy than the policy that was in effect one year prior to the transaction. The hospital must provide affirmation that the compliant charity care policy will remain in effect for a two-year period following the change of ownership transaction	X
1130.520(b)(4) - A statement as to the anticipated benefits of the proposed changes in ownership to the community	X

1130.520(b)(5) - The anticipated or potential cost savings, if any, that will result for the community and the facility because of the change in ownership;	X
1130.520(b)(6) - A description of the facility's quality improvement program mechanism that will be utilized to assure quality control;	X
1130.520(b)(7) - A description of the selection process that the acquiring entity will use to select the facility's governing body;	X
1130.520(b)(8) - A statement that the applicant has prepared a written response addressing the review criteria contained in 77 Ill. Adm. Code 1110.240 and that the response is available for public review on the premises of the health care facility	X
1130.520(b)(9)- A description or summary of any proposed changes to the scope of services or levels of care currently provided at the facility that are anticipated to occur within 24 months after acquisition.	X

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

SECTION IV.CHARITY CARE INFORMATION

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 7.

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

APPEND DOCUMENTATION AS ATTACHMENT 7, 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	23-27
2	Site Ownership	28-37
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	38-40
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	41-43
5	Background of the Applicant	44-51
6	Change of Ownership	149-151
7	Charity Care Information	86-107

Section I

Attachment 1

Applicant Information

The Certificates of Good Standing for SRC Hospital Investments II, LLC ("SRC"), Pipeline – West Suburban Medical Center, LLC ("WSMC OpCo"), VHS West Suburban Medical Center, Inc. ("VHS"), and Tenet Healthcare Corporation ("Tenet") are attached at ATTACHMENT 1.

ATTACHMENT 1

File Number 0689124-1

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 I am the keeper of the records of the Department of Business Services. I certify that

SRC HOSPITAL INVESTMENTS II, LLC, A DELAWARE LIMITED LIABILITY COMPANY HAVING OBTAINED ADMISSION TO TRANSACT BUSINESS IN ILLINOIS ON AUGUST 09, 2018, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A FOREIGN LIMITED LIABILITY COMPANY ADMITTED TO TRANSACT BUSINESS IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 10TH *day of* AUGUST *A.D.* 2018 .

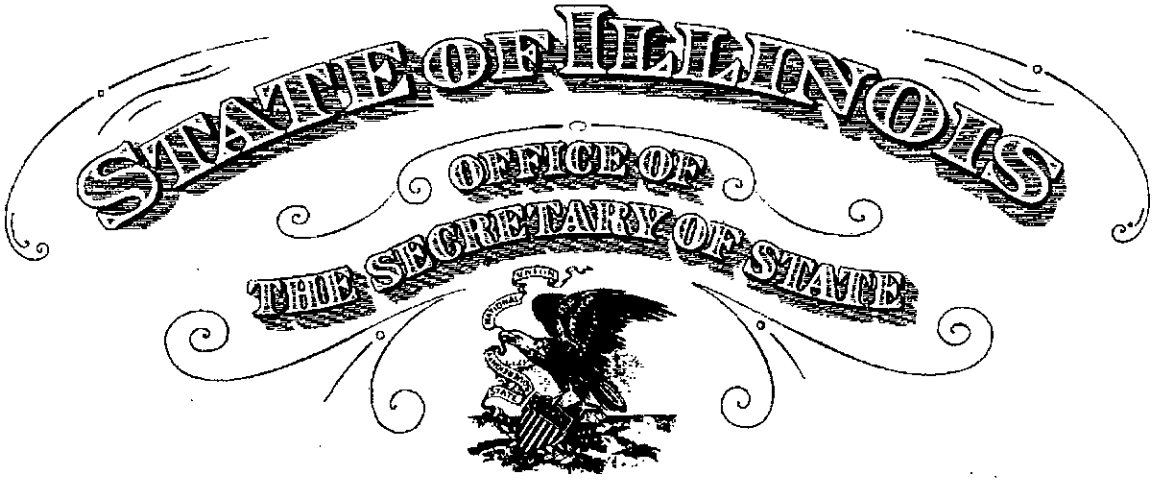
Authentication #: 1822202268 verifiable until 08/10/2019
Authenticate at: http://www.cyberdriveillinois.com

Jesse White

SECRETARY OF STATE

ATTACHMENT 1

File Number 6704-411-8



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

VHS WEST SUBURBAN MEDICAL CENTER, INC., INCORPORATED IN DELAWARE AND LICENSED TO TRANSACT BUSINESS IN THIS STATE ON MARCH 04, 2010, 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* 24TH *day of* AUGUST *A.D.* 2018 .

Authentication #: 1823602580 verifiable until 08/24/2019
Authenticate at: http://www.cyberdriveillinois.com

Jesse White

SECRETARY OF STATE

File Number 0689280-9

STATE OF ILLINOIS
OFFICE OF
THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

PIPELINE - WEST SUBURBAN MEDICAL CENTER, LLC, A DELAWARE LIMITED LIABILITY COMPANY HAVING OBTAINED ADMISSION TO TRANSACT BUSINESS IN ILLINOIS ON AUGUST 20, 2018, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A FOREIGN LIMITED LIABILITY COMPANY ADMITTED TO TRANSACT BUSINESS IN THE STATE OF JLLINOIS.

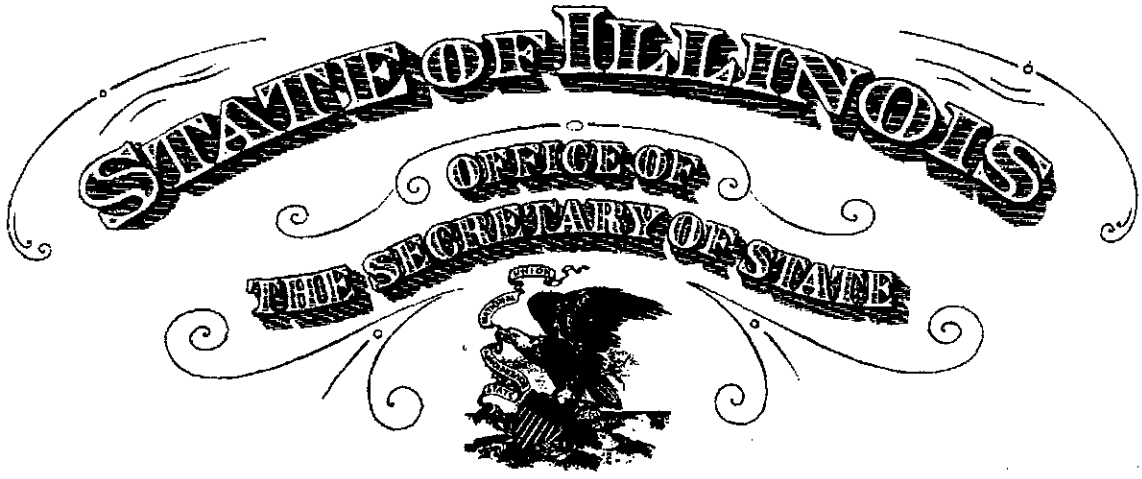
In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 29TH *day of* AUGUST *A.D.* 2018 .

Authentication #: 1824103136 verifiable until 08/29/2019
Authenticate at: http://www.cyberdriveillinois.com

Jesse White
SECRETARY OF STATE

ATTACHMENT 1

File Number 6878-488-3



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

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* 29TH *day of* AUGUST *A.D.* 2018 .

Authentication #: 1824103166 verifiable until 08/29/2019
Authenticate at: http://www.cyberdriveillinois.com

Jesse White

SECRETARY OF STATE

ATTACHMENT 1

Section I

Attachment 2

Site Ownership

VHS West Suburban Medical Center, Inc. currently owns the land, buildings, and other real estate comprising the campus of VHS West Suburban Medical Center ("WSMC"). A copy of the real property deed evidencing such ownership is attached at ATTACHMENT 2.

Following the Transaction, (i) WSMC PropCo will own the land and other real estate comprising the campus of WSMC, and (ii) WSMC OpCo will own all of the buildings and operating assets comprising of WSMC.

Following the Transaction, SRC will be the licensee and operator of WSMC.

ATTACHMENT 2

QUITCLAIM DEED

AFTER RECORDING RETURN TO:

VHS West Suburban
Medical Center, Inc.
c/o Vanguard Health
Systems, Inc.
20 Burton Hills Boulevard
Suite 100
Nashville, TN 37215

THIS INSTRUMENT PREPARED BY AND:

THOMAS L. HEFTY
MCDERMOTT WILL & EMERY LLP
227 WEST MONROE STREET
CHICAGO, ILLINOIS 60606

This Deed is exempt pursuant to 35 ILCS 200/31-45(e)

Date 7/30/2010 Seller or Agent

Property Address and PIN:
See Exhibit A

8502 445 10/12

Doc#: 1021741035 Fee: $52.00
Eugene "Gene" Moore RHSP Fee:$10.00
Cook County Recorder of Deeds
Date: 08/05/2010 01:02 PM Pg: 1 of 9

WEST SUBURBAN MEDICAL CENTER, an Illinois not-for-profit corporation, whose address is 7435 West Talcott Avenue, Chicago, Illinois ("Grantor"), for and in consideration of TEN AND NO/100 DOLLARS ($10.00) and other good and valuable consideration in hand paid, **CONVEYS** and **QUITCLAIMS** to **VHS WEST SUBURBAN MEDICAL CENTER, INC.**, a Delaware corporation, whose address is 20 Burton Hills Boulevard, Suite 100, Nashville, Tennessee, all of Grantor's right, title and interest in and to the following described real estate situated in the River Forest, Cook County, Illinois (the "Premises"), to-wit:

[See Exhibit A attached hereto and made a part hereof by this reference]

EXEMPTION APPROVED
Teresa Powell
VILLAGE CLERK
VILLAGE OF OAK PARK

DM_US 25810650-1.037442.0104

This Quitclaim Deed is signed this 1st day of August, 2010.

WEST SUBURBAN MEDICAL CENTER
an Illinois not-for-profit corporation

By: Sandra Bruce
Name: Sandra Bruce
Its: President

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

I, the undersigned, a Notary Public in and for said County, in the State aforesaid, DO HEREBY CERTIFY that Sandra Bruce, personally known to me to be the President of WEST SUBURBAN MEDICAL CENTER, an Illinois not-for-profit corporation, and personally known to me to be the same person whose name is subscribed to the foregoing instrument, appeared before me this day in person and acknowledged that as such PRESIDENT, he/she signed, sealed and delivered said instrument as PRESIDENT of said corporation, pursuant to authority, given by the Board of Directors of said corporation as his/her free and voluntary act, and as the free and voluntary act and deed of said corporation, for the uses and purposes therein set forth.

Given under my hand and official seal, this 1st day of August, 2010.

Notary Public

My Commission Expires:
August 26, 2010

OFFICIAL SEAL
FLORITA DEJESUS-ORTIZ
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 8-26-2010

Grantee's Address and Send Subsequent Tax Bills To:

VHS WEST SUBURBAN MEDICAL CENTER, INC.,, a Delaware corporation
20 Burton Hills Boulevard, Suite 100,
Nashville, Tennessee 37215

DM_US 25810630-1.037442.0104

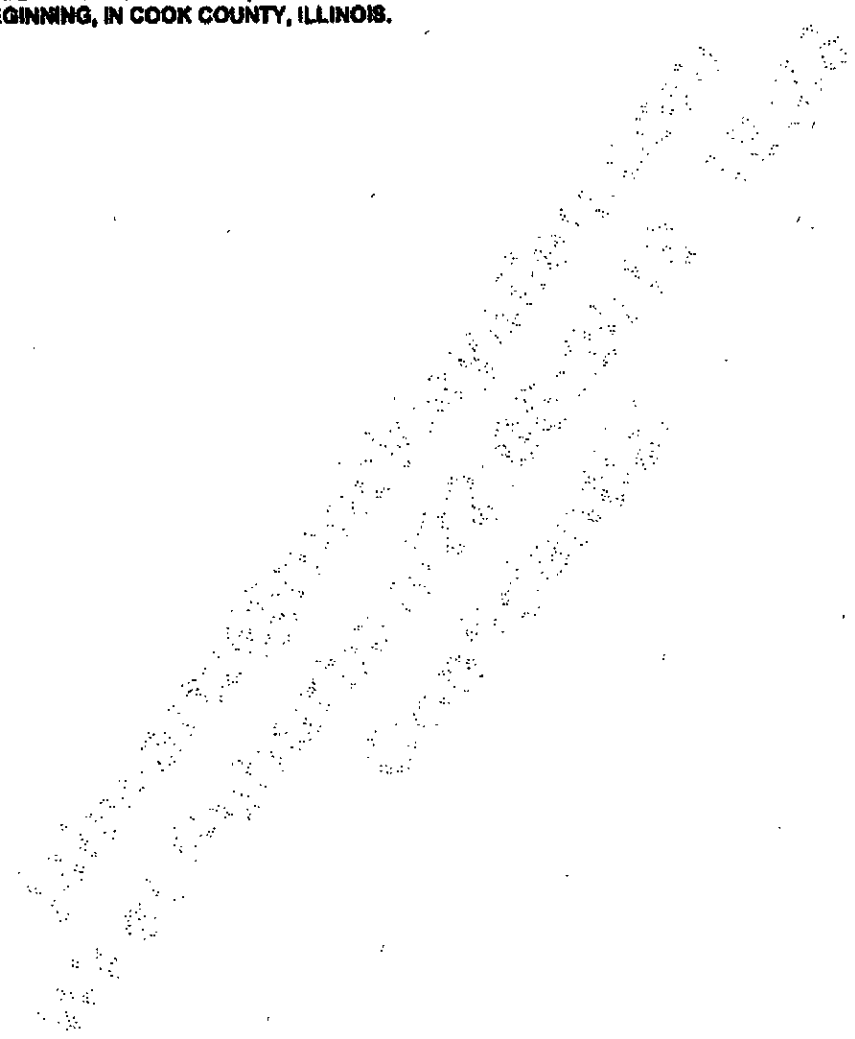
Exhibit A
Legal Description

ALL THAT PART OF LOTS 4 THROUGH 9 INCLUSIVE, IN BLOCK 17; LOTS 4 THROUGH 15 INCLUSIVE IN BLOCK 18, TOGETHER WITH THAT PART OF THE VACATED NORTH-SOUTH 20 FOOT ALLEY IN SAID BLOCK 18, VACATED BY ORDINANCE RECORDED NOVEMBER 30, 1978, AS DOCUMENT NUMBER 24743006 AND BY ORDINANCE PASSED MARCH 31, 1980 AND RECORDED AS DOCUMENT NUMBER 22430617; LOTS 1 THROUGH 9 INCLUSIVE IN BLOCK 19, VACATED BY ORDINANCE RECORDED APRIL 4, 1973 AS DOCUMENT NUMBER 22273801; LOTS 6 THROUGH 9 INCLUSIVE IN BLOCK 20, ALL IN THE VILLAGE OF RIDGELAND, BEING A SUBDIVISION OF THE EAST 1/2 OF THE EAST 1/2 OF SECTION 7 AND ALSO THE NORTHWEST 1/4 AND THE WEST 1/2 OF THE WEST 1/2 OF THE SOUTHWEST 1/4 OF SECTION 8, TOWNSHIP 39 NORTH, RANGE 13 EAST OF THE THIRD PRINCIPAL MERIDIAN; LOTS 1 THROUGH 12 INCLUSIVE IN HENRY DATE'S RESUBDIVISION OF LOTS 10 TO 18 INCLUSIVE, OF BLOCK 19, OF THE VILLAGE OF RIDGELAND, AFORESAID; LOTS 1 THROUGH 7 INCLUSIVE, TOGETHER WITH THE NORTH-SOUTH 10 FOOT ALLEY, LYING EAST OF AND ADJOINING SAID LOT 7 AND LYING NORTH OF THE SOUTH LINE OF SAID LOT 7 EXTENDED EAST, VACATED BY ORDINANCE RECORDED NOVEMBER 30, 1978, AS DOCUMENT NUMBER 24743006, AND THAT PART OF THE EAST-WEST 10 FOOT ALLEY, LYING SOUTH OF THE SOUTH LINE OF LOT 7 AND ITS EASTERLY EXTENSION TO THE WEST LINE OF LOT 4, IN THE RESUBDIVISION OF LOTS 1 THROUGH 4, IN BLOCK 20, IN THE VILLAGE OF RIDGELAND AFORESAID, (SAID 10 FOOT ALLEY VACATED BY ORDINANCE RECORDED MARCH 2, 2007 AS DOCUMENT NUMBER 0706134053, AND ORDINANCE AUTHORIZING AGREEMENT FOR VACATION OF ALLEY, RECORDED MARCH 8, 2007, AS DOCUMENT NUMBER 0706731040, AND ORDINANCE AUTHORIZING THE FIRST AMENDMENT FOR VACATION OF ALLEY, RECORDED MAY 1, 2008, AS DOCUMENT NUMBER 0812245161); ALL THAT PART OF VACATED ERIE STREET AND VACATED HUMPHREY AVENUE, VACATED BY ORDINANCE RECORDED NOVEMBER 30, 1978, AS DOCUMENT NUMBER 2473006, AND PART OF VACATED HUMPHREY AVENUE (VACATED BY ORDINANCE RECORDED MARCH 2, 2007, AS DOCUMENT NUMBER 0706134053, AND ORDINANCE AUTHORIZING AGREEMENT FOR VACATION OF STREET, RECORDED MARCH 8, 2007, AS DOCUMENT NUMBER 0706731040, AND ORDINANCE AUTHORIZING THE FIRST AMENDMENT FOR VACATION OF STREET, RECORDED MAY 1, 2008 AS DOCUMENT NUMBER 0812245161),AND PART OF VACATED HUMPHREY AVENUE (VACATED BY ORDINANCE RECORDED OCTOBER 29, 1984, AS DOCUMENT NUMBER 84897562), ALL TAKEN AS ONE TRACT, BOUNDED AND DESCRIBED AS FOLLOWS:

BEGINNING AT THE NORTHWEST CORNER OF LOT 4 IN BLOCK 17, IN THE VILLAGE OF RIDGELAND SUBDIVISION AFORESAID; THENCE NORTH 89 DEGREES 59 MINUTES 48 SECONDS EAST, ALONG THE NORTH LINE OF SAID LOT, A DISTANCE OF 171.31 FEET TO THE NORTHEAST CORNER THEREOF; THENCE SOUTH 0 DEGREES 13 MINUTES 45 SECONDS EAST, ALONG THE <ELINE OF LOTS 4 AND 5, IN BLOCK 17, IN THE VILLAGE OF RIDGELAND SUBDIVISION AFORESAID (BEING ALSO THE WEST LINE OF HUMPHREY AVENUE), 75.09 FEET TO ITS POINT OF INTERSECTION WITH THE NORTH LINE OF THE SOUTH 1/2 OF SAID LOT 5; THENCE SOUTH 89 DEGREES 59 MINUTES 50 SECONDS EAST, ALONG THE EASTERLY EXTENSION OF THE NORTH LINE OF THE SOUTH 1/2 OF LOT 5, IN BLOCK 17 AFORESAID, 24.00 FEET; THENCE SOUTH ALONG A LINE DRAWN 24.00 FEET EAST OF AND PARALLEL WITH THE EAST LINE OF LOT 5, IN BLOCK 17 AFORESAID, 30.00 FEET; THENCE SOUTHEASTERLY AND NORTHEASTERLY, 79.06 FEET ALONG THE ARC OF A CIRCLE, CONVEX SOUTHERLY, HAVING A RADIUS OF 30.00 FEET, AND WHOSE CHORD BEARS SOUTH 74 DEGREES 49 MINUTES 14 SECONDS EAST, 58.06 FEET TO A POINT OF COMPOUND CURVATURE ON THE WEST LINE OF LOT 13, IN BLOCK 18 AFORESAID (SAID WEST LIEN BEING ALSO THE EAST LINE OF HUMPHREY AVENUE); THENCE NORTHWESTERLY, 31.32 FEET ALONG THE ARC OF A CIRCLE CONVEX EASTERLY, HAVING A RADIUS OF 30.00 FEET, AND WHOSE CHORD BEARS NORTH 0 DEGREES 13 MINUTES 45 SECONDS WEST, 29.92 FEET TO A POINT ON THE WEST LINE OF LOT 14, IN BLOCK 18 AFORESAID (SAID WEST LINE BEING ALSO THE EAST LINE OF HUMPHREY AVENUE);

THENCE NORTH 0 DEGREES 13 MINUTES 45 SECONDS WEST, ALONG THE WEST LINE OF LOTS 14 AND 15 IN BLOCK 18 AFORESAID (SAID WEST LINE BEING ALSO THE EAST LINE OF HUMPHREY AVENUE), 75.50 FEET TO ITS POINT OF INTERSECTION WITH THE SOUTH LINE OF THE NORTH 15.00 FEET OF LOT 15, IN BLOCK 18 AFORESAID; THENCE SOUTH 89 DEGREES 59 MINUTES 16 SECONDS EAST, ALONG SAID SOUTH LINE, 171.14 FEET TO THE EAST LINE OF SAID LOT 15; THENCE SOUTH 0 DEGREES 14 MINUTES 23 SECONDS EAST, ALONG SAID EAST LINE (BEING ALSO THE WEST LINE OF A NORTH-SOUTH 20 FOOT PUBLIC ALLEY, IN BLOCK 18 AFORESAID), 1.00 FOOT; THENCE SOUTH 89 DEGREES 59 MINUTES 16 SECONDS EAST, ALONG THE WESTERLY EXTENSION OF THE SOUTH LINE OF THE NORTH 16.00 FEET OF LOT 4, IN BLOCK 18, IN THE VILLAGE OF RIDGELAND SUBDIVISION AFORESAID AND ALONG SAID SOUTH LINE OF THE NORTH 16.00 FEET OF LOT 4;, BEING ALSO THE SOUTH LINE OF A 16 FOOT PUBLIC ALLEY OPENED BY ORDINANCE RECORDED NOVEMBER 30, 1978; AS DOCUMENT NUMBER 24743006, AFORESAID, 191.14 TO ITS INTERSECTION WITH THE EAST LINE OF LOT 4 AFORESAID, SAID EAST LINE BEING ALSO THE WEST LINE OF AUSTIN BOULEVARD; THENCE SOUTH 0 DEGREES 15 MINUTES 01 SECONDS EAST, ALONG THE EAST LINE OF LOTS 4 THROUGH 9, IN BLOCK 18, IN THE VILLAGE OF RIDGELAND SUBDIVISION AFORESAID, BEING ALSO THE WEST LIEN OF AUSTIN BOULEVARD, 269.37 FEET TO THE SOUTHEAST CORNER OF LOT 9 AFORESAID; THENCE SOUTH 0 DEGREES 22 MINUTES 48 SECONDS EAST, ALONG THE EASTERLY TERMINUS OF VACATED ERIE STREET, BY ORDINANCE RECORDED NOVEMBER 30, 1978, AS DOCUMENT NUMBER 24743006 AFORESAID, 66.22 FEET TO THE NORTHEAST CORNER OF LOT 1, IN BLOCK 19, IN THE VILLAGE OF RIDGELAND SUBDIVISION AFORESAID; THENCE SOUTH 0 DEGREES 15 MINUTES 16 SECONDS EAST, ALONG THE EAST LINE OF LOTS 1 THROUGH 9, IN BLOCK 19, IN THE VILLAGE OF RIDGELAND SUBDIVISION AFORESAID, BEING ALSO THE WEST LINE OF AUSTIN BOULEVARD, 429.17 FEET TOT HE SOUTHEAST CORNER OF LOT 9 AFORESAID; THENCE NORTH 89 DEGREES 59 MINUTES 55 SECONDS WEST, ALONG THE SOUTH LINE OF BLOCK 19, IN THE VILLAGE OF RIDGELAND SUBDIVISION AFORESAID, BEING ALSO THE NORTH LINE OF ONTARIO STREET, 382.70 FEET TO THE SOUTHWEST CORNER OF LOT 12, IN BLOCK 19 AFORESAID; THENCE SOUTH 89 DEGREES 51 MINUTES 25 SECONDS WEST, ALONG THE WESTERLY TERMINUS OF VACATED HUMPHREY AVENUE (BY ORDINANCE RECORDED MARCH 2, 2007, AS DOCUMENT NUMBER 0706134053, AND ORDINANCE AUTHORIZING AGREEMENT FOR VACATION OF STREET, RECORDED MARCH 6, 2007, AS DOCUMENT NUMBER 0706731040, AND ORDINANCE AUTHORIZING THE FIRST AMENDMENT FOR VACATION OF STREET RECORDED MAY 1, 2008 AS DOCUMENT NUMBER 0812245181) AFORESAID, 80.04 FEET TO THE SOUTHEAST CORNER OF LOT 9, IN BLOCK 20, IN THE VILLAGE OF RIDGELAND SUBDIVISION AFORESAID; THENCE NORTH 89 DEGREES 58 MINUTES 47 SECONDS WEST, ALONG THE SOUTH LINE OF LOT 9, IN BLOCK 20 AFORESAID, SAID SOUTH LINE BEING ALSO THE NORTH LINE OF ONTARIO STREET, 171.68 FEET TO ITS SOUTHWEST CORNER THEREOF; THENCE NORTH 0 DEGREES 12 MINUTES 29 SECONDS WEST, ALONG THE WEST LINE OF LOTS 6 THROUGH 9, IN BLOCK 20, SAID WEST LINE BEING ALSO THE EAST LINE OF A 20 FOOT NORTH-SOUTH PUBLIC ALLEY, IN THE VILLAGE OF RIDGELAND SUBDIVISION AFORESAID AND ALONG THE WEST LINE OF LOTS 6 AND 5, IN BLOCK 20, IN THE RESUBDIVISION OF LOTS 1 THROUGH 4, IN BLOCK 20 IN THE VILLAGE OF RIDGELAND AFORESAID, AND ALONG THE WESTERLY TERMINUS OF A 10 FOOT VACATED ALLEY (BY ORDINANCE RECORDED MARCH 2, 2007 AS DOCUMENT NUMBER 0706134053, AND ORDINANCE AUTHORIZING AGREEMENT FOR VACATION OF ALLEY, RECORDED MARCH 6, 2007 AS DOCUMENT NUMBER 0706731040, AND ORDINANCE AUTHORIZING THE FIRST AMENDMENT FOR VACATION OF ALLEY, RECORDED MAY 1, 2008, AS DOCUMENT NUMBER 0812245181), AND ALONG THE WEST LINE OF LOT 7, IN BLOCK 20, IN THE RESUBDIVISION OF LOTS 1 THROUGH 4, IN BLOCK 20, IN THE VILLAGE OF RIDGELAND SUBDIVISION AFORESAID, 429.61 FEET TO THE NORTHWEST CORNER OF SAID LOT 7, SAID WEST LINE OF LOTS AND WESTERLY TERMINUS OF VACATED EAST-WEST 10 FOOT ALLEY BEING ALSO THE EAST LIN E OF A 20 FOOT NORTH-SOUTH PUBLIC ALLEY, IN BLOCK 20, AFORESAID; THENCE NORTH 0 DEGREES 24 MINUTES 57 SECONDS WEST, ALONG THE WESTERLY TERMINUS OF VACATED ERIE STREET BY ORDINANCE RECORDED NOVEMBER 30, 1978, AS DOCUMENT NUMBER 24743006 AFORESAID,

65.91 FEET TO THE SOUTHWEST CORNER OF LOT 9 IN BLOCK 17, IN THE VILLAGE OF RIDGELAND SUBDIVISION, AFORESAID; THENCE NORTH 0 DEGREES 09 MINUTES 58 SECONDS WEST, ALONG THE WEST LINE OF LOTS 4 THROUGH 9, IN BLOCK 19, IN THE VILLAGE OF RIDGELAND SUBDIVISION, AFORESAID, SAID WEST LINE BEING ALSO THE EAST LINE OF A 20 FOOT NORTH-SOUTH PUBLIC ALLEY, IN BLOCK 17, IN THE VILLAGE OF RIDGELAND SUBDIVISION AFORESAID, 285.31 FEET TO THE HEREINABOVE DESIGNATED POINT OF BEGINNING, IN COOK COUNTY, ILLINOIS.



16-08-110-017-0000	321 NORTH HUMPHREY, OAK PARK	WEST LOT	WEST SUBURBAN MEDICAL CENTER
16-08-110-018-0000	317 NORTH HUMPHREY, OAK PARK	WEST LOT	WEST SUBURBAN MEDICAL CENTER
16-08-110-019-0000	315 NORTH HUMPHREY, OAK PARK	WEST LOT	WEST SUBURBAN MEDICAL CENTER
16-08-110-020-0000	311 NORTH HUMPHREY, OAK PARK	WEST LOT	WEST SUBURBAN MEDICAL CENTER
16-08-110-021-0000	307 NORTH HUMPHREY, OAK PARK	WEST LOT	WEST SUBURBAN MEDICAL CENTER
16-08-110-022-0000	303 NORTH HUMPHREY, OAK PARK	WEST LOT	WEST SUBURBAN MEDICAL CENTER
16-08-110-023-0000	301 NORTH HUMPHREY, OAK PARK	WEST LOT	WEST SUBURBAN MEDICAL CENTER
16-08-111-006-0000	306 NORTH HUMPHREY, OAK PARK	PARKING GARAGE	WEST SUBURBAN MEDICAL CENTER
16-08-111-009-0000	308 NORTH HUMPHREY, OAK PARK	PARKING GARAGE	WEST SUBURBAN MEDICAL CENTER
16-08-111-013-0000	622 NORTH AUSTIN, OAK PARK	PARKING GARAGE	WEST SUBURBAN MEDICAL CENTER
16-08-111-014-0000	620 NORTH AUSTIN, OAK PARK	PARKING GARAGE	WEST SUBURBAN MEDICAL CENTER
16-08-111-015-0000	618 NORTH AUSTIN, OAK PARK	PARKING GARAGE	WEST SUBURBAN MEDICAL CENTER
16-08-111-016-0000	616 NORTH AUSTIN, OAK PARK	PARKING GARAGE	WEST SUBURBAN MEDICAL CENTER
16-08-111-017-0000	614 NORTH AUSTIN, OAK PARK	PARKING GARAGE	WEST SUBURBAN MEDICAL CENTER
16-08-111-018-0000	600 NORTH AUSTIN, OAK PARK	PARKING GARAGE	WEST SUBURBAN MEDICAL CENTER
16-08-111-021-0000	305 NORTH HUMPHREY, OAK PARK	PARKING GARAGE	WEST SUBURBAN MEDICAL CENTER
16-08-111-022-0000	316 NORTH HUMPHREY, OAK PARK	PARKING GARAGE	WEST SUBURBAN MEDICAL CENTER
16-08-116-012-0000	52 ERIE, OAK PARK	WEST LOT	WEST SUBURBAN MEDICAL CENTER
16-08-116-013-0000	233 NORTH HUMPHREY, OAK PARK	WEST LOT	WEST SUBURBAN MEDICAL CENTER
16-08-116-014-0000	229 NORTH HUMPHREY, OAK PARK	WEST LOT	WEST SUBURBAN MEDICAL CENTER
16-08-116-015-0000	227 NORTH HUMPHREY, OAK PARK	WEST LOT	WEST SUBURBAN MEDICAL CENTER
16-08-116-016-0000	223 NORTH HUMPHREY, OAK PARK	WEST LOT	WEST SUBURBAN MEDICAL CENTER
16-08-116-017-0000	221 NORTH HUMPHREY, OAK PARK	WEST LOT	WEST SUBURBAN MEDICAL CENTER
16-08-116-018-0000	219 NORTH HUMPHREY, OAK PARK	WEST LOT	WEST SUBURBAN MEDICAL CENTER

DM_US 25821931-2.037442.0104

16-08-116-019-0000	217 NORTH HUMPHREY, OAK PARK	WEST LOT	WEST SUBURBAN MEDICAL CENTER
16-08-116-020-0000	215 NORTH HUMPHREY, OAK PARK	WEST LOT	WEST SUBURBAN MEDICAL CENTER
16-08-116-021-0000	213 NORTH HUMPHREY, OAK PARK	GREEN SPACE	WEST SUBURBAN MEDICAL CENTER
16-08-116-022-0000	211 NORTH HUMPHREY, OAK PARK	GREEN SPACE	WEST SUBURBAN MEDICAL CENTER
16-08-116-023-0000	209 NORTH HUMPHREY, OAK PARK	RESIDENCE	WEST SUBURBAN MEDICAL CENTER
16-08-116-024-0000	207 NORTH HUMPHREY, OAK PARK	GREEN SPACE	WEST SUBURBAN MEDICAL CENTER
16-08-116-025-0000	205 NORTH HUMPHREY, OAK PARK	GREEN SPACE	WEST SUBURBAN MEDICAL CENTER
16-08-116-026-0000	201 NORTH HUMPHREY, OAK PARK	GREEN SPACE	WEST SUBURBAN MEDICAL CENTER
16-08-117-001-0000	232 NORTH HUMPHREY, OAK PARK	HOSPITAL	WEST SUBURBAN MEDICAL CENTER
16-08-117-007-0000	216 NORTH HUMPHREY, OAK PARK	HOSPITAL	WEST SUBURBAN MEDICAL CENTER
16-08-117-008-0000	214 NORTH HUMPHREY, OAK PARK	HOSPITAL	WEST SUBURBAN MEDICAL CENTER
16-08-117-009-0000	212 NORTH HUMPHREY, OAK PARK	HOSPITAL	WEST SUBURBAN MEDICAL CENTER
16-08-117-010-0000	210 NORTH HUMPHREY, OAK PARK	HOSPITAL	WEST SUBURBAN MEDICAL CENTER
16-08-117-011-0000	206 NORTH HUMPHREY, OAK PARK	HOSPITAL	WEST SUBURBAN MEDICAL CENTER
16-08-117-012-0000	200 NORTH HUMPHREY, OAK PARK	HOSPITAL	WEST SUBURBAN MEDICAL CENTER
16-08-117-013-0000	500 NORTH AUSTIN, OAK PARK	HOSPITAL	WEST SUBURBAN MEDICAL CENTER
16-08-117-015-0000	1 ERIE CT., OAK PARK	PROFESSIONAL OFFICE BUILDING	WEST SUBURBAN MEDICAL CENTER
16-08-117-016-0000	1 ERIE CT., OAK PARK	PROFESSIONAL OFFICE BUILDING	WEST SUBURBAN MEDICAL CENTER

STATEMENT BY GRANTOR AND GRANTEE

The grantor or his agent affirms that, to the best of his knowledge, the name of the grantee shown on the deed or assignment of beneficial interest in a land trust is either a natural person, an Illinois corporation or foreign corporation authorized to do business or acquire and hold title to real estate in Illinois, a partnership authorized to do business or acquire and hold title to real estate in Illinois, or other entity recognized as a person and authorized to do business or acquire and hold title to real estate under the laws of the State of Illinois.

Dated August 1, 2010
Signature: Sandra Bruce (Grantor or Agent)

Subscribed and sworn to before me by the

said SANDRA BRUCE

this 1st day of August

20 10.

Florita De Jesus-Ortiz (Notary Public)

OFFICIAL SEAL
FLORITA DE JESUS-ORTIZ
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 6-09-2010

The grantee or his agent affirms and verifies that the name of the grantee shown on the deed or assignment of beneficial interest in a land trust is either a natural person, an Illinois corporation or foreign corporation authorized to do business or acquire and hold title to real estate in Illinois, a partnership authorized to do business or acquire and hold title to real estate in Illinois, or other entity recognized as a person and authorized to do business or acquire and hold title to real estate under the laws of the State of Illinois.

Dated _____, 20____
Signature: _____ (Grantee or Agent)

Subscribed and sworn to before me by the

said _____

this ____ day of _____

20 ____.

_____ (Notary Public)

NOTE: Any person who knowingly submits a false statement concerning the identity of a grantee shall be guilty of a Class C misdemeanor for the first offense and of a Class A misdemeanor for subsequent offenses.

STATEMENT BY GRANTOR AND GRANTEE

The grantor or his agent affirms that, to the best of his knowledge, the name of the grantee shown on the deed or assignment of beneficial interest in a land trust is either a natural person, an Illinois corporation or foreign corporation authorized to do business or acquire and hold title to real estate in Illinois, a partnership authorized to do business or acquire and hold title to real estate in Illinois, or other entity recognized as a person and authorized to do business or acquire and hold title to real estate under the laws of the State of Illinois.

Dated _____, 20____
Signature: _____ (Grantor or Agent)

Subscribed and sworn to before me by the

said _____

this _____ day of _____

20 ____.

_____ (Notary Public)

The grantee or his agent affirms and verifies that the name of the grantee shown on the deed or assignment of beneficial interest in a land trust is either a natural person, an Illinois corporation or foreign corporation authorized to do business or acquire and hold title to real estate in Illinois, a partnership authorized to do business or acquire and hold title to real estate in Illinois, or other entity recognized as a person and authorized to do business or acquire and hold title to real estate under the laws of the State of Illinois.

VHS WEST SUBURBAN MEDICAL CENTER, INC.

Dated 9-28-10, 20
Signature: _____ (Grantee or Agent)
James H. Spalding, Senior
Vice President

Subscribed and sworn to before me by the

said James H. Spalding

this 28th day of July

20 10.

_____ (Notary Public)

JEANNE M. PERRI
STATE OF TENNESSEE
NOTARY PUBLIC
DAVIDSON COUNTY, TENN.

My Commission Expires MAY 20, 2014

NOTE: Any person who knowingly submits a false statement concerning the identity of a grantee shall be guilty of a Class C misdemeanor for the first offense and of a Class A misdemeanor for subsequent offenses.

Section I

Attachment 3

Operating Entity/Licensee

VHS West Suburban Medical Center, Inc. is currently licensee and operator of WSMC. Copies of WSMC's general acute care hospital license and Joint Commission accreditation are attached at ATTACHMENT 3.

Following the Transaction, WSMC OpCo will be the licensee and operator of WSMC.

The Certificate of Good Standing for WSMC OpCo is attached at ATTACHMENT 1.

The following Persons own a 5% or greater interest in VHS:

Name	Percentage Interest
Vanguard Health Financial Company, LLC	100%

The following Persons own a 5% or greater interest in Vanguard Health Financial Company, LLC:

Name	Percentage Interest
Vanguard Health Systems, Inc.	100%

The following Persons own a 5% or greater interest in Vanguard Health Systems, Inc.:

Name	Percentage Interest
Tenet Healthcare Corporation	100%

The following Persons own a 5% or greater interest in Pipeline – West Suburban Medical Center, LLC:

Name	Percentage Interest
SRC Hospital Investments II, LLC	100%

HF116077

Illinois 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.

Nirav D. Shah, M.D.,J.D.
Director

Issued under the authority of the Illinois Department of Public Health

EXPIRATION DATE	CATEGORY	ID NUMBER
7/31/2019		0005694

General Hospital

Effective: 08/01/2018

VHS West Suburban Medical Center, Inc.
dba West Suburban Medical Center
3 Erie Court

Oak Park, IL 60302

The face of this license has a colored background. Printed by Authority of the State of Illinois • P.O. #43240 5M 5/16

DISPLAY THIS PART IN A CONSPICUOUS PLACE

Exp. Date 7/31/2019

Lic Number 0005694

Date Printed 6/14/2018

VHS West Suburban Medical Center, I
dba West Suburban Medical Center
3 Erie Court
Oak Park, IL 60302

FEE RECEIPT NO.

ATTACHMENT 3

West Suburban Medical Center

Oak Park, IL

has been Accredited by

The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the

Hospital Accreditation Program

July 2, 2016

Accreditation is customarily valid for up to 36 months.

Craig W. Jones, FACHE
Chair, Board of Commissioners

ID #7399
Print/Reprint Date: 09-19/2016

Mark R. Chassin, MD, FACP, MPP, MPH
President

The Joint Commission is an independent, not-for-profit national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.

Section I

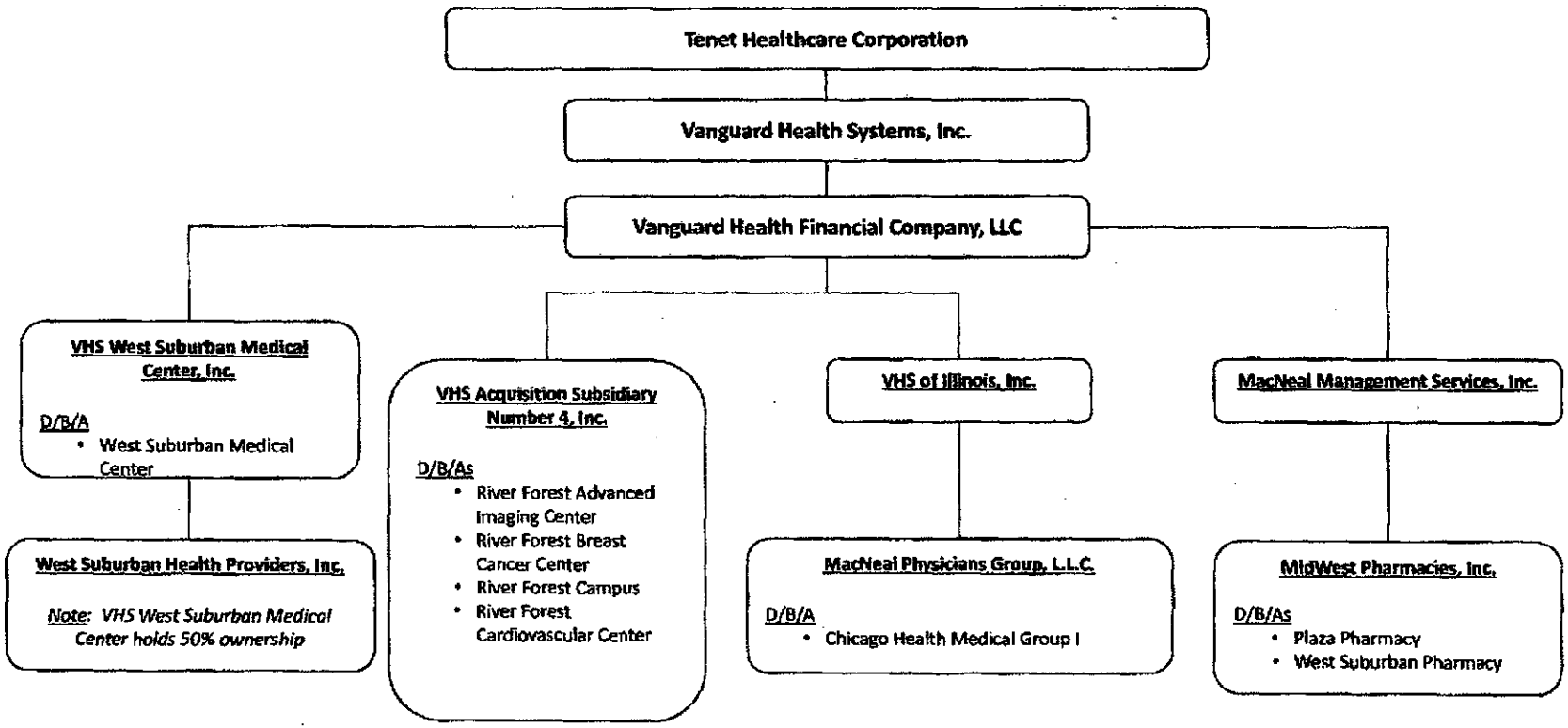
Attachment 4

Organizational Relationships

The organizational charts for each Applicant is attached at ATTACHMENT 4.

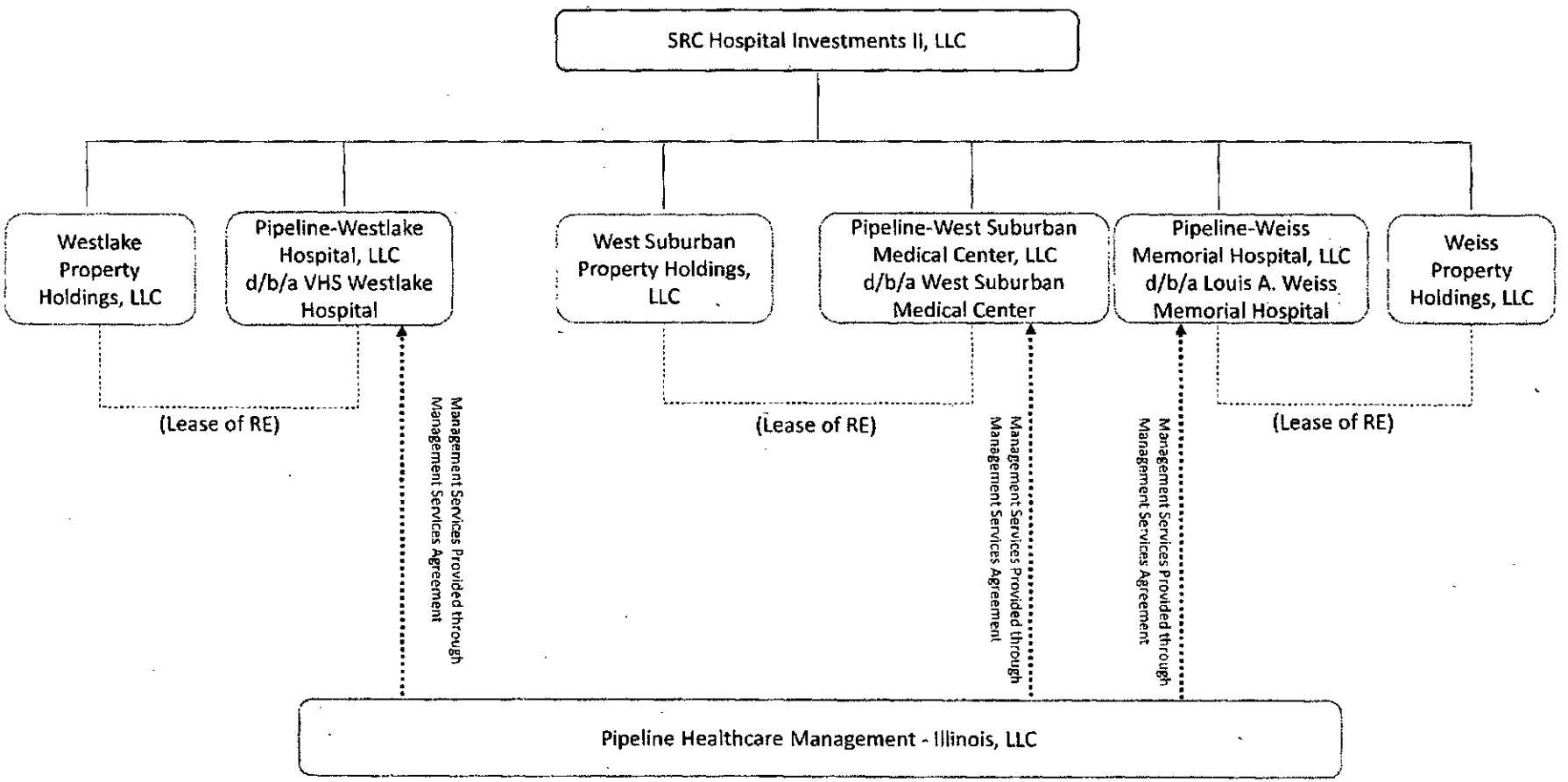
ATTACHMENT 4

Pre-Transaction Structure



ATTACHMENT 4

Post-Transaction Structure



ATTACHMENT 4

Section III

Attachment 6

Criterion 1110.230(a), Background of Applicants

SRC

1. SRC is a Delaware limited liability company.

2. SRC has not previously owned or operated hospitals or other health care facilities in Illinois.

3. An authorization letter granting access to the Review Board and the Illinois Department of Public Health ("IDPH") to verify information regarding SRC is attached at ATTACHMENT 5.

WSMC OpCo

4. WSMC OpCo is a Delaware limited liability company. WSMC OpCo will be the licensee and operator of WSMC following the consummation of the Transaction.

5. SRC is the sole member of WSMC OpCo.

6. WSMC OpCo has not previously owned or operated hospitals or other health care facilities in Illinois.

7. An authorization letter granting access to the Review Board and the Illinois Department of Public Health ("IDPH") to verify information regarding WSMC OpCo is attached at ATTACHMENT 5.

VHS

8. VHS is a Delaware business corporation.

9. Vanguard is the sole member of VHF.

10. There have been no adverse actions taken against any facility owned or operated in Illinois by VHS during the three (3) year period prior to the filing of this Application. A letter certifying the above information is attached at ATTACHMENT 5.

11. An authorization letter granting access to the Review Board and IDPH to verify information regarding VHS is attached at ATTACHMENT 5.

12. VHS West Suburban Medical Center, Inc. is currently licensee and operator of WSMC. Copies of WSMC's general acute care hospital license and Joint Commission accreditation are attached at ATTACHMENT 5.

ATTACHMENT 5

Tenet

13. Tenet is the sole shareholder of Vanguard.

14. There have been no adverse actions taken against any facility owned or operated in Illinois by Tenet during the three (3) year period prior to the filing of this Application. A letter certifying the above information is attached at ATTACHMENT 5.

15. An authorization letter granting access to the Review Board and IDPH to verify information regarding Tenet is attached at ATTACHMENT 5.

16. The Applicants submit for informational purposes certain information in an Illinois Health Facilities and Services Review Board Application for Exemption Permit filed by Tenet, Gottlieb Community Health Services Corporation, Loyola University Health System, Trinity Health Corporation, and VHS of Illinois, Inc. in connection with the change of ownership of MacNeal Hospital, which application was filed on January 1, 2018. The information relates to adverse actions against Tenet affiliates located in South Carolina and Georgia, and is attached at ATTACHMENT 5.

NOTE: SRC and its affiliated entities have not previously owned or operated hospitals or other health care facilities in Illinois.

September , 2018

Ms. Courtney R. Avery
Administrator
Illinois Health Facilities & Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761-0001

Mr. Michael Constantino
Supervisor, Project Review Section
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761-0001

Re: Authorization to Access Information (VHS West Suburban Medical Center Certificate of Exemption).

Dear Ms. Avery and Mr. Constantino:

Pursuant to 77 Ill. Admin. Code §1110.230, I hereby authorize the Illinois Health Facilities & Services Review Board (the "Board") and the Illinois Department of Public Health ("IDPH") to access all information necessary to verify any documentation or information submitted by Pipeline – West Suburban Medical Center, LLC with this application. I further authorize the Board and IDPH to obtain any additional documentation or information which the Board or IDPH finds pertinent and necessary to process this application.

Sincerely,

_____
Nicholas Orzano
Chief Executive Officer

SUBSCRIBED AND SWORN
to before me this _____ day
of September, 2018

_____
Notary Public

August 29, 2018

Ms. Courtney R. Avery
Administrator
Illinois Health Facilities & Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761-0001

Mr. Michael Constantino
Supervisor, Project Review Section
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761-0001

Re: Authorization to Access Information (VHS West Suburban Medical Center Certificate of Exemption).

Dear Ms. Avery and Mr. Constantino:

Pursuant to 77 Ill. Admin. Code §1110.230, I hereby authorize the Illinois Health Facilities & Services Review Board (the "Board") and the Illinois Department of Public Health ("IDPH") to access all information necessary to verify any documentation or information submitted by Tenet Healthcare Corporation with this application. I further authorize the Board and IDPH to obtain any additional documentation or information which the Board or IDPH finds pertinent and necessary to process this application.

Sincerely,

Michael T. Maloney
Senior Vice President, Acquisitions & Development

SUBSCRIBED AND SWORN
to before me this 29 day
of August, 2018

Notary Public

GIGI ALDRETE
My Commission Expires
April 04, 2019

0047

August 29, 2018

Ms. Courtney R. Avery
Administrator
Illinois Health Facilities & Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761-0001

Mr. Michael Constantino
Supervisor, Project Review Section
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761-0001

Re: Authorization to Access Information (VHS West Suburban Medical Center Certificate of Exemption).

Dear Ms. Avery and Mr. Constantino:

Pursuant to 77 Ill. Admin. Code §1110.230, I hereby authorize the Illinois Health Facilities & Services Review Board (the "Board") and the Illinois Department of Public Health ("IDPH") to access all information necessary to verify any documentation or information submitted by VHS West Suburban Medical Center, Inc. with this application. I further authorize the Board and IDPH to obtain any additional documentation or information which the Board or IDPH finds pertinent and necessary to process this application.

Sincerely,

Michael T. Maloney
Vice President

SUBSCRIBED AND SWORN
to before me this 29 day
of August, 2018

Notary Public

GIGI ALDRETE
My Commission Expires
April 04, 2019

0048

August 29, 2018

Ms. Courtney R. Avery
Administrator
Illinois Health Facilities & Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761-0001

Mr. Michael Constantino
Supervisor, Project Review Section
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761-0001

Re: No Adverse Actions Certification (VHS West Suburban Medical Center Certificate of Exemption).

Dear Ms. Avery and Mr. Constantino:

I hereby certify, under the penalty of perjury as provided in §1-109 of the Illinois Code of Civil Procedure, 735 ILCS 5/1-109, and pursuant to 77 Ill. Admin. Code § § 1110.230 and 1130.520(b)(1)(B), that there have been no adverse actions taken against any Illinois facility owned or operated by VHS West Suburban Medical Center, Inc. during the three (3) years prior to the filing of this application for a Certificate of Exemption.

Sincerely,

Michael T. Maloney
Vice President

SUBSCRIBED AND SWORN
to before me this 29 day
of August, 2018

Notary Public

NOTARY PUBLIC STATE OF TEXAS
GIGI ALDRETE
My Commission Expires
April 04, 2019

0049

August 29, 2018

Ms. Courtney R. Avery
Administrator
Illinois Health Facilities & Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761-0001

Mr. Michael Constantino
Supervisor, Project Review Section
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761-0001

Re: No Adverse Actions Certification (VHS West Suburban Medical Center Certificate of Exemption).

Dear Ms. Avery and Mr. Constantino:

I hereby certify, under the penalty of perjury as provided in §1-109 of the Illinois Code of Civil Procedure, 735 ILCS 5/1-109, and pursuant to 77 Ill. Admin. Code § § 1110.230 and 1130.520(b)(1)(B), that there have been no adverse actions taken against any Illinois facility owned or operated by Tenet Healthcare Corporation during the three (3) years prior to the filing of this application for a Certificate of Exemption.

Sincerely,

Michael T. Maloney
Senior Vice President, Acquisitions & Development

SUBSCRIBED AND SWORN
to before me this 29 day
of August, 2018

Notary Public

NOTARY PUBLIC STATE OF TEXAS
GIGI ALDRETE
My Commission Expires
April 04, 2019

0050

tenet HEALTH

January 9, 2018

Ms. Courtney R. Avery
Administrator
Illinois Health Facilities & Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761-0001

Mr. Michael Constantino
Supervisor, Project Review Section
Illinois Health Facilities & Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761-0001

Re: No Adverse Actions Certification (MacNeal Hospital Certificate of Exemption)

Dear Ms. Avery and Mr. Constantino:

I hereby certify, under penalty of perjury as provided in § 1-109 of the Illinois Code of Civil Procedure, 735 ILCS 5/1-109, and pursuant to 77 Ill. Admin. Code §§ 1110.230 and 1130.520(b)(1)(B), as follows:

1. In or about September of 2016, Tenet Healthcare Corporation ("Tenet"), and certain of Tenet's affiliates located in South Carolina and Georgia, executed that certain Settlement Agreement with the United States Department of Justice (the "DOJ") and the Office of the Inspector General of the Department of Health and Human Services, pursuant to which Tenet, and certain of Tenet's affiliates located in South Carolina and Georgia, resolved certain civil and criminal allegations arising from certain operations at Atlanta Medical Center and North Fulton Medical Center in Georgia. A copy of the DOJ Press Release is attached.

2. There have been no adverse actions taken against any Illinois facility owned or operated by Tenet during the three (3) years prior to the filing of this Certificate of Exemption.

Sincerely,

By: _____

Its: Vice President

SUBSCRIBED AND SWORN
to before me this 9th day
of January, 2018.

_____
Notary Public

JENNIFER L COSSA
My Commission Expires
June 13, 2019

Tenet Healthcare
1445 Ross Avenue, Suite 1400, Dallas, Texas 75202-2703 T 469-893-2000 W tenethealth.com

JUSTICE NEWS

Department of Justice

Office of Public Affairs

FOR IMMEDIATE RELEASE

Monday, October 3, 2016

Hospital Chain Will Pay over $513 Million for Defrauding the United States and Making Illegal Payments in Exchange for Patient Referrals; Two Subsidiaries Agree to Plead Guilty

A major U.S. hospital chain, Tenet Healthcare Corporation, and two of its Atlanta-area subsidiaries will pay over $513 million to resolve criminal charges and civil claims relating to a scheme to defraud the United States and to pay kickbacks in exchange for patient referrals.

Principal Deputy Assistant Attorney General David Bitkower of the Justice Department's Criminal Division; U.S. Attorney John Horn of the Northern District of Georgia; Principal Deputy Assistant Attorney General Benjamin C. Mizer, head of the Justice Department's Civil Division; U.S. Attorney G.F. Peterman III of the Middle District of Georgia; Georgia Attorney General Samuel S. Olens; Acting Special Agent in Charge George Crouch of the FBI's Atlanta Field Office; and Special Agent in Charge Derrick L. Jackson of the U.S. Department of Health and Human Services-Office of Inspector General (HHS-OIG) in Atlanta made the announcement.

In addition, two Tenet subsidiaries, Atlanta Medical Center Inc. and North Fulton Medical Center Inc., have agreed to plead guilty to conspiracy to defraud the United States and to pay health care kickbacks and bribes in violation of the Anti-Kickback Statute (AKS). The plea agreements remain subject to acceptance by the court. Up until April 2016, Atlanta Medical Center Inc. and North Fulton Medical Center Inc. owned and operated acute-care hospitals located in the greater Atlanta metropolitan area.

Atlanta Medical Center Inc. and North Fulton Medical Center Inc. were charged in a criminal information filed today in federal court in Atlanta with conspiracy to defraud the United States by obstructing the lawful government functions of HHS and to violate the AKS, which, among other things, prohibits payments to induce the referral of patients for services paid for by federal health care programs. The two Tenet subsidiaries have agreed to plead guilty to the charges alleged in the criminal information and will forfeit over $145 million to the United States – which represents the amount paid to Atlanta Medical Center Inc. and North Fulton Medical Center Inc. by the Medicare and Georgia Medicaid programs for services provided to patients referred as part of the scheme.

Tenet HealthSystem Medical Inc. and its subsidiaries (collectively THSM) entered into a non-prosecution agreement (NPA) with the Criminal Division's Fraud Section and the U.S. Attorney's Office of the Northern District of Georgia related to the charges in the criminal information. THSM is the parent company of Atlanta Medical Center Inc., North Fulton Medical Center Inc., Spalding Regional Medical Center Inc. and Hilton Head Hospital, and employed their executives. THSM is a subsidiary of Tenet Healthcare Corporation. Under the terms of the NPA, THSM and Tenet will avoid prosecution if they, among other requirements, cooperate with the government's ongoing investigation and enhance their compliance and

as well as related guilty pleas by two of its Atlanta-based hospitals, Atlanta Medical Center Inc., and North Fulton Medical Center Inc., are a clear example of those efforts. In addition, the FBI's Major Provider Response Team (MPRT) assisted the Atlanta Field Office in the civil and criminal investigation of Tenet. The MPRT was created in 2011 in response to numerous healthcare related corporate-level schemes resulting in billions in losses to healthcare plans. The FBI, along with its MPRT, will continue to aggressively address the threat of large-scale corporate healthcare schemes significantly impacting both private and government healthcare benefit plans."

"OIG continues to emphasize investigation of improper financial relationships between health care providers," said Special Agent in Charge Jackson. "Using their positions of trust, health providers – after receiving payments from Tenet – sent expectant women specifically to Tenet hospitals. Patients were often directed to Tenet facilities miles and miles from their homes and on their journeys passed other hospitals that could have provided needed care. These women were thereby placed at increased risk during one of the most vulnerable points in their lives. HHS-OIG will continue to protect patients by exposing such illegal arrangements."

As alleged in the criminal information as well as civil complaints filed by the department and the state of Georgia in 2014 and 2013, Atlanta Medical Center Inc., North Fulton Medical Center Inc., Spalding Regional Medical Center Inc. and Hilton Head Hospital paid bribes and kickbacks to the owners and operators of prenatal care clinics serving primarily undocumented Hispanic women in return for the referral of those patients for labor and delivery medical services at Tenet hospitals. These kickbacks and bribes allegedly helped Tenet obtain more than $145 million in Medicaid and Medicare funds based on the resulting patient referrals.

According to the criminal information, as part of the scheme, expectant mothers were in some cases told at the prenatal care clinics that Medicaid would cover the costs associated with their childbirth and the care of their newborn only if they delivered at one of the Tenet hospitals, and in other cases were simply told that they were required to deliver at one of the Tenet hospitals, leaving them with the false belief that they could not select the hospital of their choice. The criminal information alleges that as a result of these false and misleading statements and representations, many expectant mothers traveled long distances from their homes to deliver at the Tenet hospitals, placing their health and safety, and that of their newborn babies, at risk.

The criminal information also charges Atlanta Medical Center Inc. and North Fulton Medical Center Inc. with conspiring to defraud HHS in its administration and oversight of the Medicare and Medicaid Programs, including HHS-OIG's enforcement of Tenet's September 2006 corporate integrity agreement (the CIA). The criminal information and the civil complaint allege that many of the unlawful payments happened while Tenet was under the CIA. The criminal information further alleges that certain executives of Atlanta Medical Center Inc., North Fulton Medical Center Inc. and others concealed these unlawful payments from HHS-OIG during the pendency of the CIA by, among other things, falsely certifying compliance with the requirements of the CIA and failing to disclose reportable events relating to the unlawful relationship under the CIA.

* * *

Deputy Chief Joseph S. Beemsterboer, Assistant Chief Robert A. Zink and Trial Attorneys Sally B. Molloy, Antonio M. Pozos and A. Brendan Stewart of the Criminal Division's Fraud Section and Chief Randy S. Chartash and Deputy Chief Stephen McClain of the Northern District of Georgia's Economic Crime Section represented the government in the criminal prosecution. The U.S. Attorney's Office of the Middle District of Georgia and the Civil Division's Commercial Litigation Branch represented the federal government in the

civil case. The HHS Office of Counsel to the Inspector General, the FBI and the Georgia and South Carolina Medicaid Fraud Control Units provided assistance in this matter.

The FBI's Atlanta Field Office, HHS-OIG and the FBI Healthcare Fraud Unit MPRT investigated the case.

This settlement illustrates the government's emphasis on combating health care fraud and marks another achievement for the Health Care Fraud Prevention and Enforcement Action Team (HEAT) initiative, which was announced in May 2009 by the Attorney General and the Secretary of HHS. The partnership between the two departments has focused efforts to reduce and prevent Medicare and Medicaid financial fraud through enhanced cooperation. One of the most powerful tools in this effort is the False Claims Act. Since January 2009, the Justice Department has recovered a total of more than $30.9 billion through False Claims Act cases, with more than $18.6 billion of that amount recovered in cases involving fraud against federal health care programs.

If you believe you are a victim of this offense, please visit this website or call (888) 549-3945.

Attachment(s):
Download Tenet Civil Settlement Agreement
Download Tenet NPA and Attachments
Download Criminal Information for Atlanta Medical Center Inc. and North Fulton Medical Center Inc.

Topic(s):
False Claims Act
Health Care Fraud

Component(s):
Civil Division
Criminal Division
Criminal - Criminal Fraud Section
USAO - Georgia, Middle
USAO - Georgia, Southern

Press Release Number:
16-1144

Updated April 27, 2017

August 21 2018

Ms. Courtney R. Avery
Administrator
Illinois Health Facilities & Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761-0001

Mr. Michael Constantino
Supervisor, Project Review Section
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761-0001

Re: Authorization to Access Information (VHS West Suburban Medical Center Certificate of Exemption).

Dear Ms. Avery and Mr. Constantino:

Pursuant to 77 Ill. Admin. Code §1110.230, I hereby authorize the Illinois Health Facilities & Services Review Board (the "Board") and the Illinois Department of Public Health ("IDPH") to access all information necessary to verify any documentation or information submitted by SRC Hospital Investments II, LLC with this application. I further authorize the Board and IDPH to obtain any additional documentation or information which the Board or IDPH finds pertinent and necessary to process this application.

Sincerely,

Nicholas Orzano
Chief Executive Officer

SUBSCRIBED AND SWORN
to before me this 21 day
of August, 2018.

Please Attached

Notary Public

0056

CALIFORNIA JURAT CERTIFICATE

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California

County of Los Angeles

Subscribed and sworn to (or affirmed) before me on this 28th day of August 20 18, by Nicholas Orzano

proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

WITNESS MY HAND AND OFFICIAL SEAL.

Signature of Notary Public

MIN YOUNG PARK
Commission No. 2092038
NOTARY PUBLIC-CALIFORNIA
LOS ANGELES COUNTY
My Comm. Expires DECEMBER 30, 2018

(Notary Seal)

OPTIONAL INFORMATION

The jurat contained within this document is in accordance with California law. Any affidavit subscribed and sworn to before a notary shall use the preceding wording or substantially similar wording pursuant to Civil Code sections 1189 and 8202. ***A jurat certificate cannot be affixed to a document sent by mail or otherwise delivered to a notary public, including electronic means, whereby the signer did not personally appear before the notary public, even if the signer is known by the notary public. The seal and signature cannot be affixed to a document without the correct notarial wording. As an additional option an affiant can produce an affidavit on the same document as the notarial certificate wording to eliminate the use of additional documentation.***

DESCRIPTION OF ATTACHED DOCUMENT

Authorization to Access Information
(Title of document)

Number of Pages 1 (Including jurat)

Document Date August 28, 2018

VHS West Suburban Medical Center Certificate of Exemption
(Additional Information)

CAPACITY CLAIMED BY SIGNER

- [X] Individual
- [ ] Corporate Officer
- [ ] Partner
- [ ] Attorney-In-Fact
- [ ] Trustee
- [ ] Other: _____

63-4

Section III

Attachment 6

Criterion 1130.520 Requirements for Exemptions Involving the Change of Ownership of a Health Care Facility

Criterion 1130.520(b)(1)(A), Name of the Parties

1. See Criterion 1110.230(a), Background of the Applicants, in support of this Criterion.

Criterion 1130.520(b)(1)(B), Background of the Applicants

1. See Criterion 1110.230(a), Background of the Applicants, in support of this Criterion.

Criterion 1130.520(b)(1)(C), Structure of the Transaction

1. WSMC OpCo and WSMC PropCo are acquiring the real estate, buildings, and assets comprising WSMC pursuant to the Purchase Agreement.

2. Under the terms of the Purchase Agreement, SRC will be acquiring Weiss Hospital, Westlake, WSMC, and certain assets used in connection with the operation of the hospitals for Seventy Million Dollars ($70,000,000.00), subject to adjustments for working capital and capital expenditures (the "Purchase Price"). The Purchase Price paid to Tenet will be funded with cash by SRC.

Criterion 1130.520(b)(1)(D), Licensing Party

1. WSMC OpCo will be the licensee of WSMC following the Closing. Pipeline Illinois will provide certain management and administrative services to the Hospital. Pipeline Illinois will be eighty percent (80%) owned and controlled by Pipeline Healthcare Management, LLC ("Pipeline"). Pipeline has experience managing academic medical centers and community hospitals in California, Texas, Nevada, and New Mexico, including management and operation of the largest emergency room management company on the West Coast. Pipeline's experience also includes management of (i) a network of urgent care clinics, (ii) the nation's largest telemedicine platform, and (iii) a hospitalist staffing company. Weiss PropCo will have no role in operations or care delivery at Weiss Hospital. TWG Partners, LLC ("TWG") will own the remaining twenty percent (20%) of Pipeline Illinois. TWG brings to Pipeline Illinois experience in founding and developing a range of health care companies in the areas of health care technology, Medicaid-managed care, and Medicare Part D insurance operating in Illinois and other numerous other States, and a local understanding of the Chicago-area health care market and clinical operations, as well as Illinois policy, which will complement Pipeline's national health system management experience.

Criterion 1130.520(b)(1)(E), List of Ownership Interests in the Licensed Party

1. VHS is currently the owner, licensee, and operator of WSMC. VHS currently owns the land, buildings, and other real estate comprising the campus of WSMC.

2. Following the Transaction, WSMC OpCo will be the licensee and operator of WSMC.

3. Following the Transaction, (i) WSMC PropCo will own the land and other real estate comprising the campus of WSMC, and (ii) WSMC OpCo will own all of the buildings and operating assets comprising of WSMC.

Criterion 1130.520(b)(1)(F), Fair Market Value of Assets Being Transferred

1. Under the terms of the Purchase Agreement, (i) WSMC PropCo and WSMC OpCo, will be acquiring the real estate, buildings, and assets associated with WSMC, (ii) Westlake Property Holdings, LLC and Pipeline-Westlake Hospital, LLC will be acquiring the real estate, buildings, and assets associated with Westlake, and (iii) Weiss Hospital Property Holdings, LLC and Pipeline-Weiss Memorial Hospital, LLC will be acquiring the assets and real estate associated with Weiss Hospital, for Seventy Million Dollars ($70,000,000.00), subject to adjustments for working capital and capital expenditures (the "Purchase Price").

2. The Purchase Price was negotiated at arms-length and represents fair market value.

Criterion 1130.520(b)(1)(G), Purchase Price of the Assets Being Transferred

1. Under the terms of the Purchase Agreement, (i) WSMC PropCo and WSMC OpCo, will be acquiring the real estate, buildings, and assets associated with WSMC, (ii) Westlake Property Holdings, LLC and Pipeline-Westlake Hospital, LLC will be acquiring the real estate, buildings, and assets associated with Westlake, and (iii) Weiss Hospital Property Holdings, LLC and Pipeline-Weiss Memorial Hospital, LLC will be acquiring the real estate, buildings, and assets associated with Weiss Hospital, for Seventy Million Dollars ($70,000,000.00), subject to adjustments for working capital and capital expenditures (the "Purchase Price").

Criterion 1130.520(b)(2), Completion of Pending CONs

1. There are no pending Certificates of Need or Certificates of Exemption for SRC, WSMC OpCo, WSMC PropCo, VHS, VHF, Vanguard, or Tenet

Criterion 1130.520(b)(3), Charity Care Policies

1. The current charity care policies for WSMC are attached at ATTACHMENT 7.

2. Following the Transaction, SRC will be adopting a Charity Care Policy at WSMC, copies of which are attached at ATTACHMENT 7 (the "SRC Charity Care Policy").

3. The SRC Charity Care Policy is not more restrictive than the current charity care policies at WSMC.

4. The SRC Charity Care Policy will remain in place for no less than two (2) years following the consummation of the Transaction. See ATTACHMENT 7.

Criterion 1130.520(b)(4), Benefits to the Community

1. Following the Transaction, WSMC will continue to operate for the benefit of the residents of Chicago and the greater Chicago area, including serving poor and underserved individuals through WSMC's charitable activities.

Criterion 1130.520(b)(5), Cost Savings

1. At this time, it is not possible to predict with specificity the cost savings that will be realized.

Criterion 1130.520(b)(6), Quality Improvement

1. Following the Transaction, SRC will have an extensive quality improvement program in place for WSMC, to be overseen by the local WSMC Governing Board and administered by Pipeline Illinois.

Criterion 1130.520(b)(7), Governing Body

1. Following the Transaction, WSMC will be governed by the WSMC Local Governing Board (subject to the reserve powers of SRC as sole member). The current local WSMC Governing Board will be elected to the WSMC Governing Board (and certain members of the current WSMC Governing Board will exit from the WSMC Governing Board).

Criterion 1130.520(b)(8), Section 1110.240 Written Response

1. The review criteria set forth in 77 Ill. Admin. Code §1110.240 have been addressed, a copy of which is available for public review at WSMC.

Criterion 1130.520(b)(9), Scope of Service Changes or Charity Care Changes

1. The Transaction set forth in this COE will result in no changes to the scope of services offered at WSMC.

2. Following the Transaction, SRC will be implementing a Charity Care Policy at WSMC.

3. The SRC Charity Care will not be more restrictive than the current Charity Care Policy of WSMC, and will remain in effect for at least two (2) years after the Transaction.

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PAGE: 1 of 10	**REPLACES POLICY DATED:**
APPROVED: June 1, 2004	**RETIRED:**
EFFECTIVE DATE: July 1, 2004	**REFERENCE NUMBER:** 11-0801

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 7

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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

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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.

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

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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

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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.

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.

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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 whose 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.

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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 - $1,000	Director
$1,001 - $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 for previous twelve months services (with outstanding balances) can be considered as part of the current request for financial assistance.**

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.

9. **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.

10. **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.

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

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

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."

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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.

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10. **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 69 Federal Register 7336 (February 13, 2004.)

FINANCIAL ASSISTANCE ELIGIBILITY GUIDELINES

Based on Federal Poverty Guidelines Effective February 13, 2004

Schedule A (shaded)
Financially Indigent

Schedule B (unshaded)
Medically Indigent

Number In Household	100%	200%	300%	400%	500%
1	9,310	18,620	27,930	37,240	46,550
2	12,490	24,980	37,470	49,960	62,450
3	15,670	31,340	47,010	62,680	78,350
4	18,850	37,700	56,550	75,400	94,250
5	22,030	44,060	66,090	88,120	110,150
6	25,210	50,420	75,630	100,840	126,050
7	28,390	56,780	85,170	113,560	141,950
8	31,570	63,140	94,710	126,280	157,850
Discount	100%		80%	60%	40%
Financially Indigent Classification					

Schedule C

Catastrophic Eligibility as Medically Indigent -

Only applicable if patients income exceeds 500% of 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%

[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* — $_____ *Discount Amount* — $_____ *Remaining Balance Due After Discount*

Employee Name (Print)_____

Employee Signature_____ Approved By _____

Date_____ Approved By _____

Approved By_____

$1 - $1,000	Director
$1,001 - $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		

6/2004

ATTACHMENT 7

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.

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GRNTOR #: _____

HOSP CODE: _____

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 Provedor De Sereisios 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

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ATTACHMENT 7

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/Cuenta 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 Nacimento	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:

AFFIDAVIT/DECLARACION JURADA

6/2004

I declare under penalty of perjury that the answers I have given are true and correct to the best of my knowledge. I agree to tell the provider of service within ten (10) days if there are any changes in my (or the persons on whose behalf I am acting) income, property, expenses or in the persons household or any change	Declaro bajo pena de perjurio que las respuestas que he dado son verdaderas y correctas al mejor de mi conocimiento. Acuerdo decirle al abastecedor del servicio en el plazo de diez dias si hay algunos cambios en mi (o personas en el favor que yo este actuando) renta, propiedad, gastos o en la casa de las personas o

ATTACHMENT 7

Women, Infants, and Children (WIC): provides federal grants to states for supplemental foods, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to age five who are found to be at nutritional risk.

IV. POLICY

It is Conifer RCS policy that:

A. The determination of charity care generally should be made at the time of admission, or shortly thereafter; however, events after discharge could change the patient's ability to pay.

B. Designation as charity care will only be considered after all payment sources have been exhausted.

C. The co-pay amount will be pursued for all charity accounts with the exception of deceased and homeless patients with no other guarantor.

D. Patient account transactions for charity care must be posted in the month the determination is made.

E. The flat rate co-pay amount is based on patient type: Emergency department patients and outpatients are required to pay $100 flat rate, and inpatients are required to pay $200 per day, with a $2,000 cap.

F. If the account has been assigned as bad debt as part of the monthly journal entry, it will reverse the Patient Access recovery that was given on an account determined to be charity care.

G. Employees of Conifer RCS should never indicate or suggest to the patient that he/she will be relieved of the debt by way of a write-off to charity care until the determination has been made.

H. Conifer RCS and the client facility reserve the right to limit or deny financial assistance at their sole discretion.

V. PROCEDURE

A. MECS Procedure

1. The MECS patient financial counselor should screen patients for potential linkage to government/county programs. During the screening process, the patient advocate should secure a Financial Assistance Application. Use the application for potential charity care determination only if MECS is unable to obtain eligibility for the patient for government programs reimbursement. For potential linkage to government/ county programs, the patient advocate will:

a. Change the financial class and assign the account to MECS within five days from date of discharge, thereby netting the account to expected governmental reimbursement.

b. Make a final determination as to whether linkage will prevail within an additional 25 days from the assignment date, totaling no more than 30 days from date of discharge.

c. Return the account to the client facility for assignment as Self-Pay if it is determined that program linkage will not prevail within the additional 25 days from assignment date, and there are no other payment or third-party payment sources. Those meeting the financial guidelines for charity care will be assigned by the client facility with the appropriate financial class. The co-pay should be collected by the client facility's financial counselor or business office representative.

2. If, during the initial interview with the patient, it is revealed that there is no viable source of payment, and the patient will not qualify for any governmental programs, the patient advocate will:

a. Offer the patient a Financial Assistance Application.

b. Assist the patient in completing a Financial Assistance Application, which will document the patient's financial need.

c. Obtain the patient's signature on the Financial Assistance Application and forward the application to the financial counselor, as deemed appropriate.

d. Refer the patient to the client facility financial counselor for collection of the co-pay.

B. MECS Processing For Charity Care

1. For those accounts that remain in MECS past 30 days from assignment with no government program linkage, and that meet the financial criteria for charity care, MECS should have gathered all substantial information to enable the client facility to effect its charity care policy. Included in the charity care packet is a Financial Assistance Application. If the MECS representative has exhausted all efforts to secure all necessary verifications, submit the application for charity care to the financial counselor for review and finalization without the verifications.

a. MECS is required to notify the client facility of the inability to obtain eligibility, or the potential qualification for charity care classification, and to return the account to the client facility.

b. The client facility is required to update the plan ID and financial class.

C. Financial Counselor Procedure (client specific):

1. Patients whom a financial counselor finds to have no third-party coverage and/or benefits available will:

   a. Be offered the client facility flat rate or Prompt Pay Discount Program where allowed by state law/regulation.

   b. Be assessed for charity care if the patient is unable to pay the client facility flat rate or Prompt Pay Discount Program amount (as applicable to state law/regulation), and meets the income/asset and other guidelines set forth by the client facility's charity care policy.

2. The financial counselor will take the appropriate steps as outlined below:

   a. For patients who appear to meet the income guidelines set forth in this policy for charity care, the account should be updated with the financial class of charity on the client facility system, at which time a one hundred percent (100%) charity care reserve should be taken, and the co-pay amount should be collected.

   b. Patients who do not qualify for charity care should be treated as a self-pay, and standard accounts receivable collection procedures will apply.

D. Documentation

1. Financial Assistance Application

   a. To qualify for charity care, Conifer RCS requests each patient or family to complete the Financial Assistance Application. This application allows the collection of information about income and the documentation of other requirements as defined below. Pending the completion of the application, the patient should be treated as a charity care patient in accordance with the client facility's charity care policy. The patient's account will have the financial class changed to charity care on the client facility's system.

   b. In cases where the patient is unable to complete the written application, verbal attestation is acceptable if state law/regulation allows it.

   c. A Financial Assistance Application completed by the patient may not be required for patients who are deemed to be already eligible for other federal, state, and county assistance programs. Such programs include, but are not limited to, Medicaid, county assistance programs, MIA, MSI, AFDC, food stamps, and WIC.

i. Family members – Conifer RCS will require patients to provide the number of family members in their household.

a. Adults – To calculate the number of family members in an adult patient's household, include the patient, the patient's spouse and/or legal guardian, and all of their dependents.

b. Minors – To calculate the number of family members in a minor patient's household, include the patient, the patient's mother/father and/or legal guardian, and all of their other dependents.

ii. Income calculation - Conifer RCS requires patients to provide their household's yearly gross income.

a. Adults – The term "yearly income" on the application means the sum of the total yearly gross income of the patient and the patient's spouse.

b. Minors – If the patient is a minor, the term "yearly income" means the income from the patient, the patient's mother/father and/or legal guardian, and all of their other dependents.

iii. Expired patients – Expired patients may be deemed to have no income for purposes of the Conifer RCS calculation of income. Although no documentation of income and no Financial Assistance Application are required for expired patients, the patient's financial status will be reviewed at the time of death by the financial counselor to ensure that a charity care adjustment is appropriate. The co-pay will be waived if no other guarantor appears on the patient account.

iv. Homeless patients – Patients may be deemed homeless once the financial counselor has exhausted verification processes. The co-pay will be waived if no other guarantor appears on the patient account.

2. Income Verification

a. Conifer RCS requests patients to attest to the income set forth in the application. In determining a patient's total income, Conifer RCS may consider other financial assets and liabilities of the patient, as well as the patient's family income, when assessing the ability to pay. If a determination is made that the patient has the ability to pay the bill, such determination does not preclude a reassessment of the patient's ability to pay upon presentation of additional documentation. Any of the following documents are appropriate for substantiating the need for charity care:

i. Income Documentation – Income documentation may include IRS W-2 form, wage and earnings statement, paycheck stub, tax returns, telephone

verification by employer of the patient's income, signed attestation to income, bank statements, or verbal verification from patient.

ii. Participation in a Public Benefit Program – Public benefit program documentation showing current participation in programs, such as social security, workers' compensation, unemployment insurance, Medicaid, county assistance programs, AFDC, food stamps, WIC, or other similar indigence-related programs.

iii. Assets – All liquid assets should be considered as a possible source of payment for services rendered. For patients with no source of regular income (employment, SSI, disability, etc.) other than liquid assets, those assets would be the patient's income source and should be measured against the FPG.

3. Information Falsification

Information falsification will result in denial of the charity care application. If, after a patient is granted financial assistance, the client facility finds material provision(s) of the application to be untrue, charity care status may be revoked, and the patient's account will follow the normal collection processes.

4. Revenue Classification

Critical changes in account class are defined as:

a. Any account originally assigned to the financial counselors self-pay that is re-classed as a result of meeting the criteria for charity care; or

b. Any account originally assigned to the financial counselor as charity that is re-classed to self-pay as a result of denying charity care.

E. Denied Charity Care Recommendations

1. If the client facility chief financial officer (CFO) denies a patient's application for charity care, place documentation in the client facility collection system as to the reason for the rejection of the recommendation.

2. The client facility CFO is also to indicate on the Financial Assistance Application the reason for denial and the date of the denial. The packet is then to be sent to the financial counselor for review.

3. After an initial review and discussion with the client facility CFO, for those patient accounts where disagreement persists, and the accounts that meet Conifer RCS guidelines for charity care as set forth here, a denial summary will be sent to the respective client regional vice president of finance by the financial counselor for resolution.

a. For those patient accounts that the client regional vice president of finance has denied to have met the client facility charity care guidelines as set forth here, a denial summary will be sent to the respective client divisional senior vice president of finance for conference and resolution.

F. Reservation of Rights

1. Non-covered services – Conifer RCS and its client facilities reserve the right to designate certain services that are not subject to the client facilities' charity care policies.

2. No Effect on other regions/client facility policies – This policy shall not alter or modify other Conifer RCS policies regarding efforts to obtain payments from third-party payers, patient transfers, emergency care, state-specific regulations, state-specific requirements for statutory charity care classification, or programs for uncompensated care.

VI. ENFORCEMENT

All employees whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance management may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.

August 29 2018

Ms. Courtney R. Avery
Administrator
Illinois Health Facilities & Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761-0001

Mr. Michael Constantino
Supervisor, Project Review Section
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761-0001

Re: Charity Care Certification (VHS West Suburban Medical Center Certificate of Exemption).

Dear Ms. Avery and Mr. Constantino:

I hereby certify, under the penalty of perjury as provided in §1-109 of the Illinois Code of Civil Procedure, 735 ILCS 5/1-109, and pursuant to 77 Ill. Admin. Code § § 1110.230 and 1130.520(b)(1)(B), that Pipeline-West Suburban Medical Center, LLC ("WSMC OpCo") (i) intends to adopt the charity care policy attached hereto at ATTACHMENT 7 (the "WSMC Care Policy") following the acquisition of VHS West Suburban Medical Center by WSMC OpCo and West Suburban Property Holdings, LLC; and (ii) WSMC OpCo shall maintain the WSMC Care Policy for no less than two (2) years thereafter.

Sincerely,

Nicholas Orzano
Chief Executive Officer

SUBSCRIBED AND SWORN
to before me this 29th day
of August, 2018

Please see attached

Notary Public

0086

CALIFORNIA JURAT CERTIFICATE

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California

County of Los Angeles

Subscribed and sworn to (or affirmed) before me on this 28th day of August 20 18 , by Nicholas Orzano

proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

WITNESS MY HAND AND OFFICIAL SEAL.

MIN YOUNG PARK
Commission No. 2092038
NOTARY PUBLIC-CALIFORNIA
LOS ANGELES COUNTY
My Comm. Expires DECEMBER 30, 2018

Signature of Notary Public

(Notary Seal)

OPTIONAL INFORMATION

The jurat contained within this document is in accordance with California law. Any affidavit subscribed and sworn to before a notary shall use the preceding wording or substantially similar wording pursuant to Civil Code sections 1189 and 8202. ***A jurat certificate cannot be affixed to a document sent by mail or otherwise delivered to a notary public, including electronic means, whereby the signer did not personally appear before the notary public, even if the signer is known by the notary public. The seal and signature cannot be affixed to a document without the correct notarial wording. As an additional option an affiant can produce an affidavit on the same document as the notarial certificate wording to eliminate the use of additional documentation.***

DESCRIPTION OF ATTACHED DOCUMENT

Charity Care Certificaiton
(Title of document)

Number of Pages 1 (Including jurat)

Document Date August 28, 2018

VHS West Suburban Medical Center Certificate of Exemption
(Additional Information)

CAPACITY CLAIMED BY SIGNER

X Individual
____ Corporate Officer
____ Partner
____ Attorney-In-Fact
____ Trustee
____ Other: ____

63-3

SRC HOSPITAL INVESTMENTS II, LLC

Charity Care, Financial Assistance and Billing & Collection Policies for Uninsured Patients

SCOPE:

This Charity Care, Financial Assistance and Billing & Collection Policies for Uninsured Patients (the "Policy") shall apply to Louis A. Weiss Memorial Hospital, VHS West Suburban Medical Center, and VHS Westlake Hospital (each, a "Hospital," and collectively, the "Hospitals").

PURPOSE:

This Policy is established to provide the operational guidelines for the Hospitals to (i) identify Uninsured Patients who are Financially Indigent or Medically Indigent that may qualify for charity care (free care) or financial assistance, (ii) process Patient applications for charity care or financial assistance and (iii) bill and collect from Uninsured Patients, including those who qualify as Financially Indigent or Medically Indigent under this Policy.

DEFINITIONS:

The following definitions shall apply to this Policy:

1. **Family Income**: the sum of a family's annual earnings and cash benefits from all sources before taxes, less payments made for child support.

2. **Federal Poverty Income Guidelines**: the federal poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human services under authority 42 U.S.C. 9902(2).

3. **Financially Indigent**: a person who qualifies for financial assistance under Section A.6 of this Policy.

4. **Guarantor**: a Patient's spouse or Partner and if the Patient is a minor, the Patient's parents or guardians.

5. **Health Care Services**: any Medically Necessary inpatient or outpatient Hospital service, including pharmaceuticals or supplies.

6. **IHUPDA**: the Illinois Hospital Uninsured Patient Discount Act, as may be amended from time to time.

7. **Medically Indigent**: a person who qualifies for financial assistance under Section A.7 of this Policy.

8. **Illinois Fair Patient Billing Act**: the Illinois Fair Patient Billing Act and implementing regulations, as may be amended from time to time.

9. **Medically Necessary**: means any inpatient or outpatient Hospital service, including pharmaceuticals or supplies provided by the Hospital to a Patient, covered under Title XVIII of the federal Social Security Act for beneficiaries with the same clinical presentation as the Uninsured Patient. A medically necessary service does not include any of the following: (i) non-medical services such as social and vocational services, or (ii) elective cosmetic surgery, but not plastic surgery designed to correct disfigurement caused by injury, illness, or congenital defect or deformity.

10. **Partner**: a person who has established a civil union pursuant to the Illinois Religious Freedom Protection and Civil Union Act or similar state law.

11. **Patient**: the individual receiving services from a Hospital or any individual who is a Guarantor of the payment for services received from a Hospital.

12. **Qualifying Individual**: an individual qualifying for a charitable discount under this Policy, including a Medically Indigent or Financially Indigent person.

13. **Uninsured Patient**: an Illinois resident who is a Patient of a Hospital and is not covered under a policy of health insurance and is not a beneficiary under a public or private health insurance, health benefit, or other health coverage program, including high deductible health insurance plans, workers' compensation, accident liability insurance, or other third party liability. In order to be considered an Illinois resident, a person must live in the State of Illinois and intend to remain living within Illinois indefinitely; relocating to Illinois solely for the purpose of receiving health care benefits does not satisfy the residency requirement.

CHARITY CARE AND FINANCIAL ASSISTANCE POLICIES:

1. **Charity Care or Financial Assistance**. The Hospitals shall provide charity care (free care) or financial assistance to Uninsured Patients for their Medically Necessary Health Care Services to the extent they qualify for such financial assistance as set forth below. Charity care or financial assistance does not apply to any non-Hospital services, including, but not limited to, physician services.

2. **Assistance Under IHUPDA**:

a. The Hospitals shall provide a charitable discount of 100% of its charges for all Medically Necessary Health Care Services exceeding $300 in any one inpatient admission or outpatient encounter to any Uninsured Patient who applies for a discount and has Family Income of not more than 200% of the Federal Poverty Income Guidelines.

b. The Hospitals shall provide a charitable discount of 135% of the Hospital's Cost to Charge Ratio (determined from its most recently filed Medicare cost) report times the applicable charges, to any Uninsured Patient who applies for a discount and has Family Income between 201% and 600% of the Federal Poverty Income Guidelines for all Medically Necessary Health Care Services exceeding $300 in any one inpatient admission or outpatient encounter.

3. **Presumptive Eligibility**. In accordance with the Illinois Fair Patient Billing Act, the Hospitals shall apply the presumptive eligibility criteria set forth in Section A.8 of this Policy, in order to deem an Uninsured Patient eligible for Hospital financial assistance without further scrutiny by the Hospital. These presumptive eligibility criteria shall be applied to an Uninsured Patient as soon as possible after receipt of Health Care Services by the Patient and prior to the issuance of any bill for those Health Care Services by the Hospital.

4. **Medical Indigence**. The Hospitals shall provide charity care to certain Uninsured Patients who have Hospital bills exceeding a specified percentage of Patient income or Family Income, as set forth in Section A.7 of this Policy.

5. **Billing and Collection Processes for Uninsured Patients**. All Uninsured Patients receiving care at the Hospitals will be treated with respect and in a professional manner before, during and after receiving care. Each of the Hospitals will adopt a written policy in conformity with the Policy set forth herein for its billing and collection practices in respect of all Uninsured Patients, including those Uninsured Patients who qualify for classification as a Qualified Individual under this Policy.

ATTACHMENT 7

PROCEDURE:

A. CHARITY CARE AND FINANCIAL ASSISTANCE PROCESS

1. **Application.** Each Hospital will request that each Patient applying for charity care financial assistance complete a Financial Assistance Application Form that conforms to the Illinois Fair Patient Billing Act (the "Assistance Application"). An example of the Assistance Application is attached hereto as Exhibit A. 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.

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

ii. *Minors.* For persons under the age of 18 (the "Minor Patient"). In calculating the number of people in the Minor Patient's household, the Hospital will include the Minor Patient, the Minor Patient's mother, dependents of the Minor Patient's mother, the Minor Patient's father, and dependents of the Minor Patient's father.

b. **Calculation of Income.**

i. *Adults.* For adults, determine the Family Income. The Hospital may consider other financial assets of the Patient and the Patient's family and the Patient's or the Patient's family's ability to pay.

2. **Income Verification.** The Hospital shall request that the Patient verify Family Income and provide the documentation requested as set forth in the Assistance Application.

a. **Documentation Verifying Income.** Family Income may be verified through any of the following mechanisms:

i. Tax Returns (for year prior to date of admission);

ii. IRS Form W-2;

iii. Wage and Earnings Statement;

iv. Pay Check Remittance;

v. Social Security;

vi. Worker's Compensation or Unemployment Compensation Determination Letters;

vii. Qualification within the preceding six (6) months for governmental assistance program (including food stamps, CDIC, Medicaid and AFDC);

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

3. **Information Falsification**. Falsification of information may result in denial of the Assistance Application. If, after a Patient is granted financial assistance as a Qualifying Individual, and the 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 documentation is not provided, the Hospital will contact the Patient and request additional information. If the Patient does not comply with the request within thirty (30) 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 the 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:

a. Medicaid accounts-Exhausted Days/Benefits;

b. Medicaid spend down accounts;

c. Medicaid or Medicare Dental denials; and

d. Medicare Replacement accounts with Medicaid as secondary-where Medicare Replacement plan left Patient with responsibility.

6. **Classification as Financially Indigent**. The Hospital shall classify as "Financially Indigent" any Uninsured Patient who qualifies for assistance under IHUPDA as set forth above in CHARITY CARE AND FINANCIAL ASSISTANCE Policy #2.

7. **Classification as Medically Indigent**. The Hospital may classify as "Medically Indigent" any Uninsured Patient whose hospital bills exceed a specified percentage of the person's Family Income, and who is unable to pay the remaining bill. In the event a Patient is Medically Indigent, the Hospital will not collect additional amounts from the Patient for Health Care Services, to the extent set forth below.

a. **Medical Indigence Under the IHUDPA**. The Hospital shall accept a Patient as Medically Indigent when he or she meets the acceptance criteria set forth below:

i. The Patient is Financially Indigent; and

ii. The Patient's bill, in any twelve (12) month period, is greater than 25% of the Patient's Family Income, calculated in accordance with the Hospital's income verification procedures. The twelve (12) month period to which the maximum amount applies shall begin on the first date an Uninsured Patient receives Health Care Services that qualify for financial assistance under IHUDPA. To be eligible to have this maximum amount applied to subsequent charges, the Uninsured Patient shall inform the Hospital in subsequent inpatient admissions or outpatient encounters that the Patient has previously received Health Care Services from that Hospital and was determined to qualify for financial assistance under IHUDPA.

iii. **Other Medical Indigence**. The Hospital, in its sole discretion, also may deem an Uninsured Patient to be Medically Indigent if the Patient's bill is greater than 50% of the Patient's income calculated in accordance with Hospital income verification procedures and the Patient is not otherwise Financially Indigent.

8. **Presumptive Eligibility**.

a. Uninsured Patients demonstrating one (1) or more of the following shall be deemed presumptively eligible for hospital financial assistance, pursuant to the Illinois Fair Patient Billing Act:

i. Homelessness;

ii. Deceased with no estate;

iii. Mental incapacitation with no one to act on Patient's behalf;

iv. Medicaid eligibility, but not on date of service or for non-covered service;

v. Enrollment in the following assistance programs for low-income individuals having eligibility criteria at or below 200% of the Federal Poverty Income Guidelines;

- Women, Infants and Children Nutrition Program (WIC);
- Supplemental Nutrition Assistance Program (SNAP);
- Illinois Free Lunch and Breakfast Program;
- Low Income Home Energy Assistance Program (LIHEAP);
- Enrollment in an organized community-based program providing access to medical care that assesses and documents limited low-income financial status as a criterion for membership;
- Receipt of grant assistance for medical services.

b. The Hospital also may deem presumptively eligible for Hospital financial assistance those Patients listed above in Section A.5 of this Policy.

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

$1 - $1,000	Director
$1,001 - $50,000	Director and CFO
$50,001 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

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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 the application is approved, approval for previous twelve months services (with outstanding balances) can be considered as part of the current request for financial assistance.***

10. **Denial for Financial Assistance**. If the Hospital determines that the Patient is not Financially Indigent or Medically Indigent under this policy, it shall notify the Patient of this denial in writing.

11. **Document Retention Procedures**. The Hospital will maintain documentation sufficient to identify for each Patient qualified as Financially Indigent or Medically Indigent, the Patient's Family 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 one calendar year. After which, the documents will be boxed and marked as: "FINANCIAL ASSISTANCE DOCUMENTATION, JANUARY YYYY-DECEMBER YYYY" and forwarded to the Hospital storage facility, where it will then be retained for an additional six (6) years before shredding.

12. **Reservation of Rights**. It is the policy of the Hospitals to reserve the right to limit or deny financial assistance at the sole discretion of each, subject to applicable law.

13. **Non-covered Services**. Services not defined as Medically Necessary 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 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 Hospital. The 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 shall include (a) the date or dates that health care services were provided to the Patient; (b) an itemized list of services and charges; (c) the total amount owed for hospital services; (d) hospital contact information for addressing billing inquiries; and (e) a prominent statement regarding how an Uninsured Patient may apply for consideration under the hospital's financial assistance policy on or with each hospital bill sent to an Uninsured Patient. The bill shall also include (a) a statement on the bill or in an enclosure to the bill that indicates that if the Patient meets certain Family 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 or financial assistance from the Hospital. For further information, please contact our customer service department at (XXX) XXX-XXXX."

4. **Notices**. Each of the Hospitals should post notices regarding the availability of financial assistance to Uninsured Patients in English and in any other language that is the primary language of at least 5% of Patients. These notices should be posted in conspicuous 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.: "You may be eligible for financial assistance under the terms and conditions the hospital offers to qualified patients. For more information, please call or ask to see our Financial Counselor or call (XXX) XXX- XXXX (M-F 8:30 am to 4:30 pm)." In addition, this notice, along with a brochure in plain language summarizing the financial assistance process substantially in the form of Exhibit B to this Policy, and a Financial Assistance Application substantially in the form of Exhibit A to this Policy, shall be posted in a prominent place on each Hospital's website.

5. **Liens on Primary Residences**. The 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 Family Income in excess of 600% of the Federal Poverty Guidelines, the Hospitals may place liens on primary residences as a means of collecting discounted hospital bills, but the Hospitals may not pursue foreclosure actions in respect of such liens.

6. **Garnishments**. The 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 Family Income or assets to pay his discounted bill.

7. **Collection Actions Against Uninsured Patients**. Each of the Hospitals should have written policies outlining when and under whose authority an unpaid balance of any Uninsured Patient is advanced to collection, and the Hospitals should use their best efforts to ensure that Patient accounts for all Uninsured Patients are processed fairly and consistently. No Uninsured Patient shall be referred to a collection agency unless (i) the Uninsured Patient is given an opportunity to (x) assess the accuracy of the bill, (y) apply for financial assistance under the Hospital's financial assistance policy, and (z) avail themselves of a reasonable payment plan, (ii) if the Uninsured Patient has indicated the inability to pay the full amount in one payment, the Hospital has offered the Uninsured Patient a reasonable payment plan, (iii) if the circumstances suggest potential eligibility for charity care or financial assistance, the Uninsured Patient has first been given sixty (60) days following the date of discharge or receipt of outpatient care to submit an application for financial assistance, (iv) the Uninsured Patient has agreed to a reasonable payment plan and has failed to make payments under such payment plan, or (v) the Uninsured Patient informs the Hospital that he or she has applied for health care coverage under Medicaid, Kidcare, or other government-sponsored health care programs (and there is a reasonable basis to believe that the Patient will qualify for such program) but the Patient's application is denied. The Hospital shall not pursue legal action for non-payment of a Hospital bill against Uninsured Patients who have clearly demonstrated that they have neither sufficient Family Income nor assets to meet their financial obligations. In addition, the Hospital will not refer any portion of a bill to a collection agency or other third party for collection, unless (i) the Patient is first offered the opportunity to request a reasonable payment plan within the first thirty (30) days following the Patient's initial bill, or (ii) the Patient fails to agree to a plan within thirty (30) days of the Patient's request for such repayment plan. Notwithstanding anything herein to the contrary, the Hospital shall not recommend for collection any bill of a Patient who is acting reasonably and cooperating in good faith with the Hospital to provide all reasonably requested financial and other relevant information and documentation needed to determine the Patient's eligibility under a financial

assistance policy within thirty (30) days of any such request by the Hospital. All Hospital collection actions against Uninsured Patients shall comply with the requirements of IHUPDA and the Illinois Fair Patient Billing Act.

8. **Interest Free, Extended Payment Plans**. All Uninsured Patients shall be offered extended payment plans by the Hospitals to assist the Patients in settling past due outstanding Hospital bills. The Hospitals will not charge Uninsured Patients any interest under such extended payment plans.

9. **Body Attachments**. The Hospitals shall not use body attachment to require that its Uninsured Patients or responsible party appear in court.

10. **Collection Agencies Follow Hospital Collection Policies**. The Hospitals should define the standards and scope of practices to be used by third-party 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 shall not be inconsistent with the Hospitals' internal collection practices set forth in this Policy. No third-party collection agencies may initiate legal action against a Patient for non-payment of a Hospital bill without the written approval of an authorized Hospital employee who reasonably believes the conditions for pursuing collections have been met.

C. RESERVATION OF RIGHTS AGAINST THIRD PARTIES.

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

D. FINANCIAL ASSISTANCE REPORTING REQUIREMENTS.

Each Hospital shall file annually a Hospital Financial Assistance Report with the Office of the Illinois Attorney General. Which report shall include the following:

1. A copy of the Hospital Financial Assistance Application;

2. A copy of the Hospital's Presumptive Eligibility Policy, which shall identify each of the criteria used by the hospital to determine whether a Patient is presumptively eligible for Hospital financial assistance;

3. Hospital financial assistance statistics, which shall include:

a. The number of Hospital Financial Assistance Applications submitted to the Hospital, both complete and incomplete, during the most recent fiscal year;

b. The number of Hospital Financial Assistance Applications the Hospital approved under its Presumptive Eligibility Policy during the most recent fiscal year;

c. The number of Hospital Financial Assistance Applications the Hospital approved outside its Presumptive Eligibility Policy during the most recent fiscal year;

d. The number of Hospital Financial Assistance Applications denied by the Hospital during the most recent fiscal year; and

e. The total dollar amount of financial assistance provided by the Hospital during the most recent fiscal year, based on actual cost of care.

ATTACHMENT 7

EXHIBIT A

[HOSPITAL LOGO]

FINANCIAL ASSISTANCE APPLICATION

Patient Name: _____

MRN: _____

IMPORTANT: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help _____ Hospital determine if you can receive free or discounted services or other public programs that can help pay for your healthcare. Please submit this application to the Hospital.

IF YOU ARE UNINSURED, A SOCIAL SECURITY NUMBER IS NOT REQUIRED TO QUALIFY FOR FREE OR DISCOUNTED CARE.

However, a Social Security Number is required for some public programs, including Medicaid. Providing a Social Security Number is not required, but will help the hospital determine whether you qualify for any public programs. Please complete this form and submit it in person, by mail, by electronic mail, or by fax to apply for free or discounted care within sixty (60) days following the date of discharge or receipt of outpatient care. Patient acknowledges that he or she has made a good faith effort to provide all information requested in the application to assist the hospital in determining whether the patient is eligible for financial assistance.

IF YOU ARE UNINSURED AND MEET SPECIFIC PRESUMPTIVE ELIGIBILITY CRITERIA, YOU ARE NOT REQUIRED TO COMPLETE THIS APPLICATION.

- __ Homelessness
- __ Deceased with no estate
- __ Mental incapacitation with no one to act on patient's behalf
- __ Medicaid eligibility, but not on date of service
- __ Enrollment in assistance programs for low-income individuals:
- __ Women, Infants, and Children Nutrition Program (WIC)
- __ Supplemental Nutrition Assistance Program (SNAP)
- __ Illinois Free Lunch and Breakfast Program (LIHEAP)

APPLICANT

Applicant Name		Social Security #	Date of Birth
Home Address	City	State	Zip
Home Phone Number	Cell Phone Number		Email Address
Preferred Method of Contact __ US Mail __ Email __ Home Phone __ Cell Phone __ I am homeless		Annual Household Income	
Applicant's Marital Status __ Married __ Single __ Separated __ Divorced __ Widow		# of Individuals in your Household *(as reported on your taxes)*	
Employment Status __ Employed __ Self-Employed __ Retired __ Disabled __ Unemployed – Last date worked: _____			
Employer Name		Phone Number	
Employer Address	City	State	Zip
Name of Health Insurance Plan Offered by Employer __ Health Insurance not provided			

SPOUSE/PARTNER/GUARANTOR (when applicable)

Relationship			
Name		Social Security #	Date of Birth
Employment Status __ Employed __ Self-Employed __ Retired __ Disabled __ Unemployed – Last date worked. _____			
Employer Name		Phone Number	
Employer Address	City	State	Zip
Name of Health Insurance Plan Offered by Employer __ Health Insurance not provided			

[HOSPITAL LOGO]

FINANCIAL ASSISTANCE APPLICATION

Patient Name: _____

MRN: _____

INSURANCE COVERAGE

1. Are you covered or eligible for any health insurance policy, including foreign coverage, Health Insurance Marketplace, Veterans' benefits, Medicaid, or Medicare?
   a. If yes, please provide the following information:

Policy Holder	Insurer	Policy Number
Policy Holder	Insurer	Policy Number

QUESTIONNAIRE

1. Were you an Illinois resident when you received your care? __ yes __ no
2. Are you a foreign national residing in Illinois on a U.S. Visa? __ yes __ no
   a. If yes, what type of Visa? _____
3. Are you seeking financial assistance for care received in our emergency room? __ yes __ no
4. If you are divorced or separated, is your former spouse/partner financially responsible for medical care per the dissolution or separation agreement? __ yes __ no
5. Is the treatment provided related to either of the following?
   ___ Accident ___ Crime
6. Have you already applied for Medicaid? (*we may require that you do so*) __ yes-awaiting approval ___ yes – not eligible __ no
   a. If no, please check all of the lines below that apply:

___ You are 19 years or younger	___ You are 65 Years or older	___ You are blind
___ You are taking medication to control diabetes, high blood pressure, or seizures	___ You are disabled as determined by the Social Security Administration	___ You are pregnant
		___ You have children under the age of 19 living with you

ASSETS

1. <u>Property</u>. Please provide information regarding any property (*buildings and/or land*) that you own **other than your primary residence**
   a. What is the value of all buildings and land minus the amount owed on the property? $ _____ ___ N/A
      i. Is this property used as income? ___ yes ___ no
   b. What is the value of the land (without buildings) minus the amount owed on the property? $ _____ ___ N/A
      i. Is this property used as income? ___ yes ___ no
2. <u>Bank Accounts/ Investments</u>. Please list the total current balance for each of the following:
   a. Checking/Savings/Credit Union Accounts $ _____ ___ N/A
   b. Other investments (*bonds, stocks, etc. **excluding** IRA and/or retirement accounts*): $ _____ ___ N/A

EXPENSES

3. Please provide estimated monthly expenses, including those for housing, utilities, food, transportation, child care, loans, medical expenses, and other expenses $ _____

I certify that the information in this application is true and correct to the best of my knowledge. I will apply for any state, federal, or local assistance for which I may be eligible to help pay for this hospital bill. I understand that the information provided may be verified by this hospital, and I authorize this hospital to contact third parties to verify the accuracy of the information provided in this application. I understand that if I knowingly provide untrue information in this application, or if the application otherwise contains a material error or omission, I will be ineligible for financial assistance, and any financial assistance granted to me may be reversed and I will be responsible for the payment of the bill.

_____ Applicant Signature

_____ Spouse/Partner/Parent/Guarantor Signature (when applicable)

_____ Date

_____ Date

Please return completed application and supporting documents by mail, electronic mail, or hand-deliver to:

[Hospital address]

[HOSPITAL LOGO]

FINANCIAL ASSISTANCE APPLICATION
Patient Name: _____
MRN: _____

Financial Assistance Required Supporting Documents

Please provide the documents requested below. Your application will be delayed or denied in the event that any of the required documents are not included. If you cannot provide the document, please provide a letter of explanation.

Required:

- Tax Documents: Provide your most recent federal tax return and W-2 or IRS Form 4506-T: Request for Transcript of Tax Return.

- Valid Government-Issued Photo ID:
  - ☐ Driver's license, passport, etc.

- Proof of Illinois Residency: Provide at least one of the following documents:
  - ☐ Valid state-issued photo ID or driver's license
  - ☐ Recent utility bill with an Illinois address
  - ☐ IL Voter Registration card
  - ☐ Current mail addressed to applicant from a government or other credible source
  - ☐ Letter from homeless shelter

- Proof of Income: Provide all applicable documents listed below
  - ☐ Copies of your two most recent unemployment checks or stubs
  - ☐ Copies of your two most recent employer checks or stubs
  - ☐ Copies of your two most recent Social Security checks or stubs

- Proof of Assets: Provide your most recent statement for all checking, savings, and credit union accounts

- Proof of Expenses: Provide documentation of your monthly expenses, including those for housing, utilities, food, transportation, child care, loans, medical expenses, and other expenses

- Completed and signed application

Supplemental/Other:

- Proof of Non-Wage Income: Provide the following applicable documents, only if you have not submitted a tax return for the previous calendar year or if any of the following income sources will vary between this calendar year and the previous calendar year.
  - ☐ Statement of alimony income
  - ☐ Statement of business income
  - ☐ Statement of retirement or pension income

- If Married or in a Civil Union: Provide the following applicable documents regarding your spouse/partner.
  - ☐ Proof of income and non-wage income (as described above)
  - ☐ Federal tax return and W-2 or IRS Form 4506-T: Request for Transcript of Tax Return
  - ☐ Most recent statement for all checking, savings, and credit union accounts

- Supplemental/Other (if applicable):
  - ☐ If a foreign national, copy of your passport and United States Visa
  - ☐ Health insurance card (please copy front and back)
  - ☐ Medicaid approval/denial letter
  - ☐ Letter of support (i.e. if your living expenses are being paid by another party)

[HOSPITAL LOGO] **EXHIBIT B**

FINANCIAL ASSISTANCE PLAIN LANGUAGE SUMMARY

General Information about _____ Hospital Financial Assistance. The Hospital is committed to meeting the health care needs of those within the hospital community who are unable to pay for medically necessary or emergency care, including the uninsured. When needed, the Hospital provides medically necessary care at free or discounted rates ("Financial Assistance"). To manage its resources and responsibilities, and to provide Financial Assistance to as many people as possible, the Hospital has established program guidelines for providing Financial Assistance. However, the Hospital will always provide emergency care, regardless of a patient's ability to pay. Payment plans are also available. To be considered for free or discounted care, you may need to fill out an Application and provide supporting documentation about you and your family's financial circumstances, such as your income and assets.

Eligibility Requirements. Financial Assistance is only applied to your personal balances, after all other third party benefits (such as insurance benefits, government programs, proceeds from legal actions, or private fundraising) have been used. In addition, the Hospital will screen you to see if you are eligible for other payment assistance programs such as Medicaid. You are expected to cooperate by applying for such payment assistance. To be eligible for Financial Assistance, your annual household income ordinarily must be less than or equal to 600% of the Federal Poverty Income Level ("FPL") for your family size. The Hospital may also consider your assets in determining your eligibility and, in some situations, apply additional screening requirements. If you are approved for Financial Assistance, you must notify the Hospital within 30 days if your financial situation changes. Finally, to be fair to other patients, if you intentionally withhold information or provide false information, you may be disqualified for Financial Assistance.

Financial Assistance Programs

Program	Eligibility Requirements	Assistance
Uninsured Patients	Uninsured IL residents receiving medically necessary care* & any uninsured patient receiving emergency care	Free care for patients earning 200% or less of the applicable FPL; discounted care for those earning between 200% and 600% of applicable FPL; free care if Hospital bills exceed a specified percentage of Family Income
Presumptive Eligibility	Uninsured IL residents who qualify under certain federal and state assistance programs	Free care

* Not all services are covered by Financial Assistance, and Financial Assistance is not available for out-of-network services. In addition, your physician or non-Hospital provider may not participate in the Hospital's Financial Assistance program.

If you receive discounted care and are responsible for paying a portion of your bill, the Hospital will not charge you more than the amount we generally bill patients who have insurance covering such care.

When to apply for Financial Assistance. When you call to make an appointment, you may be asked to make financial arrangements. If you cannot apply for Financial Assistance before your visit, you should do so as early as possible and within 60 days following Hospital discharge or outpatient treatment. The Hospital will then decide if you are eligible for Financial Assistance and how much you can receive. If you disagree with our determination, you can contact the Financial Counseling Department.

How to Get Copies of the Hospital's Financial Assistance Policy & Application or Further Assistance. You can obtain a free copy of the Hospital's Policy and Application: i) on the Hospital's website at [_____], ii) in our Financial Counseling Departments, Patient Services Departments, and our Emergency Rooms at Admitting and Registration; or iii) by mail if you call the respective Financial Counseling Department.

Copies of our Financial Assistance Policy, Application, and this summary are available in English & Spanish.

Copias de nuestra Póliza de Asistencia Financiera, la Aplicación y este resumen están disponibles en Ingles y Españo.

ATTACHMENT 7

Ownership, Management and General Information

ADMINISTRATOR NAME:	Christopher Fryaztek
ADMINISTRATOR PHONE:	708-763-2254
OWNERSHIP:	VHS West Suburban Medical Center
OPERATOR:	VHS West Suburban Medical Center
MANAGEMENT:	For Profit Corporation
CERTIFICATION:	(Not Answered)
FACILITY DESIGNATION:	(Not Answered)
ADDRESS	3 Erie Court CITY: Oak Park COUNTY: Suburban Cook County

Patients by Race

White	13.9%
Black	71.6%
American Indian	0.0%
Asian	0.5%
Hawaiian/ Pacific	0.1%
Unknown	13.9%

Patients by Ethnicity

Hispanic or Latino:	8.0%
Not Hispanic or Latino:	86.1%
Unknown:	5.9%

IDPH Number:	5694
HPA	A-06
HSA	7

Facility Utilization Data by Category of Service

Clinical Service	Authorized CON Beds 12/31/2016	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy Rate %	Staffed Bed Occupancy Rate %
Medical/Surgical	135	101	101	4,861	20,162	1,748	4.4	59.9	44.3	59.3
0-14 Years				*0*	*0*					
15-44 Years				*1,006*	*3,424*					
45-64 Years				*1,697*	*7,491*					
65-74 Years				*989*	*4,172*					
75 Years +				*1,089*	*5,075*					
Pediatric	5	6	5	15	38	0	2.5	0.1	2.1	2.1
Intensive Care	24	14	14	1,097	3,246	8	3.0	8.9	37.0	63.5
Direct Admission				*872*	*2,472*					
Transfers - Not Included in Facility Admissions				*225*	*774*					
Obstetric/Gynecology	20	20	20	1,586	3,883	36	2.5	10.7	53.5	53.5
Maternity				*1,577*	*3,861*					
Clean Gynecology				*9*	*22*					
Neonatal	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long Term Care	60	42	38	548	9,887	0	18.0	27.0	54.0	64.3
Swing Beds			0	0	0		0.0	0.0		
Total AMI	0			0	0	0	0.0	0.0	0.0	
Adolescent AMI		0	0	0	0	0	0.0	0.0		0.0
Adult AMI		0	0	0	0	0	0.0	0.0		0.0
Rehabilitation	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long-Term Acute Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Dedicated Observation	*0*					*0*				
Facility Utilization	234			7,662	37,216	1,792	4.9	106.6	46.5	

Inpatients and Outpatients Served by Payor Source

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Totals
Inpatients	28.1%	9.1%	0.0%	59.7%	1.7%	1.4%	
	2241	728	0	4765	133	115	7,982
Outpatients	17.9%	5.5%	0.0%	72.0%	2.4%	2.2%	
	27367	8458	0	110048	3649	3364	152,886

Financial Year Reported: 1/1/2016 to 12/31/2016

Inpatient and Outpatient Net Revenue by Payor Source

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Totals	Charity Care Expense
Inpatient Revenue ($)	35.6%	21.2%	0.0%	43.1%	0.1%	100.0%	
	31,760,631	16,884,261	0	38,487,054	85,172	89,217,118	525,615
Outpatient Revenue ($)	21.9%	0.3%	0.0%	77.6%	0.1%	100.0%	
	9,760,840	132,097	0	34,555,046	56,811	44,504,794	1,398,936

Total Charity Care Expense 1,924,553

Total Charity Care as % of Net Revenue 1.4%

Birthing Data

Number of Total Births:	1,537
Number of Live Births:	1,521
Birthing Rooms:	0
Labor Rooms:	0
Delivery Rooms:	0
Labor-Delivery-Recovery Rooms:	12
Labor-Delivery-Recovery-Postpartum Rooms:	0
C-Section Rooms:	12
CSections Performed:	346

Newborn Nursery Utilization

	Level I	Level II	Level II+
Beds	25	8	0
Patient Days	2,593	1,610	0
Total Newborn Patient Days			4,203

Laboratory Studies

Inpatient Studies	280,059
Outpatient Studies	146,838
Studies Performed Under Contract	0

Organ Transplantation

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

ATTACHMENT 7

Ownership, Management and General Information

ADMINISTRATOR NAME:	Jennifer (Farnbauch) Lamont
ADMINISTRATOR PHONE	708-763-2531
OWNERSHIP:	VHS West Suburban Medical Center
OPERATOR:	VHS West Suburban Medical Center
MANAGEMENT:	For Profit Corporation
CERTIFICATION:	(Not Answered)
FACILITY DESIGNATION:	General Hospital
ADDRESS	3 Erie Court **CITY:** Oak Park **COUNTY:** Suburban Cook County

Patients by Race

White	16.7%
Black	69.9%
American Indian	0.0%
Asian	0.5%
Hawaiian/ Pacific	0.0%
Unknown	12.8%

Patients by Ethnicity

Hispanic or Latino:	6.1%
Not Hispanic or Latino:	87.1%
Unknown:	4.8%

IDPH Number:	5694
HPA	A-06
HSA	7

Facility Utilization Data by Category of Service

Clinical Service	Authorized CON Beds 12/31/2015	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy Rate %	Staffed Bed Occupancy Rate %
Medical/Surgical	135	101	101	5,277	22,500	1,598	4.6	66.0	48.9	65.4
0-14 Years				*0*	*0*					
15-44 Years				*1,052*	*3,555*					
45-64 Years				*1,992*	*8,326*					
65-74 Years				*1,015*	*4,688*					
75 Years +				*1,218*	*5,931*					
Pediatric	5	5	5	17	29	0	1.7	0.1	1.6	1.6
Intensive Care	24	14	14	1,163	2,310	6	2.0	6.3	26.4	45.3
Direct Admission				*958*	*1,640*					
Transfers				*205*	*670*					
Obstetric/Gynecology	20	20	20	1,656	4,022	69	2.5	11.3	56.3	56.3
Maternity				*1,641*	*3,985*					
Clean Gynecology				*15*	*37*					
Neonatal	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long Term Care	50	42	36	650	10,509	0	16.2	28.8	57.6	68.6
Swing Beds			0	0	0		0.0	0.0		
Acute Mental Illness	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Rehabilitation	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long-Term Acute Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Dedicated Observation	*0*					*0*				
Facility Utilization	**234**			**8,668**	**39,370**	**1,693**	**4.8**	**112.5**	**48.1**	

(Includes ICU Direct Admissions Only)

Inpatients and Outpatients Served by Payor Source

	Medicare	*Medicaid*	*Other Public*	*Private Insurance*	*Private Pay*	*Charity Care*	*Totals*
Inpatients	**29.3%**	**14.3%**	**0.0%**	**53.9%**	**1.0%**	**1.4%**	
	2609	1226	0	4612	89	122	**8,558**
Outpatients	**17.0%**	**12.6%**	**0.0%**	**65.7%**	**2.3%**	**2.6%**	
	26289	19296	0	101770	3589	3955	**154,909**

Financial Year Reported: 1/1/2015 *to* 12/31/2015

Inpatient and Outpatient Net Revenue by Payor Source

	Medicare	*Medicaid*	*Other Public*	*Private Insurance*	*Private Pay*	*Totals*	*Charity Care Expense*	*Total Charity Care Expense*
Inpatient Revenue ($)	**34.6%**	**24.6%**	**0.0%**	**40.7%**	**0.1%**	**100.0%**		**1,765,245**
	29,680,742	21,067,276	0	34,884,720	95,018	85,727,756	512,361	*Total Charity Care as % of Net Revenue*
Outpatient Revenue ($)	**22.1%**	**5.0%**	**0.0%**	**70.7%**	**2.1%**	**100.0%**		
	11,935,716	2,696,709	0	38,191,833	1,159,770	53,984,028	1,252,884	**1.3%**

Birthing Data

Number of Total Births:	1,578
Number of Live Births:	1,566
Birthing Rooms:	0
Labor Rooms:	0
Delivery Rooms:	0
Labor-Delivery-Recovery Rooms:	12
Labor-Delivery-Recovery-Postpartum Rooms:	0
C-Section Rooms:	2
CSections Performed:	363

Newborn Nursery Utilization

	Level I	Level II	Level II+
Beds	25	8	0
Patient Days	2,587	1,504	0
Total Newborn Patient Days			4,091

Laboratory Studies

Inpatient Studies	304,799
Outpatient Studies	138,050
Studies Performed Under Contract	0

Organ Transplantation

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

ATTACHMENT 7

Surgery and Operating Room Utilization

Surgical Specialty	Operating Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Cardiovascular	0	0	0	0	89	125	367	238	605	4.1	1.9
Dermatology	0	0	0	0	0	0	0	0	0	0.0	0.0
General	0	0	8	8	796	1267	1453	1833	3286	1.8	1.4
Gastroenterology	0	0	0	0	0	0	0	0	0	0.0	0.0
Neurology	0	0	0	0	0	0	0	0	0	0.0	0.0
OB/Gynecology	0	0	0	0	147	499	388	757	1145	2.6	1.5
Oral/Maxillofacial	0	0	0	0	0	0	0	0	0	0.0	0.0
Ophthalmology	0	0	0	0	1	662	2	821	823	2.0	1.2
Orthopedic	0	0	0	0	254	436	813	852	1665	3.2	2.0
Otolaryngology	0	0	0	0	9	26	16	36	52	1.8	1.4
Plastic Surgery	0	0	0	0	3	61	9	184	193	3.0	3.0
Podiatry	0	0	0	0	5	131	7	215	222	1.4	1.6
Thoracic	0	0	0	0	12	2	30	4	34	2.5	2.0
Urology	0	0	0	0	98	282	247	522	769	2.5	1.9
Totals	**0**	**0**	**8**	**8**	**1414**	**3491**	**3332**	**5462**	**8794**	**2.4**	**1.6**

SURGICAL RECOVERY STATIONS Stage 1 Recovery Stations 16 Stage 2 Recovery Stations 25

Dedicated and Non-Dedicated Procedure Room Utilization

Procedure Type	Procedure Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Gastrointestinal	0	0	4	4	610	3925	1211	7018	8229	2.0	1.8
Laser Eye Procedures	0	0	0	0	0	0	0	0	0	0.0	0.0
Pain Management	0	0	0	0	0	0	0	0	0	0.0	0.0
Cystoscopy	0	0	0	0	0	0	0	0	0	0.0	0.0
Multipurpose Non-Dedicated Rooms											
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0

Emergency/Trauma Care

Certified Trauma Center		No
Level of Trauma Service	Level 1 (Not Answered)	Level 2 Not Answered
Operating Rooms Dedicated for Trauma Care		0
Number of Trauma Visits:		0
Patients Admitted from Trauma		0
Emergency Service Type:		Comprehensive
Number of Emergency Room Stations		25
Persons Treated by Emergency Services:		50,497
Patients Admitted from Emergency:		5,365
Total ED Visits (Emergency+Trauma):		50,497

Free-Standing Emergency Center

Beds in Free-Standing Centers	0
Patient Visits in Free-Standing Centers	0
Hospital Admissions from Free-Standing Center	0

Outpatient Service Data

Total Outpatient Visits	154,909
Outpatient Visits at the Hospital/ Campus:	100,071
Outpatient Visits Offsite/off campus	54,838

Cardiac Catheterization Labs

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

Cardiac Catheterization Utilization

Total Cardiac Cath Procedures:	706
Diagnostic Catheterizations (0-14)	0
Diagnostic Catheterizations (15+)	518
Interventional Catheterizations (0-14):	0
Interventional Catheterization (15+)	188
EP Catheterizations (15+)	0

Cardiac Surgery Data

Total Cardiac Surgery Cases:	20
Pediatric (0 - 14 Years):	0
Adult (15 Years and Older):	20
Coronary Artery Bypass Grafts (CABGs) performed of total Cardiac Cases :	12

Diagnostic/Interventional Equipment	Owned	Contract	Examinations Inpatient	Outpt	Contract
General Radiography/Fluoroscopy	14	0	8,586	30,816	0
Nuclear Medicine	3	0	478	725	0
Mammography	3	0	0	20,286	0
Ultrasound	14	0	2,702	14,913	0
Angiography	1	0			
Diagnostic Angiography			0	0	0
Interventional Angiography			934	1,505	0
Positron Emission Tomography (PET)	0	0	0	0	0
Computerized Axial Tomography (CAT)	5	0	3,583	8,441	0
Magnetic Resonance Imaging	3	0	497	2,911	0

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

Source: 2015 Annual Hospital Questionnaire, Illinois Department of Public Health, Health Systems Development.

ATTACHMENT 7

Ownership, Management and General Information

ADMINISTRATOR NAME:	Patrick Maloney
ADMINISTRATOR PHONE	708-763-6700
OWNERSHIP:	VHS West Suburban Medical Center
OPERATOR:	VHS West Suburban Medical Center
MANAGEMENT:	For Profit Corporation
CERTIFICATION:	None
FACILITY DESIGNATION:	General Hospital
ADDRESS	3 Erie Court **CITY:** Oak Park **COUNTY:** Suburban Cook County

Patients by Race

White	16.7%
Black	71.5%
American Indian	0.0%
Asian	0.3%
Hawaiian/ Pacific	0.0%
Unknown	11.4%

Patients by Ethnicity

Hispanic or Latino:	8.3%
Not Hispanic or Latino:	88.6%
Unknown:	3.1%

IDPH Number:	5694
HPA	A-06
HSA	7

Facility Utilization Data by Category of Service

Clinical Service	Authorized CON Beds 12/31/2014	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy Rate %	Staffed Bed Occupancy Rate %
Medical/Surgical	135	95	95	5,323	22,396	1,847	4.6	66.4	49.2	69.9
0-14 Years				*0*	*0*					
15-44 Years				*1,164*	*3,995*					
45-64 Years				*2,065*	*8,341*					
65-74 Years				*902*	*4,157*					
75 Years +				*1,192*	*5,903*					
Pediatric	5	5	2	16	50	0	3.1	0.1	2.7	2.7
Intensive Care	24	19	13	1,069	2,689	2	2.7	7.9	33.0	60.9
Direct Admission				*865*	*2,109*					
Transfers				*204*	*780*					
Obstetric/Gynecology	20	20	20	1,782	4,455	160	2.6	12.6	63.2	63.2
Maternity				*1,771*	*4,425*					
Clean Gynecology				*11*	*30*					
Neonatal	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long Term Care	50	42	40	656	10,492	0	16.0	28.7	57.5	68.4
Swing Beds			0	0	0		0.0	0.0		
Acute Mental Illness	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Rehabilitation	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long-Term Acute Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Dedicated Observation	*0*					*0*				
Facility Utilization	234			8,642	40,282	2,009	4.9	115.8	49.5	

(Includes ICU Direct Admissions Only)

Inpatients and Outpatients Served by Payor Source

	Medicare	*Medicaid*	*Other Public*	*Private Insurance*	*Private Pay*	*Charity Care*	*Totals*
Inpatients	29.1%	24.7%	0.0%	43.5%	1.1%	1.5%	
	2519	2135	0	3757	99	132	8,642
Outpatients	18.2%	19.7%	0.0%	56.1%	3.3%	2.8%	
	27520	29813	0	84917	4989	4237	151,476

Financial Year Reported: 1/1/2014 *to* 12/31/2014

Inpatient and Outpatient Net Revenue by Payor Source

	Medicare	*Medicaid*	*Other Public*	*Private Insurance*	*Private Pay*	*Totals*	*Charity Care Expense*	*Total Charity Care Expense*
Inpatient Revenue ($)	40.6%	12.8%	0.0%	41.6%	5.0%	100.0%		1,680,680
	32,154,085	10,144,156	0	32,940,425	3,935,335	79,174,001	331,190	*Total Charity Care as % of Net Revenue*
Outpatient Revenue ($)	21.9%	16.9%	0.0%	59.3%	1.9%	100.0%		
	12,863,249	9,901,353	0	34,806,590	1,106,178	58,677,370	1,349,490	1.2%

Birthing Data

Number of Total Births:	1,741
Number of Live Births:	1,724
Birthing Rooms:	0
Labor Rooms:	0
Delivery Rooms:	0
Labor-Delivery-Recovery Rooms:	12
Labor-Delivery-Recovery-Postpartum Rooms:	0
C-Section Rooms:	2
CSections Performed:	397

Newborn Nursery Utilization

	Level I	Level II	Level II+
Beds	25	8	0
Patient Days	2,952	1,854	0
Total Newborn Patient Days			4,806

Laboratory Studies

Inpatient Studies	336,327
Outpatient Studies	142,509
Studies Performed Under Contract	0

Organ Transplantation

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

ATTACHMENT 7

Surgery and Operating Room Utilization

Surgical Specialty	Operating Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Cardiovascular	0	0	0	0	100	127	419	267	686	4.2	2.1
Dermatology	0	0	0	0	0	0	0	0	0	0.0	0.0
General	0	0	8	8	915	1023	1677	1594	3271	1.8	1.6
Gastroenterology	0	0	0	0	1	1	2	2	4	2.0	2.0
Neurology	0	0	0	0	0	0	0	0	0	0.0	0.0
OB/Gynecology	0	0	0	0	209	442	545	684	1229	2.6	1.5
Oral/Maxillofacial	0	0	0	0	0	0	0	0	0	0.0	0.0
Ophthalmology	0	0	0	0	0	585	0	744	744	0.0	1.3
Orthopedic	0	0	0	0	216	504	652	1011	1663	3.0	2.0
Otolaryngology	0	0	0	0	4	19	9	30	39	2.3	1.6
Plastic Surgery	0	0	0	0	10	79	35	211	246	3.5	2.7
Podiatry	0	0	0	0	6	99	9	160	169	1.5	1.6
Thoracic	0	0	0	0	16	0	46	0	46	2.9	0.0
Urology	0	0	0	0	116	290	360	540	900	3.1	1.9
Totals	**0**	**0**	**8**	**8**	**1593**	**3169**	**3754**	**5243**	**8997**	**2.4**	**1.7**

SURGICAL RECOVERY STATIONS Stage 1 Recovery Stations 16 Stage 2 Recovery Stations 25

Dedicated and Non-Dedicated Procedure Room Utilization

Procedure Type	Procedure Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Gastrointestinal	0	0	4	4	636	4006	1227	7145	8372	1.9	1.8
Laser Eye Procedures	0	0	0	0	0	0	0	0	0	0.0	0.0
Pain Management	0	0	0	0	0	0	0	0	0	0.0	0.0
Cystoscopy	0	0	0	0	0	0	0	0	0	0.0	0.0
Multipurpose Non-Dedicated Rooms											
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0

Emergency/Trauma Care

Certified Trauma Center		No
Level of Trauma Service	Level 1	Level 2
Operating Rooms Dedicated for Trauma Care		0
Number of Trauma Visits:		0
Patients Admitted from Trauma		0
Emergency Service Type:		Comprehensive
Number of Emergency Room Stations		25
Persons Treated by Emergency Services:		50,178
Patients Admitted from Emergency:		5,222
Total ED Visits (Emergency+Trauma):		50,178

Free-Standing Emergency Center

Beds in Free-Standing Centers	
Patient Visits in Free-Standing Centers	
Hospital Admissions from Free-Standing Center	

Outpatient Service Data

Total Outpatient Visits	151,476
Outpatient Visits at the Hospital/ Campus:	94,580
Outpatient Visits Offsite/off campus	56,896

Cardiac Catheterization Labs

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

Cardiac Catheterization Utilization

Total Cardiac Cath Procedures:	852
Diagnostic Catheterizations (0-14)	0
Diagnostic Catheterizations (15+)	571
Interventional Catheterizations (0-14):	0
Interventional Catheterization (15+)	281
EP Catheterizations (15+)	0

Cardiac Surgery Data

Total Cardiac Surgery Cases:	24
Pediatric (0 - 14 Years):	0
Adult (15 Years and Older):	24
Coronary Artery Bypass Grafts (CABGs) performed of total Cardiac Cases :	18

Diagnostic/Interventional Equipment	Owned	Contract	Examinations Inpatient	Examinations Outpt	Examinations Contract
General Radiography/Fluoroscopy	14	0	9,420	32,638	0
Nuclear Medicine	3	0	459	741	0
Mammography	3	0	0	19,710	0
Ultrasound	14	0	2,823	15,469	0
Angiography	1	0			
Diagnostic Angiography			0	0	0
Interventional Angiography			923	1,597	0
Positron Emission Tomography (PET)	0	0	0	0	0
Computerized Axial Tomography (CAT)	5	0	3,474	8,242	0
Magnetic Resonance Imaging	3	0	497	2,906	0

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

Source: 2014 Annual Hospital Questionnaire, Illinois Department of Public Health, Health Systems Development.

ATTACHMENT 7

Section IV

Attachment 7

Charity Care

CHARITY CARE			
	Year 2014	**Year 2015**	**Year 2016**
Ratio of Charity Care to Net Patient Revenue	1.2 %	1.3%	1.4%
Net Patient Revenue	$137,851,371 00	$139,711,784.00	$133,721,912.00
Cost of Charity Care	$1,680,680.00	$1,765,245.00	$1,924,553.00

HINCKLEY ALLEN

28 State Street
Boston, MA 02109-1775
p: 617-345-9000 f: 617-345-9020
hinckleyallen.com

Anne M. Murphy
amurphy@hinckleyallen.com
(617) 378-4368

September 5, 2018

VIA OVERNIGHT MAIL

Mike Constantino
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd floor
Springfield, IL 62761

Re: Certificate of Exemption Application-Change of Ownership of VHS West Suburban Medical Center

Dear Mike:

I enclose an original and one (1) copy of the captioned Certificate of Exemption Application, reflecting the proposed Change of Ownership of VHS West Suburban Medical Center.

Thank you in advance for your review. Please let me know if you have any questions.

Very truly yours,

Anne M. Murphy

Enclosure

AMM/bp
Enclosure

ORIGINAL

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

CHANGE OF OWNERSHIP EXEMPTION APPLICATION

AUGUST 2018 EDITION

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ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
525 WEST JEFFERSON STREET, 2nd FLOOR
SPRINGFIELD, ILLINOIS 62761
(217) 782-3516