

ORIGINAL

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD  
APPLICATION FOR PERMIT

14068

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

RECEIVED

This Section must be completed for all projects.

DEC 22 2014

Facility/Project Identification

Facility Name: Monroe County Surgery Center		
Street Address: 501 N. Hamacher Street		
City and Zip Code: Waterloo, IL.		
County: Monroe	Health Service Area: 11	Health Planning Area: 11

HEALTH FACILITIES &  
SERVICES REVIEW BOARD

Applicant /Co-Applicant Identification

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

Exact Legal Name: Red Bud Illinois Hospital Company, LLC
Address: 325 Spring Street, Red Bud, IL. 62278
Name of Registered Agent: CT Corporation
Name of Chief Executive Officer: Shane Watson
CEO Address: Same as Hospital
Telephone Number: 618-282-3831

Type of Ownership of Applicant/Co-Applicant

<input type="checkbox"/> Non-profit Corporation	<input type="checkbox"/> Partnership
<input type="checkbox"/> For-profit Corporation	<input type="checkbox"/> Governmental
<input checked="" type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Sole Proprietorship
	<input type="checkbox"/> Other

o Corporations and limited liability companies must provide an **Illinois certificate of good standing**.

o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.

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

Primary Contact

[Person to receive ALL correspondence or inquiries)

Name: Clare Connor Ranalli
Title: Partner
Company Name: McDermott, Will & Emery
Address: 227 W. Monroe Street, Suite 4400
Telephone Number: 312-984-3365
E-mail Address: cranalli@mwe.com
Fax Number:

Additional Contact

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

Name: Jesse Neil
Title: Vice President & Associate General Counsel – Division III
Company Name: Community Health Systems, Inc.
Address: 4000 Meridian Boulevard, Franklin, TN 37067
Telephone Number: 615-465-7115
E-mail Address: Jesse_Neil@chs.net
Fax Number: 615-465-3012

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

**SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION**

**This Section must be completed for all projects.**

**Facility/Project Identification**

Facility Name: Monroe County Surgery Center		
Street Address: 501 N. Hamacher Street		
City and Zip Code: Waterloo, IL.		
County: Monroe	Health Service Area 11	Health Planning Area: 11

**Applicant /Co-Applicant Identification**

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

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

**Type of Ownership of Applicant/Co-Applicant**

<input type="checkbox"/> Non-profit Corporation <input checked="" type="checkbox"/> For-profit Corporation <input type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Partnership <input type="checkbox"/> Governmental <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Other
<ul style="list-style-type: none"> <li>o Corporations and limited liability companies must provide an <b>Illinois certificate of good standing</b>.</li> <li>o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.</li> </ul>	
<p><b>APPEND DOCUMENTATION AS ATTACHMENT-1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b></p>	

**Primary Contact**

**[Person to receive ALL correspondence or inquiries]**

Name: Clare Connor Ranalli
Title: Partner
Company Name: McDermott, Will & Emery
Address: 227 W. Monroe Street, Suite 4400
Telephone Number: 312-984-3365
E-mail Address: cranalli@mwe.com
Fax Number:

**Additional Contact**

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

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

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

**SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION**

**This Section must be completed for all projects.**

**Facility/Project Identification**

Facility Name: Monroe County Surgery Center		
Street Address: 501 N. Hamacher Street		
City and Zip Code: Waterloo, IL.		
County: Monroe	Health Service Area 11	Health Planning Area: 11

**Applicant /Co-Applicant Identification**

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

Exact Legal Name: Monroe County Surgical Center, LLC
Address: 509 Hamacher Street, Suite 222, Waterloo, IL 62298
Name of Registered Agent: Donald K. Schoemaker
Name of Managers: Dr. Michael Kirk and Dr. William Reilly
CEO Address: As above
Telephone Number:

**Type of Ownership of Applicant/Co-Applicant**

<input type="checkbox"/> Non-profit Corporation	<input type="checkbox"/> Partnership
<input type="checkbox"/> For-profit Corporation	<input type="checkbox"/> Governmental
<input checked="" type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Other
<ul style="list-style-type: none"> <li>o Corporations and limited liability companies must provide an <b>Illinois certificate of good standing</b>.</li> <li>o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.</li> </ul>	

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

**Primary Contact**

**[Person to receive ALL correspondence or inquiries]**

Name: Clare Connor Ranalli
Title: Partner
Company Name: McDermott, Will & Emery
Address: 227 W. Monroe Street, Suite 4400
Telephone Number: 312-984-3365
E-mail Address: cranalli@mwe.com
Fax Number:

**Additional Contact**

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

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

### Post Permit Contact

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

Name: Shane Watson
Title: CEO
Company Name: Red Bud Regional Hospital
Address: 325 Spring Street, Red Bud, IL 62278
Telephone Number: 618-282-3831
E-mail Address: Shane_watson@chs.net
Fax Number:

### Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Medical Development Company of America, LLC
Address of Site Owner: 501 Hamacher Street, Waterloo, IL 62298
Street Address or Legal Description of Site: <b>Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statement, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease or a lease.</b>
<b>APPEND DOCUMENTATION AS ATTACHMENT-2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>

### Operating Identity/Licensee

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

Exact Legal Name: Monroe County Surgical Center, LLC
Address: 501 Hammacher St., Waterloo, IL. 62298
<input type="checkbox"/> Non-profit Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> For-profit Corporation <input type="checkbox"/> Governmental <input checked="" type="checkbox"/> Limited Liability Company <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Other
<ul style="list-style-type: none"><li>o Corporations and limited liability companies must provide an Illinois Certificate of Good Standing.</li><li>o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.</li><li>o <b>Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.</b></li></ul>
<b>APPEND DOCUMENTATION AS ATTACHMENT-3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>

### Organizational Relationships

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

<b>APPEND DOCUMENTATION AS ATTACHMENT-4, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>
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**Flood Plain Requirements**  
**NOT APPLICABLE**

[Refer to application instructions.]

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

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

**Historic Resources Preservation Act Requirements**  
**NOT APPLICABLE**

[Refer to application instructions.]

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

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

**DESCRIPTION OF PROJECT**

**1. Project Classification**

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

Part 1110 Classification:

- Substantive  
 Non-substantive

## 2. Narrative Description

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

This project proposes the change of ownership of the Monroe County Surgical Center, LLC, a multi-specialty surgery center in Waterloo, Illinois with two operating rooms. The surgery center is currently owned by physicians. After the proposed change of ownership, Red Bud Regional Hospital will own a 51% ownership interest in the surgical center, with those physicians who are current owners retaining a 49% ownership interest. There will be no change in the type of surgical procedures performed at the surgery center. There will be no modernization of the surgery center, or construction, as a result of this change of ownership. Attached as Appendix A is a copy of the letter of intent between the two parties. An executed acquisition agreement will be completed in the very near future and will be provided to the Health Facilities Services and Review Board.

This project is non-substantive under the Board's rules, as it proposes the change of ownership of a health care facility.

## Project Costs and Sources of Funds

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

Project Costs and Sources of Funds			
USE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Preplanning Costs			
Site Survey and Soil Investigation			
Site Preparation			
Off Site Work			
New Construction Contracts			
Modernization Contracts			
Contingencies			
Architectural/Engineering Fees			
Consulting and Other Fees			
Movable or Other Equipment (not in construction contracts)			
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment			
Other Costs To Be Capitalized	\$2,200,000.00		\$2,200,000.00
Acquisition of Building or Other Property (excluding land)			
<b>TOTAL USES OF FUNDS</b>	\$2,200,000.00		\$2,200,000.00
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities	\$2,200,000.00		\$2,200,000.00
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
<b>TOTAL SOURCES OF FUNDS</b>	\$2,200,000.00		\$2,200,000.00
<b>NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT-7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>			

**Related Project Costs**

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

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

**Project Status and Completion Schedules**

<b>For facilities in which prior permits have been issued please provide the permit numbers.</b>
Indicate the stage of the project's architectural drawings: <input checked="" type="checkbox"/> X None or not applicable <input type="checkbox"/> Preliminary <input type="checkbox"/> Schematics <input type="checkbox"/> Final Working
Anticipated project completion date (refer to Part 1130.140): <u>May 1, 2015</u>
Indicate the following with respect to project expenditures or to obligation (refer to Part 1130.140): <input type="checkbox"/> Purchase orders, leases or contracts pertaining to the project have been executed. <input type="checkbox"/> Project obligation is contingent upon permit issuance. Provide a copy of the contingent "certification of obligation" document, highlighting any language related to CON Contingencies <input checked="" type="checkbox"/> X Project obligation will occur after permit issuance.
<b>APPEND DOCUMENTATION AS ATTACHMENT-8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>

**State Agency Submittals**

Are the following submittals up to date as applicable: <input checked="" type="checkbox"/> X Cancer Registry <input checked="" type="checkbox"/> X APORS <input checked="" type="checkbox"/> X All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted <input type="checkbox"/> All reports regarding outstanding permits ( <b>None</b> ) <b>Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.</b>
--

**Cost Space Requirements**

NOT APPLICABLE – THIS PROJECT IS FOR CHANGE OF OWNERSHIP WITH NO ASSOCIATED CONSTRUCTION.

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

Dept. / Area	Cost	Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
		Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
<b>REVIEWABLE</b>							
Medical Surgical							
Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical							
<b>NON REVIEWABLE</b>							
Administrative							
Parking							
Gift Shop							
Total Non-clinical							
<b>TOTAL</b>							
APPEND DOCUMENTATION AS <u>ATTACHMENT-9</u> , IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.							

**Facility Bed Capacity and Utilization NOT APPLICABLE – THIS PROJECT IS FOR THE CHANGE OF OWNERSHIP OF AN ASC**

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

<b>FACILITY NAME:</b> N/A		<b>CITY:</b> N/A			
<b>REPORTING PERIOD DATES:</b> From: _____ to: _____					
<b>Category of Service</b>	<b>Authorized Beds</b>	<b>Admissions</b>	<b>Patient Days</b>	<b>Bed Changes</b>	<b>Proposed Beds</b>
Medical/Surgical					
Obstetrics					
Pediatrics					
Intensive Care					
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness					
Neonatal Intensive Care					
General Long Term Care					
Specialized Long Term Care					
Long Term Acute Care					
Other ((identify)					
<b>TOTALS:</b>					

**CERTIFICATION**

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

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

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

  
 \_\_\_\_\_  
 SIGNATURE

Martin Schweinhart  
 \_\_\_\_\_  
 PRINTED NAME

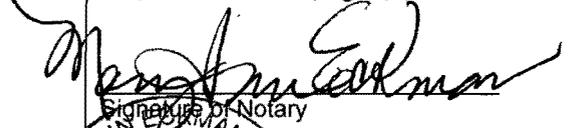
Executive Vice President  
 \_\_\_\_\_  
 PRINTED TITLE

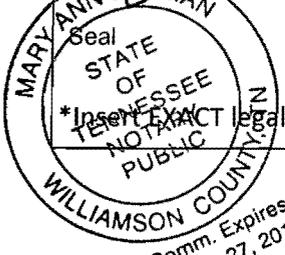
  
 \_\_\_\_\_  
 SIGNATURE

Rachel Seifert  
 \_\_\_\_\_  
 PRINTED NAME

**EVP, Secretary &**  
**General Counsel**  
 \_\_\_\_\_  
 PRINTED TITLE

Notarization:  
 Subscribed and sworn to before me  
 this 17<sup>th</sup> day of December

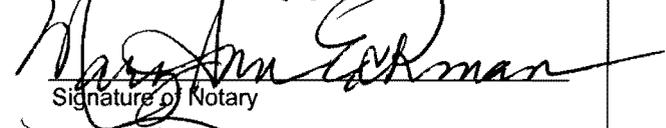
  
 \_\_\_\_\_  
 Signature of Notary

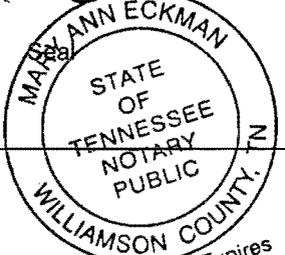


\* Insert EXACT legal name of the applicant

My Comm. Expires  
 September 27, 2015

Notarization:  
 Subscribed and sworn to before me  
 this 17<sup>th</sup> day of December

  
 \_\_\_\_\_  
 Signature of Notary



My Comm. Expires  
 September 27, 2015

**CERTIFICATION**

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

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

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



SIGNATURE  
 Martin Schweinhart  
 PRINTED NAME  
 Executive Vice President  
 PRINTED TITLE



SIGNATURE  
 Rachel Seifert  
 PRINTED NAME  
 Executive Vice President  
 General Counsel & Secretary  
 PRINTED TITLE

Notarization:  
 Subscribed and sworn to before me  
 this 17<sup>th</sup> day of December



Signature of Notary  
 Seal  
 MARY ANN ECKMAN  
 STATE OF TENNESSEE  
 NOTARY PUBLIC  
 WILLIAMSON COUNTY, TN

My Comm. Expires  
 September 27, 2015

Notarization:  
 Subscribed and sworn to before me  
 this 17<sup>th</sup> day of December



Signature of Notary  
 Seal  
 MARY ANN ECKMAN  
 STATE OF TENNESSEE  
 NOTARY PUBLIC  
 WILLIAMSON COUNTY, TN

My Comm. Expires  
 September 27, 2015

\*Insert EXACT legal name of the applicant

**CERTIFICATION**

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- o in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist);
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- o in the case of a sole proprietor, the individual that is the proprietor.

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

*Michael Kirk*  
 SIGNATURE  
 Michael Kirk, M.D.  
 PRINTED NAME  
 Managing Member  
 PRINTED TITLE

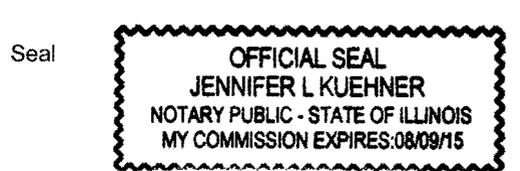
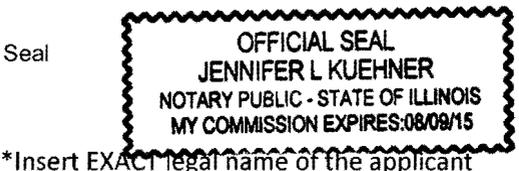
*William Reilly*  
 SIGNATURE  
 William Reilly, M.D.  
 PRINTED NAME  
 Managing Member  
 PRINTED TITLE

Notarization:  
 Subscribed and sworn to before me  
 this 15th day of December

Notarization:  
 Subscribed and sworn to before me  
 this 15th day of December

*Jennifer L. Kuehner*  
 Signature of Notary

*Jennifer L. Kuehner*  
 Signature of Notary



\*Insert EXACT legal name of the applicant

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

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

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

READ THE REVIEW CRITERION and provide the following required information:

##### BACKGROUND OF APPLICANT

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

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

##### PURPOSE OF PROJECT NOT APPLICABLE – THIS PROPOSES THE CHANGE OF OWNERSHIP OF AN EXISTING FACILITY

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

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

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

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

## ALTERNATIVES

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

Alternative options **must** include:

- A) Proposing a project of greater or lesser scope and cost;
  - B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes;
  - C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and
  - D) Provide the reasons why the chosen alternative was selected.
- 2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of total costs, patient access, quality and financial benefits in both the short term (within one to three years after project completion) and long term. This may vary by project or situation. **FOR EVERY ALTERNATIVE IDENTIFIED THE TOTAL PROJECT COST AND THE REASONS WHY THE ALTERNATIVE WAS REJECTED MUST BE PROVIDED.**
  - 3) The applicant shall provide empirical evidence, including quantified outcome data that verifies improved quality of care, as available.

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

**SECTION IV - PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE**

**Criterion 1110.234 - Project Scope, Utilization, and Unfinished/Shell Space**

**NOT APPLICABLE – CHANGE OF OWNERSHIP OF EXISTING FACILITY**

READ THE REVIEW CRITERION and provide the following information:

**SIZE OF PROJECT:**

1. Document that the amount of physical space proposed for the proposed project is necessary and not excessive. **This must be a narrative.**
2. If the gross square footage exceeds the BGSF/DGSF standards in Appendix B, justify the discrepancy by documenting one of the following:
  - a. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies;
  - b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that results in a size exceeding the standards of Appendix B;
  - c. The project involves the conversion of existing space that results in excess square footage.

**Provide a narrative for any discrepancies from the State Standard. A table must be provided in the following format with Attachment 14.**

SIZE OF PROJECT				
DEPARTMENT/SERVICE	PROPOSED BGSF/DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?

**APPEND DOCUMENTATION AS ATTACHMENT-14. IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.**

**PROJECT SERVICES UTILIZATION:** This criterion is applicable only to projects or portions of projects that involve services, functions or equipment for which HFSRB has established utilization standards or occupancy targets in 77 Ill. Adm. Code 1100.

**NOT APPLICABLE – CHANGE OF OWNERSHIP OF EXISTING FACILITY**

Document that in the second year of operation, the annual utilization of the service or equipment shall meet or exceed the utilization standards specified in 1110.Appendix B. **A narrative of the rationale that supports the projections must be provided.**

**A table must be provided in the following format with Attachment 15.**

UTILIZATION					
	DEPT./ SERVICE	HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.	PROJECTED UTILIZATION	STATE STANDARD	MET STANDARD?
YEAR 1					
YEAR 2					

**APPEND DOCUMENTATION AS ATTACHMENT-15. IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.**

**UNFINISHED OR SHELL SPACE: NOT APPLICABLE**

Provide the following information:

1. Total gross square footage of the proposed shell space;
2. The anticipated use of the shell space, specifying the proposed GSF to be allocated to each department, area or function;
3. Evidence that the shell space is being constructed due to
  - a. Requirements of governmental or certification agencies; or
  - b. Experienced increases in the historical occupancy or utilization of those areas proposed to occupy the shell space.
4. Provide:
  - a. Historical utilization for the area for the latest five-year period for which data are available; and
  - b. Based upon the average annual percentage increase for that period, projections of future utilization of the area through the anticipated date when the shell space will be placed into operation.

**APPEND DOCUMENTATION AS ATTACHMENT-16, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.**

**ASSURANCES: NOT APPLICABLE**

Submit the following:

1. Verification that the applicant will submit to HFSRB a CON application to develop and utilize the shell space, regardless of the capital thresholds in effect at the time or the categories of service involved.
2. The estimated date by which the subsequent CON application (to develop and utilize the subject shell space) will be submitted; and
3. The anticipated date when the shell space will be completed and placed into operation.

**APPEND DOCUMENTATION AS ATTACHMENT-17, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.**

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

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

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

### **A. Criterion 1110.240(b), Impact Statement**

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

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

### **B. Criterion 1110.240(c), Access**

Read the criterion and provide the following:

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

### **C. Criterion 1110.240(d), Health Care System**

Read the criterion and address the following:

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

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

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

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

**VIII. - 1120.120 - Availability of Funds**

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

\$2,200,000		<p>a) Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to:</p> <ol style="list-style-type: none"> <li>1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and</li> <li>2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion;</li> </ol>
_____		b) Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.
_____		c) Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts;
_____		d) Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including:
		<ol style="list-style-type: none"> <li>1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated;</li> <li>2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate;</li> <li>3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.;</li> <li>4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment;</li> <li>5) For any option to lease, a copy of the option, including all terms and conditions.</li> </ol>
_____		e) Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent;
_____		f) Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt;
_____		g) All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
\$2,200,000		<b>TOTAL FUNDS AVAILABLE</b>

**APPEND DOCUMENTATION AS ATTACHMENT-36, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.**

**IX. 1120.130 - Financial Viability**

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

**Financial Viability Waiver NOT APPLICABLE – ALL FUNDING IS THROUGH INTERNAL SOURCES**

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

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

See Section 1120.130 Financial Waiver for information to be provided

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

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

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

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

2. Variance

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

**APPEND DOCUMENTATION AS ATTACHMENT 38, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.**

**X. 1120.140 - Economic Feasibility**

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

**A. Reasonableness of Financing Arrangements**

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

- 1) That the total estimated project costs and related costs will be funded in total with cash and equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation; or
- 2) That the total estimated project costs and related costs will be funded in total or in part by borrowing because:
  - A) A portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or
  - B) Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

**B. Conditions of Debt Financing NOT APPLICABLE**

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

- 1) That the selected form of debt financing for the project will be at the lowest net cost available;
- 2) That the selected form of debt financing will not be at the lowest net cost available, but is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional indebtedness, term (years), financing costs and other factors;
- 3) That the project involves (in total or in part) the leasing of equipment or facilities and that the expenses incurred with leasing a facility or equipment are less costly than constructing a new facility or purchasing new equipment.

**C. Reasonableness of Project and Related Costs NOT APPLICABLE/THIS PROJECT IS FOR A CHANGE OF OWNERSHIP AND DOES NOT INVOLVE MODERNIZATION OR CONSTRUCTION**

Read the criterion and provide the following:

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

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Mod.	Gross Sq. Ft. New	Circ.*	Gross Sq. Ft. Mod.	Circ.*	Const. \$ (A x C)	Mod. \$ (B x E)	
Contingency									
<b>TOTALS</b>									

\* Include the percentage (%) of space for circulation

**D. Projected Operating Costs NOT APPLICABLE – CHANGE OF OWNERSHIP OF EXISTING ASC**

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

**E. Total Effect of the Project on Capital Costs NOT APPLICABLE – CHANGE OF OWNERSHIP OF EXISTING ASC**

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

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

**XI. Safety Net Impact Statement**

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

1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.
2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.
3. How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

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

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.
2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.
3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

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

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

	Medicaid (revenue)			
	Inpatient			
	Outpatient			
	Total			

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

**XII. Charity Care Information**

Charity Care information **MUST** be furnished for **ALL** projects.

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.
2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.
3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

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

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

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

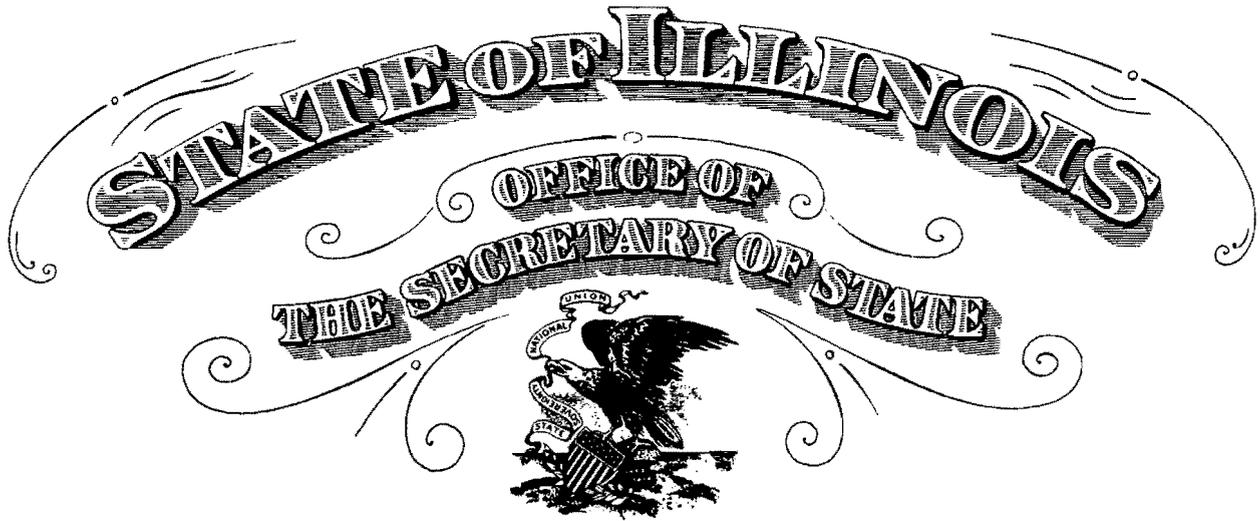
APPEND DOCUMENTATION AS ATTACHMENT-41, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

After paginating the entire, completed application, indicate in the chart below, the page numbers for the attachments included as part of the project's application for permit:

<b>INDEX OF ATTACHMENTS</b>		
<b>ATTACHMENT NO.</b>		<b>PAGES</b>
1	Applicant/Coapplicant Identification including Certificate of Good Standing	
2	Site Ownership	
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	
5	Flood Plain Requirements	
6	Historic Preservation Act Requirements	
7	Project and Sources of Funds Itemization	
8	Obligation Document if required	
9	Cost Space Requirements	
10	Discontinuation	
11	Background of the Applicant	
12	Purpose of the Project	
13	Alternatives to the Project	
14	Size of the Project	
15	Project Service Utilization	
16	Unfinished or Shell Space	
17	Assurances for Unfinished/Shell Space	
18	Master Design Project	
19	Mergers, Consolidations and Acquisitions	
	<b>Service Specific:</b>	
20	Medical Surgical Pediatrics, Obstetrics, ICU	
21	Comprehensive Physical Rehabilitation	
22	Acute Mental Illness	
23	Neonatal Intensive Care	
24	Open Heart Surgery	
25	Cardiac Catheterization	
26	In-Center Hemodialysis	
27	Non-Hospital Based Ambulatory Surgery	
28	Selected Organ Transplantation	
29	Kidney Transplantation	
30	Subacute Care Hospital Model	
31	Children's Community-Based Health Care Center	
32	Community-Based Residential Rehabilitation Center	
33	Long Term Acute Care Hospital	
34	Clinical Service Areas Other than Categories of Service	
35	Freestanding Emergency Center Medical Services	
	<b>Financial and Economic Feasibility:</b>	
36	Availability of Funds	
37	Financial Waiver	
38	Financial Viability	
39	Economic Feasibility	
40	Safety Net Impact Statement	
41	Charity Care Information	

Certificate of Good Standing/All Applicants

See attached.



**To all to whom these Presents Shall Come, Greeting:**

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

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

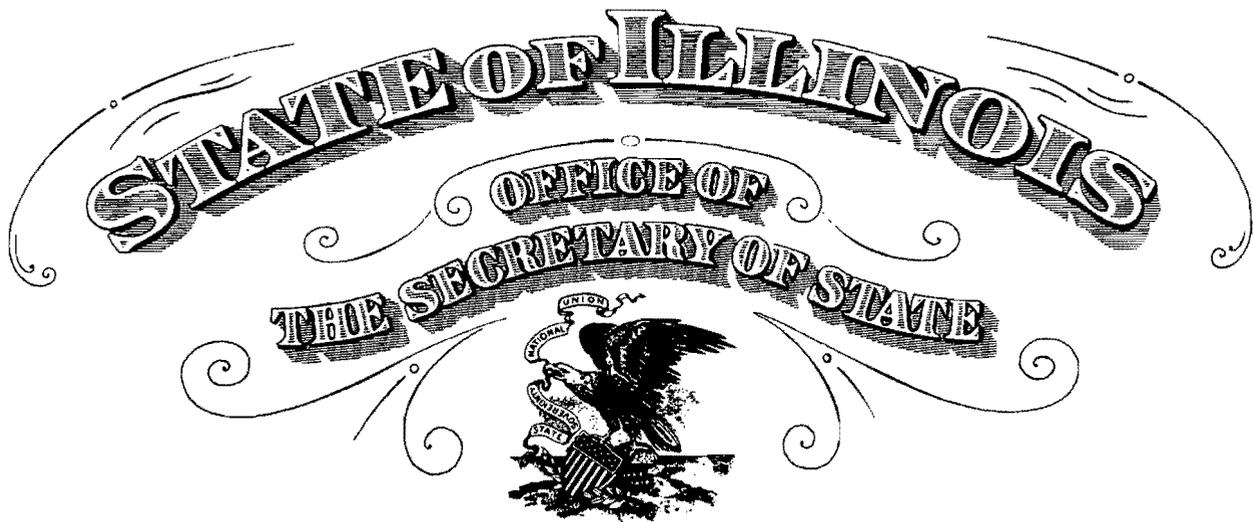
***In Testimony Whereof,*** I hereto set  
*my hand and cause to be affixed the Great Seal of  
the State of Illinois, this 17TH  
day of DECEMBER A.D. 2014 .*



Authentication #: 1435101810  
Authenticate at: <http://www.cyberdriveillinois.com>

*Jesse White*

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*

RED BUD ILLINOIS HOSPITAL COMPANY, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON MAY 23, 2001, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.



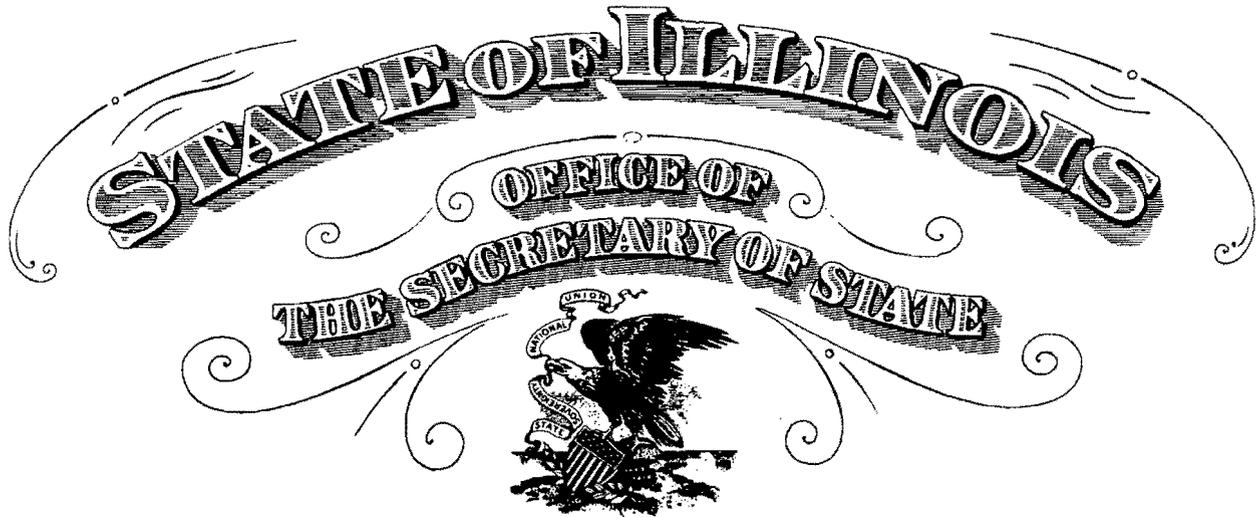
Authentication #: 1435101808

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

*In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 17TH day of DECEMBER A.D. 2014 .*

*Jesse White*

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*

MONROE COUNTY SURGICAL CENTER, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON JANUARY 09, 2007, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.

***In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 17TH day of DECEMBER A.D. 2014 .***



*Jesse White*

SECRETARY OF STATE

Authentication #: 1435101804

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

Site Ownership

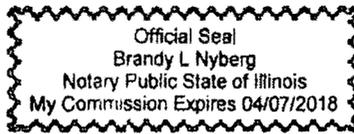
I, William J. Rebholz, do hereby attest that Medical Development Company of America, LLC is the owner of the site where the applicant surgery center is located, and the surgery center leases space from same. Attached is a copy of the lease.

*WJ Rebholz* Managing Member

Signed and sworn to before me this

14 day of December, 2014.

*Brandy Nyberg*

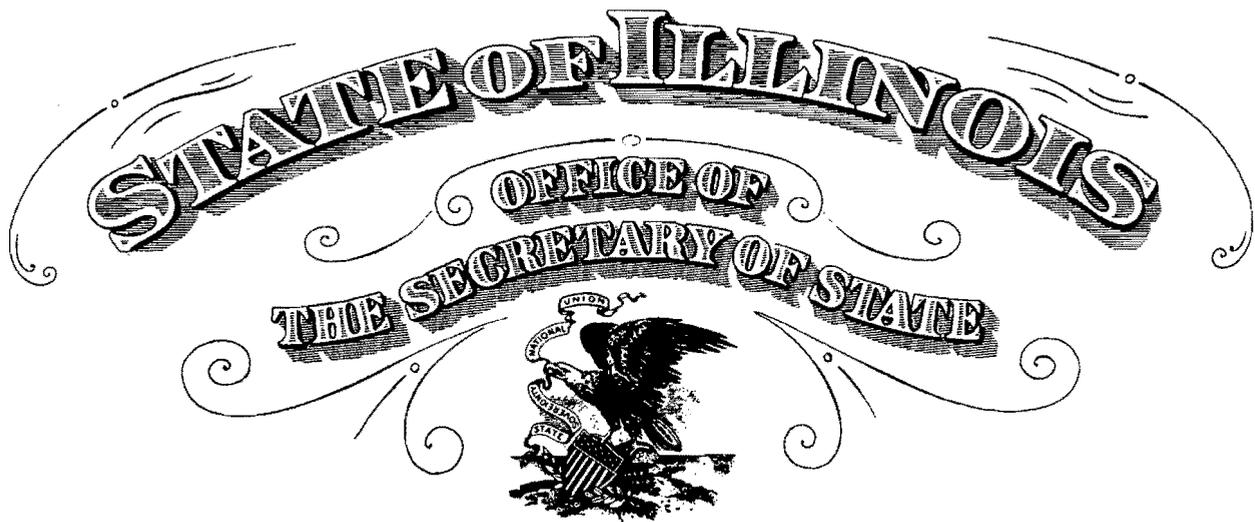


## Operating Entity

See Certificate of Good Standing for the licensed entity.

After the proposed change of ownership, other than Red Bud Regional Hospital, which will own 51%, the following physicians will own more than a 5% interest in the ASC:

Michael Kirk, M.D.	11.5%
William Reilly, M.D.	11.5%
Keith Wilkey, M.D.	8.6%
David King, M.D.	5.8%



*To all to whom these Presents Shall Come, Greeting:*

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

MONROE COUNTY SURGICAL CENTER, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON JANUARY 09, 2007, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.

*In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 17TH day of DECEMBER A.D. 2014 .*



Authentication #: 1435101804

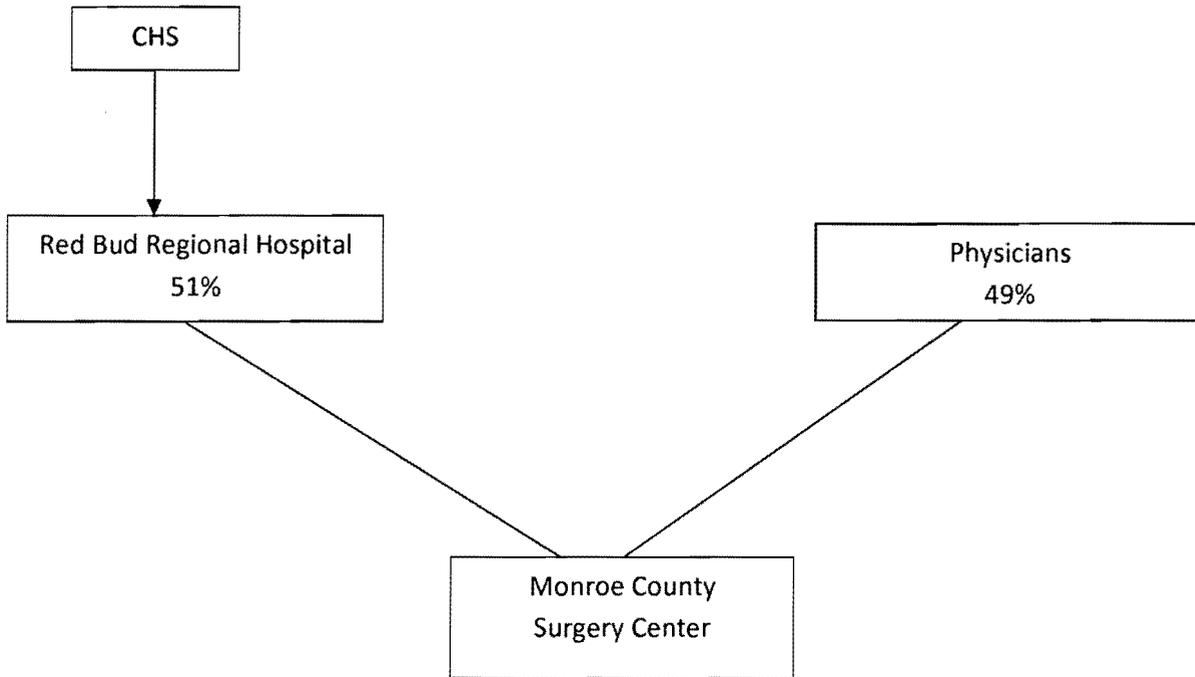
Authenticate at: <http://www.cyberdriveillinois.com>

*Jesse White*

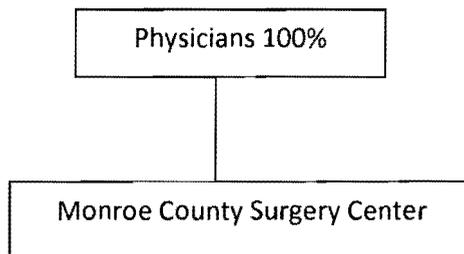
SECRETARY OF STATE

Organization Chart

Proposed



Current



Itemization of Costs

N/A – Change of Ownership

State of Illinois 2154221

Department of Public Health

LICENSE PERMIT CERTIFICATION REGISTRATION

For information only. This is not a license. It is a certification of registration. It does not guarantee the quality of the services provided. It is subject to the rules and regulations of the Department of Public Health.

LA MAR HOSPITAL, MD, NO. 123456789  
ST. LOUIS, MISSOURI 63101

11/24/14 10:00 7003161

FULL LICENSE

ANIMAL SURGICAL TREAT CENTER

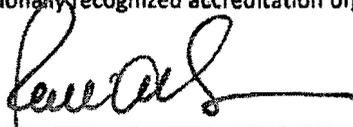
EFFECTIVE: 11/29/13

BUSINESS ADDRESS

MONROE COUNTY SURGICAL CENTER, LLC  
501 W. MADISON ST.

EXPIRES: 11/29/14  
This license is not a license to practice. It is a certification of registration. It does not guarantee the quality of the services provided. It is subject to the rules and regulations of the Department of Public Health.

Community Health Systems, Inc. owns nine hospitals in Illinois, including Red Bud Regional Hospital. There have been no adverse actions as defined by the Health Facilities and Services Review Board against any of these facilities in the past three years, including Red Bud Regional Hospital. The Health Facilities and Services Review Board and Illinois Department of Public Health may access any information necessary to verify the information as submitted, including but not limited to official records of IDPH or other State agencies or the records of nationally recognized accreditation organizations.

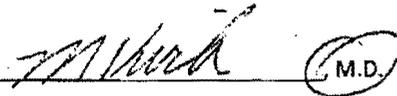


EVP, Secretary of  
Title: General Counsel

Signed and sworn to before me this

\_\_\_\_\_ day of \_\_\_\_\_, 2014

Monroe County Surgical Center, LLC does not own any health facilities other than the surgery center that is the subject of the change of ownership transaction. There have been no adverse actions as defined by the Health Facilities and Services Review Board against it for the past three years. The health Facilities and Services Review Board and Illinois Department of Public Health may access any information necessary to verify the information as submitted, including but not limited to official records of IDPH or other State agencies or the records of nationally recognized accreditation organizations.



Title: Manager

Signed and sworn to before me this

\_\_\_\_\_ day of \_\_\_\_\_, 2014.

See attached licenses for Red Bud Regional Hospital and Monroe County Surgery Center.

Facility Name	Address	City	State	Zip	Medicare #	Add'l Mcare #s	Medicaid #s	License #s
Anna Hospital Corporation d/b/a Union County Hospital	517 North Main	Anna	IL	62906	14-1342	14-Z342 14-3975	364431843001 364431843401	0002824
Blue Island Hospital Company LLC d/b/a Metrosouth Medical Center	12935 S Gregory St	Blue Island	IL	60406	14-0118	14-S118	454082512001 454082512401	0005835
Galesburg Hospital Corporation d/b/a Galesburg Cottage Hospital	695 North Kellogg Street	Galesburg	IL	61401	14-0040	14-S040 14-S690	371485782001 371485782401	0005330
Granite City Illinois Hospital Company, LLC d/b/a Gateway Regional Medical Center	2100 Madison Avenue	Granite City	IL	62040	14-0125	14-S562 14-S125 14-T125	364460628001 364460628401	0005223
Marion Hospital Corporation d/b/a Heartland Regional Medical Center	3333 West DeYoung	Marion	IL	62959	14-0184	14-U184	371359605001 371359605401	0005298
National Healthcare of Mt. Vernon, Inc d/b/a Crossroads Community Hospital	#8 Doctors Park Drive	Mt. Vernon	IL	62864	14-0294	14-U294	581622971001 581622971401	0003947
Red Bud Illinois Hospital Company, LLC d/b/a Red Bud Regional Hospital	325 Spring Street	Red Bud	IL	62278	14-1348	14-Z348 14-S309	364443919001 364443919401	0005199
Waukegan Hospital Company, LLC d/b/a Vista Medical Center East	1324 North Sheridan Road	Waukegan	IL	60085	14-0084		203978521002 203978521402	0005397
Waukegan Hospital Company, LLC d/b/a Vista Medical Center West	2615 Washington Street	Waukegan	IL	60085	14-0033	14-T033 14-S033	203978521001	0005405

## Purpose

1. The project proposes simply the change of ownership of an existing ASC. It will improve access by allowing for better physician-hospital alignment, and the ASC will have greater access to capital for improvements and continued investment in its equipment and physical plant.
  2. The planning/market area will be that currently served by the existing ASC located at 501 N. Hamacher St. in Waterloo, Illinois.
  3. There are no problems in the market area, but the proposed joint venture between the Hospital and physicians will allow for coordinated care, efficiencies in medical record coordination and communication, less costly services for patients who might otherwise receive endoscopy services at the Hospital and capital investment to maintain the ASC.
- 4-6. Not Applicable. This project proposes only the change of ownership of an existing ASC.

## Alternatives

1-2

- A. There were no real alternatives to this project, as it involves the change of ownership of the Monroe County Surgery Center. However, Red Bud Regional Hospital could have acquired all of the assets in the surgery center, versus just 51%. It is common for physicians to maintain an ownership interest in surgery centers that they previously owned/operated, and Red Bud Regional Hospital believed it best to engage in a partnership with its physicians as opposed to simply buying the surgery center in total. With physician ownership, the commitment to maintaining quality at and the integrity of the surgery center will be present not only through the Hospital, but also via the physicians who refer patients to the surgery center and perform surgical services at it. Red Bud Regional Hospital and the current ASC felt this alternative was the best approach. If it had acquired all of the assets of the surgery center, the approximate price would have been \$4M.
  - B. This project is a joint venture.
  - C. Utilizing other health care providers is not applicable, since this proposes a change of ownership.
3. There is no empirical evidence available to the applicants that the project will improve care. However, collaboration and coordination between the Hospital and physicians should set the stage for enhanced continuity and quality of care.

## Mergers/Changes of Ownership

### A. Impact Statement

There will be no change in services at the surgical center after the change of ownership. Monroe County Surgical Center, LLC will remain the operating entity, but its ownership will have changed as stated in this application.

One reason for the transaction is through the hospital's acquisition of an ownership interest, its capital will be available to the surgery center for purposes as divergent as marketing to equipment investment. Also, Red Bud and the physicians who currently own the surgery center believe that collaboration between the two providers (local hospital and physician members of the hospital Medical Staff) will ultimately prove to strengthen the surgery center's quality and other initiatives.

There are no contemplated changes with respect to the number of employees at the surgery center as a result of this transaction.

A cost/benefit analysis was not done. However, attached is a letter reflecting FMV used for purposes of analyzing the purchase of a majority interest in the surgery center.

### B. Access

The surgery center has a charity care policy (attached). It does see Medicaid patients, offers payment plans to patients who have difficulty with co-pays or are self pay and it does see undocumented patients. Per the attached certification of Red Bud Regional Hospital's CEO, Shane Watson, the Hospital's ownership will not result in any change to the admissions policy. In fact the Red Bud Regional Hospital's FA policies are more generous than the current ASC policy, which should improve access. Attached for review are Red Bud Regional Hospital's Financial Assistance Policies.

### C. Health System

Not applicable.



November 21, 2014

PERSONAL AND CONFIDENTIAL

Community Health Systems  
4000 Meridian Boulevard  
Franklin, TN 37067

Dear Community Health Systems:

We have been engaged by Community Health Systems to provide a conclusion of value of 51% interest for MONROE COUNTY SURGICAL CENTER inclusive of a Management Agreement as of June 30, 2014. The procedures performed have been described in our valuation report and we have concluded the estimated fair market value of the 51% member interest and the Management Agreement of MONROE COUNTY SURGICAL CENTER is \$2,187,900 (Two Million One Hundred Eighty-Seven Thousand Nine Hundred Dollars), as of June 30, 2014.

SOMERSET CPAs, P.C.

A handwritten signature in cursive script that reads "Thomas J. Thieme".

Thomas J. Thieme, CPA/ABV, CMA  
Indianapolis, Indiana

A handwritten signature in cursive script that reads "Stephen J. Diagostino".

Stephen J. Diagostino, CPA/ABV  
Indianapolis, Indiana

I, Shane Watson, CEO of Red Bud Regional Hospital do hereby attest that the admissions policies of the Monroe County Surgery Center will not change after the Hospital's acquisition of a 51% ownership interest in same.

Shane Watson

Signed and sworn to before me this

16<sup>th</sup> day of DECEMBER, 2014.

Subject:	Originally Issued	Date of This Revision	Page	No.
ILLINOIS UNINSURED/INSURED/SELF PAY DISCOUNT POLICY	2/01/08	10/15/14	1 of 17	

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**POLICY STATEMENT:**

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

Discounted Care will be provided to all uninsured patients without regard to race, ethnicity, sex, sexual orientation, creed, color, religious beliefs or national origin.

Patients may apply for the discount within 60 days of the discharge date from the receipt of the service.

All Illinois Hospitals will charge Illinois residents no more than 135% of charges based on their most recently filed Medicare cost report.

**PURPOSE:**

To properly identify those patients who do not have insurance and do not qualify for third party coverage, state and/or government assistance or Free Care per the Hospital's Charity Care Policy and to provide assistance with their medical expenses under the guidelines set forth herein.

All capitalized terms are defined in Appendix A hereto.

**ELIGIBILITY FOR DISCOUNTED CARE**

1. To be eligible for a reduction in a balance due the patient must be uninsured and the Hospital services not covered in whole or part, by any other third party source.
2. The Family Income must be 300% of the Federal Poverty Income guidelines, or less at Critical Access or Rural Area Hospitals or 600% of the Federal Poverty Income or less at Urban Area Hospitals. A hospital, other than a rural hospital or Critical Access Hospital, 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. A rural hospital or Critical Access Hospital 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 125% of the federal poverty income guidelines.

3. Patients who do not provide the documents required to make a determination for discounted care may either be denied a discount or may only be eligible for the minimum discount of 35%. Patients shall have 60 days from the date of discharge to apply for Discounted Care.
4. The services the patient receives must be Medically Necessary services.
5. For all health care services exceeding \$300 in any one inpatient admission or outpatient encounter, a hospital shall not collect from an uninsured patient, deemed eligible under subsection (a), more than its charges less the amount of the uninsured discount.
6. A patient applying for Discounted Care must be an Illinois Resident and provide acceptable Family Income verification. Acceptable forms of verification of Illinois residency includes one of the following in current form:
  - Any document listed on acceptable family income verification
  - A valid state issued identification card
  - A recent residential utility bill
  - A lease agreement
  - A vehicle registration card
  - A voter registration card
  - Mail addressed to the uninsured patient at an Illinois address from a government or other credible source
  - A statement from a family member of the uninsured patient who resides at the same address and presents verification of residency
  - A letter from a homeless shelter, transitional house or other similar facility verifying that the uninsured patient resides at the facility

### **THE AMOUNT OF THE DISCOUNT PROVIDED**

PATIENTS WHO DO NOT PROVIDE PROOF OF INCOME OR RESIDENCY ; WHO ARE NOT ELIGIBLE FOR SELF PAY DISCOUNT OR WHOSE CHARGE FOR AN INPATIENT OR OUTPATIENT ENCOUNTER IS LESS THAN \$300: these patients are eligible for a minimum discount of 35% off billed charges.

PATIENTS WHO PROVIDE PROOF OF ILLINOIS RESIDENCY, WHO ARE ELIGIBLE FOR A SELF PAY DISCOUNT AND WHOSE CHARGES FOR AN INPATIENT OR OUTPATIENT ENCOUNTER IS MORE THAN \$300: a discount will be provided based on 135% of the Hospital cost based on the most recently filed Medicare Cost Report. Therefore, the amount of the discount is subject to change each year.

However, the maximum amount that may be collected in a 12-month period from eligible patients is 25% of the patient's Family Income, excluding patients with substantial assets as described in Appendix B. The 12 month period to which the maximum amount applies shall

begin on the first date an uninsured patient receives health care services that are determined to be eligible for the uninsured discount at that hospital.

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

### **EXCLUDED UNDER THIS POLICY**

1. Patient's covered by any insurance, local, state or government health care coverage or other third party coverage. This includes any portion of a Hospital bill where the patient's insurance has denied or excluded certain services from coverage.
2. Patients who qualify and receive Free Care under the Hospital's Charity Care Policy.
3. Charges for services that are not Medically Necessary.
4. Any other patient/account already receiving a discount; such as (but not limited to) Industrial Accounts or Client Accounts.
5. Hospital based physician charges.

### **THE PROCESS**

1. **Identification of Patients Eligible for Discounted Care:**
  - A. The Hospital will include a statement on each Hospital bill or summary of charges of the availability of Financial Assistance for those who are uninsured or may otherwise need assistance with a bill for services and how to contact the Hospital for information for same. The statement will include information regarding income requirements. In addition, the Hospital's policy on Financial Assistance/Discounted Care and its application for same shall be posted on the Hospital's website. The application shall be in English and any other language that is common to 5% or more of the Hospital's patients.
  - B. All patients with no insurance who do not qualify for Charity Care or who do not apply for Charity Care will be eligible for a discount off billed charges (subject to charges exceeding \$300 of charges in any one Inpatient and Outpatient encounters), excluding encounters where charges are \$300 or less. No discount will be provided when the total charge for that encounter is \$300 or less.
  - C. During the screening process, the financial counselor or self pay screening vendor will screen for potential Medicaid eligibility as well as coverage by other sources,

including governmental programs. During this screening process a Financial Assistance ("FA") application will be completed. (Appendix B) Patients will be required to cooperate and apply for Medicare, Medicaid, AllKids, SCHIP, or any other public program providing there is reason to believe they would qualify. Proof of denial will be required for the patient to be eligible for the discount above the minimum uninsured discount.

- D. All uninsured patients will be screened for existing Medicaid coverage by using the Hospital's insurance eligibility software. A copy of the response will be retained as verification that the patient did not have Medicaid coverage.
- E. The Hospital will view prior accounts for the patient as well as the guarantor to determine if insurance coverage existed in the 12 months prior to the date services are rendered. If so, the Hospital will 'attempt to verify insurance coverage' and document the call and response.
- F. The Hospital reserves the right to pull a copy of the patient's credit report for verification of information provided.
- G. When it is determined the patient does not qualify for Medicare, Medicaid or any other third party coverage and the patient does not qualify for Free Care under the Hospital's Charity Care Policy, an uninsured patient the patient will be presumptively eligible for Discounted Care, but must nonetheless complete the Hospital's FA to confirm same.
- H. Patients who are not screened for Medicare, Medicaid and other third party coverage, due to the patient not returning calls or providing the necessary information to make a determination of coverage and who do not provide the necessary information to determine eligibility for Discounted Care will only be eligible for the minimum uninsured discount off billed charges.
- I. Proof of Income and/or residency must be provided within 30 days of request.

Acceptable forms of documentation of Family Income shall include one of the following:

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

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

- Any document listed on acceptable family income verification
- A valid state issued identification card
- A recent residential utility bill
- A lease agreement

- A vehicle registration card
- A voter registration card
- Mail addressed to the uninsured patient at an Illinois address from a government or other credible source
- A statement from a family member of the uninsured patient who resides at the same address and presents verification of residency
- A letter from a homeless shelter, transitional house or other similar facility verifying that the uninsured patient resides at the facility

**2. FAILURE TO PROVIDE ACCURATE INFORMATION**

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

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

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

- A. For those patients screened by the Hospital financial counselor or self pay screening vendor, once the eligibility determination has been made, the results will be documented in the comments section on the patient's account.
- B. The discount will be set in the system and will not require Hospital authorization.
- C. The transaction code used will reflect 'Self Pay Discount' and will not be considered Charity.
- D. The 35% discount applied to all self pay accounts will be adjusted with transaction codes **556** for Inpatient, and **557** for Outpatient.
- E. If the patient qualifies for the Illinois Uninsured Patient Discount; the 35% discount shall be reversed and a new discount will be applied using the following codes:

Inpatient Discount — Transaction code **558**

Outpatient Discount Transaction code **559**

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

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

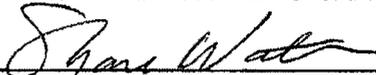
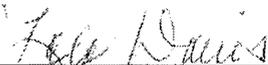
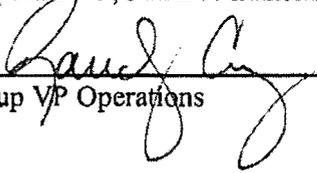
4. **REPORTING OF DISCOUNTED CARE**

Information regarding the amount of Discounted Care provided by the Hospital, based on the Hospital's fiscal year, shall be aggregated and included in the annual report filed with the Bureau of State Health Data and Process Analysis at the State Department of Health. These reports also will include information concerning the provision of government sponsored indigent health care and other county benefits. (Only for those states that require). In addition, the Hospital will provide the Attorney General's office an annual report regarding all applications for Financial Assistance, those denied and those accepted.

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

5. **POLICY REVIEW AND APPROVAL**

The below individuals have read and approved this policy:

 _____ Hospital CEO	<u>12/9/14</u> Date
 _____ Hospital CFO	<u>12/9/14</u> Date
 _____ Corporate VP, Patient Financial Services	<u>12/9/14</u> Date
 _____ Group VP Operations	<u>12/10/14</u> Date

## Appendix A Definitions

**Affiliates:** Those entities controlled by, controlling, or under common control with Hospital. For purposes of this policy, the term "Affiliates" does not include Hospital affiliates that are legally or otherwise restricted from adopting this policy.

**Amounts Generally Billed:** Charges for medically necessary services shall be limited to no more than amounts generally billed to individuals who have insurance covering such care ("AGB").

- i. In calculating the AGB, the Hospital has selected the "look-back" method whereby the AGB is determined based on actual past claims paid to the Hospital by Medicare fee-for-service together with all private health insurers paying claims to the Hospital.
- ii. The AGB percentage will be calculated at least annually by dividing the sum of all claims that have been paid in full during the prior 12 month period by the sum of the gross charges for those claims. This resulting percentage is then applied to an individual's gross charges to reduce the bill.
- iii. A revised percentage will be calculated and applied by the 45<sup>th</sup> day after the first day of the start of the fiscal year used to determine the calculations.

**Applicant:** An Applicant is the person submitting an Application for Financial Assistance, including the patient and/or the patient's guarantor.

**Application:** A Financial Assistance Application.

**Application Period:** During the Application Period, the Hospital must accept and process an application for Financial Assistance ("Application"). The Application Period begins on the date the care is provided to the individual and ends on the 240<sup>th</sup> day after the Hospital provides the patient with the first billing statement for the care.

**Billed Charge(s):** The fee for a service that is based on the Hospital's master charge schedule in effect at the time of the service.

**Completion Deadline:** The Completion Deadline is the date after which a Hospital may initiate or resume ECAs (as defined below) against an individual who has submitted an incomplete Application if that individual has not provided the Hospital with the missing information and/or documentation necessary to complete the Application. The Completion Deadline must be no earlier than the later of 30 days after the Hospital provides the individual with this written notice; or the last day of the Application Period.

**Cost-of-Care Discount: 30%**

**Discounted Care:** Care provided at less than Billed Charges other than Free Care. Discounts include the Cost-of-Care Discount and the Managed Care Discount.

**Extraordinary Collection Activity:** As defined by the Act, but includes any legal action with respect to a Patient's Account.

**Family Income:** Family Income is defined based on definitions used by the U.S. Bureau of the Census and includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance payments, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources. Non-cash benefits (such as SNAP and housing subsidies) are not considered income.

**Family Size:** The number of individuals listed under "Filing Status" on the Applicant's most recent tax return. If no tax return is available, Family Size shall be the number of individuals permanently residing in the Applicant's household. If another individual claims the Applicant as a dependent on the individual's tax return, then the Family Size shall include household members of the individual claiming dependency.

**Federal Poverty Guideline:** The Federal Poverty Guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of 42 USC 9902(2). Guidelines, attached as Appendix A-1, shall be adjusted annually within thirty (30) days following the issuance of new Federal Poverty Guidelines in the Federal Register and on the U.S. Department of Health and Human Services website.

**Financial Assistance:** Care provided to patients who meet Hospital's criteria for Financial Assistance under various programs (collectively, "Financial Assistance Program" or "Program") and are unable to pay for all or a portion of their health care services. Financial Assistance does not include bad debt or uncollectible charges that have been recorded as revenue but written off due to a patient's failure to pay, or the cost of providing that care to patients; the difference between the cost of care provided under Medicaid or other means-tested government programs or under Medicare and the revenue derived from those programs; or contractual adjustments with any third-party payors.

**Free Care:** A discount equal to one hundred percent (100%).

**Financial Assistance Policy Committee:** That committee comprised of representatives from Hospital and which makes recommendations with respect to this Policy and ensures operational alignment in implementing this Policy. If the Hospital does not have a specific committee, the CFO or his/her delegates will address this function.

**Household Income:** The sum of a family's annual earnings and cash benefits from all sources before taxes, less payments made for child support. More specifically, Household Income is equal to the adjusted gross income listed on the Applicant's most recent tax return, adjusted to subtract child support payments and to add amounts of tax-exempt interest; non-taxable pension and annuity payments, IRA distributions, and social security; and other income not included in adjusted gross income but available to Applicant. However, if the Applicant indicates that the adjusted gross income listed on the Applicant's most recent tax return is not accurate (e.g., the Applicant is no longer employed or is being paid a different amount), the Household Income shall be calculated on the basis of other available documentation (e.g., pay stubs, unemployment statements, etc.), once again adjusted to remove child support payments and to include tax-exempt interest; non-taxable pension and annuity payments, IRA distributions, and social security; and other income available to Applicant. Household Income includes the income of all members of the household.

***Illinois Resident:*** An Illinois Resident includes patients who qualify for Illinois residency under the Illinois Hospital Uninsured Patient Discount Act (“HUPDA”). HUPDA requires that the Uninsured Patient be a resident of Illinois, but does *not* require that the patient be legally residing in the United States. Patients may be required to provide evidence of Illinois residency as provided for under HUPDA. Relocation to Illinois for the sole purpose of receiving health care benefits does not satisfy the residency requirement under this definition. These patients are encouraged to seek treatment at an appropriate facility within their geographic proximity.

***Insured Patient:*** A patient covered under a policy of health insurance or a beneficiary under 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.

***Legal Illinois Resident:*** A Legal Illinois Resident includes patients legally residing within the United States *and* who have their principal residence within the state of Illinois. With respect to foreign nationals, “legally residing” shall include individuals who have current visas and who are permanent residents and temporary workers. “Legally residing” shall not include foreign nationals who have visitor or student visas. Relocation to Illinois for the sole purpose of receiving health care benefits does not satisfy the residency requirement under this definition. These patients are encouraged to seek treatment at an appropriate facility within their geographic proximity.

***Medically Necessary:*** Any inpatient or outpatient health care service, including pharmaceuticals or supplies, covered under Title XVIII of the federal Social Security Act for beneficiaries with the same clinical presentation as the Patient. A “Medically Necessary” service does not include any of the following: (1) non-medical services such as social and vocational services; or (2) elective cosmetic surgery, but not plastic surgery designed to correct disfigurement caused by injury, illness or congenital defect or deformity.

***Non-Resident:*** A Non-Resident is a patient who is neither a Legal Illinois Resident nor an Illinois Resident.

***Uninsured Patient:*** A patient not covered under a policy of health insurance or who is not a beneficiary under 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.

**Appendix A (continued)**  
Financial Assistance Program Application

RED BUD REGIONAL HOSPITAL

**HOSPITAL FINANCIAL ASSISTANCE APPLICATION  
UNDER THE FAIR PATIENT BILLING ACT**

**YOU MAY BE ELIGIBLE TO RECEIVE FREE OR DISCOUNTED CARE**

Completing this application will help Red Bud Regional Hospital determine if you are eligible for Discounted or Free Care, or other public programs or governmental health care 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 to the hospital in person, by mail, by electronic mail, or by fax to apply for free or discounted care within 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. **NOTE:** The requirement to complete and submit this form within 60 days following the date of discharge or receipt of outpatient care referenced in the Opening Statement may be increased by the hospital, but may not be decreased. The Discounted Care or Free Care options only apply to Medically Necessary health care services. The Act does not apply to elective cosmetic surgery or non-medical services such as social and vocational services. If you have questions about what is a Medically Necessary services our financial counselors can assist you in answering them. You are presumptively eligible for Free Care if you meet certain eligibility requirements, including Women, Infants and Children Nutrition program, Supplemental Nutrition Assistance program, Illinois Free Lunch and Breakfast program, Low Income Home Energy Assistance Program, enrollment in an organized community based program providing access in medical care that assess and documents limited low income financial status as a criterion for membership, receipt of grant assistance for medical services, subsidized school lunch and/or low income housing. If you meet the presumptive eligibility criteria or are otherwise presumptively eligible by virtue of you or your family's income, you shall not be required to complete the portions of the application monthly expense information and estimated expenses (see page 14). The Discount Care and/or Free Care entitled do not apply to physician services. You are entitled to apply for financial assistance within sixty (60) days from your date of discharge from inpatient or outpatient services.

Your failure to cooperate with the Hospital, including providing the information available to verify your participation in any of the above programs, failure to provide financial information as requested in this application regarding you or your family, and your failure to cooperate in enrolling in any governmental or similar financial assistance or insurance program for which it is determined you may reasonably be entitled may result in your being denied Financial Assistance to which you otherwise would be entitled. This information must be provided within thirty (30) days of receipt of an application. If you request Financial Assistance, the Hospital must notify

you within thirty days of receipt of all information required as to whether you qualify and if it cannot make that determination within that time frame must notify you why and what if any information is missing from your application.

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

However, a Social Security Number may be required for some public programs.

**FINANCIAL ASSISTANCE / FEDERAL POVERTY GUIDELINE (FPL)**

Family Size	FPG	Financial Assistance Cap
1	11,490	34,470
2	15,510	46,530
3	19,530	58,590
4	23,550	70,650
5	27,570	82,710
6	31,590	94,770
7	35,610	106,830
8	39,630	118,890

Effective date for use 01/24/13 (publication date)

For families with more than eight members, add \$4,020.00 for each additional member

**Please complete this form and submit it to the Hospital in person, by mail, by electronic mail or by fax to apply for free or discounted care within 60 days following the date of discharge or receipt of outpatient care. The requirement to complete this form within sixty days of discharge or your receipt of outpatient care may be extended by the Hospital, but may not be decreased.**

**HOSPITAL FINANCIAL ASSISTANCE APPLICATION**

\_\_\_\_\_  
 Patient Name \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 Patient's Date of Birth \_\_\_\_\_ Account Numbers \_\_\_\_\_ Account Balances \_\_\_\_\_

\_\_\_\_\_  
 Patient's Address \_\_\_\_\_ Patient's Phone Number \_\_\_\_\_

\_\_\_\_\_  
 Patient's City, State & Zip Code \_\_\_\_\_ Patient's Email Address \_\_\_\_\_

Is the applicant a resident of Illinois	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Was the services provided related to an accident	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Was the services provided work related	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Was the patient a victim of a crime	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

**HOUSEHOLD MEMBERS**  
 (list all persons living in the household)

Name	Date of Birth	Relationship to Patient

--	--	--

**Income Verification**

(list all persons in household who are employed)

Name	Employer Name & Location	Employer Phone Number	Monthly Income

**Other Income**

(list monthly amounts for each household member)

Name	Wages	Unemployment Work Comp	TANF	Social Security	SSI	VA	Child Support/ Alimony

Is there any other income in the family?       Yes       No

If yes, list source and monthly amount: \_\_\_\_\_  
 \_\_\_\_\_

Total Household Income for the Last Twelve Months?      \$ \_\_\_\_\_

**Assets**

	Yes	No	Account #	Value	Name of Owner

54

Home					
Other Property					
Auto 1					
Auto 2					
Checking Acct					
Savings Acct					
Cert. of Deposit					
Stocks/Bonds					
Health Saving Plan/Flex Spending Account					
Other					

**Expenses**

Housing	
Utilities	
Food	
Transportation	
Child Care	
Loans	
Medical Expenses	
Other Expenses	

**Certification**

"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 the Hospital, and I authorize the 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, I will be ineligible for financial assistance, any financial assistance granted to me may be reversed, and I will be responsible for the bill."

Applicant's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Hospital Agent: \_\_\_\_\_

Date: \_\_\_\_\_

## Appendix B

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

- (a) The necessary wearing apparel, bible, school books, and family pictures of the debtor and the debtor's dependents;
- (b) The debtor's equity interest, not to exceed \$4,000 in value, in any other property;
- (c) The debtor's interest, not to exceed \$2,400 in value, in any one motor vehicle;
- (d) The debtor's equity interest, not to exceed \$1,500 in value, in any implements, professional books, or tools of the trade of the debtor;
- (e) Professionally prescribed health aids for the debtor or a dependent of the debtor;
- (f) All proceeds payable because of the death of the insured and the aggregate net cash value of any or all life insurance and endowment policies and annuity contracts payable to a wife or husband of the insured, or to a child, parent, or other person dependent upon the insured, whether the power to change the beneficiary is reserved to the insured or not and whether the insured or the insured's estate is a contingent beneficiary or not;
- (g) The debtor's right to receive:
  - (1) a social security benefit, unemployment compensation, or public assistance benefit;
  - (2) a veteran's benefit;
  - (3) a disability, illness, or unemployment benefit; and
  - (4) alimony, support, or separate maintenance, to the extent reasonably necessary for the support of the debtor and any dependent of the debtor.
- (h) The debtor's right to receive, or property that is traceable to:
  - (1) an award under a crime victim's reparation law;
  - (2) a payment on account of the wrongful death of an individual of whom the debtor was a dependent, to the extent reasonably necessary for the support of the debtor;
  - (3) a payment under a life insurance contract that insured the life of an individual of whom the debtor was a dependent, to the extent reasonably necessary for the support of the debtor or a dependent of the debtor;
  - (4) a payment, not to exceed \$15,000 in value, on account of personal bodily injury of the debtor or an individual of whom the debtor was a dependent; and

- (5) any restitution payments made to persons pursuant to the federal Civil Liberties Act of 1988 and the Aleutian and Pribilof Island Restitution Act,

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

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

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

(1) any contribution to such account by the debtor as participant or donor that is made with the actual intent to hinder, delay, or defraud any creditor of the debtor;

(2) any contributions to such account by the debtor as participant during the 365 day period prior to the date of filing of the debtor's petition for bankruptcy that, in the aggregate during such period, exceed the amount of the annual gift tax exclusion under Section 2503(b) of the Internal Revenue code of 1986, as amended, in effect at the time of contribution; or

(3) any contributions to such account by the debtor as participant during the period commencing 730 days prior to and ending 366 days prior to the date of filing of the debtor's petition for bankruptcy that, in the aggregate during such period, exceed the amount of the annual gift tax exclusion under Section 2503(b) of the Internal Revenue code of 1986, as amended, in effect at the time of contribution.

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

**Red Bud Regional Hospital**

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<b>Subject:</b>	<b>Originally <u>Issued</u></b>	<b>Date of This <u>Revision</u></b>	<b><u>Page</u></b>	<b><u>No.</u></b>
<b>CHARITY CARE POLICY</b>	<i>3/1/05</i>	<i>10/15/2014</i>		

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**POLICY STATEMENT:**

In order to serve the health care needs of our community, Red Bud Regional Hospital will provide Free Care (hereinafter referred to as "Free Care") to patients without financial means to pay for *Inpatient, Emergency Room hospital services and Medically Necessary Out Patient Services (according to Medicare Medical Necessity Guidelines)*.

Free Care will be provided to all patients without regard to race, sex, sexual orientation, ethnicity, religion, color, or national origin and who are classified as financially indigent or medically indigent according to the hospital's eligibility criteria.

All capitalized terms herein are defined on Appendix A hereto.

**PURPOSE:**

To properly identify those patients who are financially indigent, medically indigent or who meet presumptive eligibility criteria, who do not qualify for state and/or government assistance, and to provide assistance with their Medically Necessary care.

**ELIGIBILITY FOR FREE CARE**

**1. FINANCIALLY INDIGENT:**

- A. A financially indigent patient is a person who is uninsured, and is accepted for care with no obligation to pay for services rendered based on the hospital's eligibility criteria as set forth in this Policy.
- B. To be eligible for Free Care as a financially indigent patient, the patient's total Household Income shall be as specified in Appendix B or C hereto. The hospital may consider other financial assets and liabilities for the person when determining eligibility.
- C. The hospital will use the most current Federal Poverty Income Guidelines issued by the U.S. Department of Health and Human Services to determine an individual's eligibility for Free Care as a financially indigent patient. The Federal Poverty Income Guidelines are published in the Federal Register in January or February of each year and for the purposes of this Policy will become effective

the first day of the month following the month of publication, even if the guidelines attached to the Policy or posted on the Website are outdated.

- D. In no event will the hospital establish eligibility criteria for financially indigent patients which sets the income level for Free Care lower than that required for counties under the State Indigent Health Care and Treatment Act, or higher than 300% of the current Federal Poverty Income Guidelines. However, the hospital may adjust the eligibility criteria from time to time based on the financial resources of the hospital and as necessary to meet the Free Care needs of the community.
- E. Patients covered by out of state Medicaid where the hospital is not an authorized provider and where the out of state Medicaid enrollment or reimbursement makes it prohibitive for the hospital to become a provider, will be eligible for Free Care upon verification of Medicaid coverage for the service dates. No other documents will be required in order to approve the Free Care application. The patient will not be required to apply for Financial Assistance to obtain Free Care. The hospital may submit the application and verification of Medicaid coverage in another State as proof of qualification.

2. **MEDICALLY INDIGENT:**

- A. A medically indigent patient is a person whose medical bills after payment by third party payers exceed a specified percentage of the person's annual gross income as defined herein and who is unable to pay the remaining bill.
- B. Patients covered under state Medical Assistance programs that owe copayments or have a 'spend down' amount are excluded from being considered for Free Care assistance. Payment of copayments and spend down amounts are a condition of coverage and should not be written off or discounted.
- C. The maximum amount the Hospital may collect in a 12-month period from an eligible patient is 25% of the patient's Family Income. The twelve month period begins on the date of service for which the hospital first determines the patient is eligible for the discount. The hospital may exclude a patient from the 25% maximum collectible amount who has substantial assets (defined as a value in excess of 600% FPL in urban areas/300% FPL at CAH/and rural areas). Certain assets cannot be considered: primary residence, personal property exempt from collections under Section 5/12-1001 of the Illinois Code of Civil Procedure, and any amounts held in a pension or retirement plan.
- D. A determination of the patient's ability to pay the remainder of the bill, or portion of the bill, will be based on whether the patient reasonably can be expected to pay the account, or portion thereof, over a 3-year period.
- E. The patient may be eligible for a charity discount for any amount beyond what the patient is expected to pay over a 3-year period.

- F. If a determination is made that a patient had the ability to pay the remainder of the bill, such a determination does not prevent a reassessment of the patient's ability to pay at a later date should there be a change in the patient's financial status.

3. **FREE CARE PRESUMPTIVE ELIGIBILITY:**

- A. A presumptively eligible patient is an uninsured person who qualifies for financial assistance based on the demonstration of participation in one of several categories, some that are mandated categories and other categories that a hospital may consider.

- B. The mandatory categories are intended to reflect the new free care mandate included in the 2012 amendment to the Hospital Uninsured Patient Discount Act (HUDPA) legislation at urban hospitals for uninsured patients up to 200% of the federal poverty level (FPL) and 125% of FPL at rural and critical access hospitals (CAHs).

- C. **All hospitals mandated** categories:

- 1. Homelessness
- 2. Deceased with no estate
- 3. Mental incapacitation – no one to act on behalf
- 4. Medicaid eligibility – not on date of service/ or for non-covered service
- 5. Community programs that treat patients based on their income being lower than the federal poverty guideline (example: Vista patients referred by Health Reach Clinic, a local Free Care clinic where the hospital is a sponsor of their indigent program will be eligible for Free Care under completion of proper application using the same Federal Poverty Income Guidelines)
- 6. Enrollment in the following programs with criteria at or below 200% of the then current Federal Poverty Guidelines:
  - a. Women, Infants, Children – WIC
  - b. Supplemental Nutrition Assistance Program – SNAP
  - c. Free Lunch and Breakfast Program, or Subsidized School Lunch
  - d. Low Income Home Energy Assistance Program – LIHEAP
  - e. Grant assistance for medical services
  - f. Temporary Assistance for Needy Families – TANF

g. Housing Development Authority Support Program

7. Incarceration in a Penal Institution with no family income or assets

4. **REPORTING:**

- A. The Hospital shall report annually to the Office of the Attorney General's Office on the number of Applications completed and approved; the number of Applications completed and not approved; and the number of Applications started but not completed.

5. **THE PROCESS**

- A. The hospital maintains posted signs, in English, *Exhibit "A"* and Spanish, *Exhibit "\_\_\_"*, and in any other language which is spoken by 5% or more of the Hospital's patients one in each admitting and/or registration offices and one in the emergency lobby that inform customers that Financial Assistance is available and the Financial Assistance criteria.
- B. All self-pay patients will be identified as quickly as possible and will be asked to complete the Financial Assistance application "FA", during the registration or financial counseling process (or if they provide information or the Hospital can obtain information that meets the Presumptive eligibility requirements a FA will not be required).
- C. Hospital will post information regarding the availability of Free Care for both uninsured and insured patients on the hospital's web site, along with the application for Financial Assistance. In addition, Hospital will provide a copy of the a Financial Assistance application and information relating to Financial Assistance upon both registration and discharge.
- D. Hospital will provide information on all billing notices about the availability of Free Care and/or Financial Assistance.
- E. All self-pay accounts will be screened for potential Medicaid eligibility as well as coverage by other sources, including governmental programs. During this screening process an "FA" will be completed if it is determined that the patient does not appear to qualify for coverage under any program.
- F. The "FA" will be sent to the Business Office for final determination by the Financial Counselor or Business Office Director.
- G. If the Financial Counselor determines through the application and documented support that the patient qualifies for Free Care she/he will give the completed and approved "FA" to the BOD for approval authorization, prior to write off.
- H. For those patients that do not meet Presumptive Eligibility requirements, the following documents will be required, subject to availability, to process a

Financially Assistance application: current monthly expenses/bills, previous year's income tax return, current employers check stub, proof of any other income, bank statements for prior 3 months, and all other medical bills. Where the patient/guarantor indicates they do not file federal tax returns, the hospital will request that the patient/guarantor complete IRS form 4506-T (Request for Transcript of Tax Return). The patient/guarantor should complete lines 1-5 after the hospital has completed lines 6-9. Hospital will complete line 6 by entering '1040', will check boxes 6(a) and box 7. In box 9, hospital will enter prior year and prior 3 years. (Exhibit E-example and a blank form).

- I. To be eligible under the Presumptive Eligibility criteria, proof of one of the mandated categories or additional criteria must be included with the Financial Assistance application.
- J. The Financial Counselor will contact any vendor who may be working the account, to stop all collection efforts on the account.
- K. Once approved for Free Care the account will be moved to the appropriate financial class until the adjustment is processed and posted/credited to the account. After the adjustment is posted, if there is a remaining balance due from the patient, the financial class will be changed to self-pay.
- L. If the "FA" is incomplete it will be the responsibility of the Financial Counselor to contact the patient via mail or phone to obtain the required information.
- M. The Fair Patient Billing Act (FPBA) states that a patient has at least 60 days from date of service to submit a "FA" application. Applications that remain incomplete after 30 days of 'request of information', and determination has been made that patient does not qualify for Medicaid, may be denied or submitted to the CFO for consideration/approval. (see # 4 on Page 7)
- N. The application may be reopened and reconsidered Free Care once the required information is received, providing the account has not been written off to bad debt.
- O. The Business Office Director, Assistant BOD or Patient Access Manager is responsible for reviewing every application to make sure required documents are attached, prior to submitting to CFO or CEO for review and approval. All fields on the application must be completed properly. Drawing lines through fields such as income is not appropriate. If the income is zero, zeros must be entered.
- P. Medicaid patients who receive covered services that meet Medicare medical necessity criteria, but have exhausted state benefit limits (IE limited IP days or limited annual ER visits, for example), will not be required to provide any supporting documents, providing verification of Medicaid coverage for the service dates indicates patient is covered.

- Q. Once an account has been written off to bad debt, the patient will not be allowed to apply for Free Care.
- S. Free Care shall be available for those patients who are legal Illinois residents and unless otherwise provided, Non-Residents who are uninsured are not eligible for Free Care.

**6. FACTOR TO BE CONSIDERED FOR FREE CARE DETERMINATION**

- A. The following factors are to be considered in determining the eligibility of the patient for Free Care:
  - 1. Gross Income
  - 2. Family Size
  - 3. Employment status and future earning capacity
  - 4. Other financial resources
  - 5. Other financial obligations
  - 6. The amount and frequency of hospital and other medical bills
- B. The income guidelines necessary to determine the eligibility for Free Care are attached on *Exhibit "C"*. The current Federal Poverty Guidelines are attached as *Exhibit "D"* and they include the definition of the following:
  - 1. Family
  - 2. Income

**7. FAILURE TO PROVIDE APPROPRIATE INFORMATION**

- A. Failure to provide information necessary to complete an application request for Free Care within 30 days of the request may result in a negative determination. If the patient and/or family member submits an incomplete application for Free Care, the Hospital will within ten (10) business days (1) suspend any Extraordinary Collection Activity ("ECA") against the patient; (2) provide a written notification that describes what additional information or documentation is needed and includes a Plain Language Summary of the Program; and (3) provide at least on written notice information the patient about the ECAs that might be taken (or resumed) if an application is not completed or payment made by a deadline specified in the write notice, which shall be no earlier than 30 days from the date of the written notice or the last day of the application period.
- B. The account may be reconsidered upon receipt of the required information, providing the account has not been written off to bad debt.

- C. If at any time during the review process it becomes apparent that an Applicant for Free Care has withheld relevant information, provided false information or provided inaccurate information, as evidenced by information obtained through credit agencies or other available sources, and the Applicant is unable to resolve discrepancies to the satisfaction of the Hospital, the Applicant may be disqualified for Financial Assistance, which shall result in the resumption of routine collection efforts until such discrepancies are resolved. The provision of a questionable social security number shall not result in automatic disqualification for Financial Assistance.
- D. Free care will only be applied to true self-pay balances, after all third party benefits/resources are reasonably exhausted, including but not limited to, benefits from insurance carriers, government programs or proceeds from litigation and/or settlements. Patients requesting Financial Assistance must, whenever possible, be screened for eligibility for Medicaid or Health Insurance Exchange coverage and, if found eligible, the patient must fully cooperate with enrollment requirements. Failure to cooperate or enroll in available Medicaid or Health Insurance Exchange coverage may result in denial of a request for Financial Assistance.

**8. EXCEPTION TO DOCUMENTATION REQUIREMENTS**

The CFO may waive the documentation requirements and approve a case for Free Care; at his/her sole discretion based on their belief the patient does/should qualify for Free Care. The amount or percentage of Free Care discount will be left to the CFO's discretion. Waiver of the documentation requirements should be noted in the comments section on the patient's account, as well as the percent or dollar amount approved for Free Care adjustment, printed out and attached to the Financial Assistance (FA) form.

**9. TIME FRAME FOR ELIGIBILITY DETERMINATION**

A determination of eligibility will be made by the Business Office within 30 working days after the receipt of all information necessary to make a determination.

**10. DOCUMENTATION OF ELIGIBILITY DETERMINATION AND APPROVAL OF WRITE-OFF**

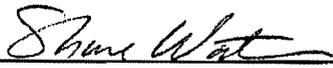
Once the eligibility determination has been made, the results will be documented in the comments section on the patient's account and the completed and approved "FA" will be filed attached to the adjustment sheet and maintained for audit purposes. The CEO, CFO, BOD will signify their review and approval of the write-off by signing the bottom of the Free Care/Financial Assistance Program Application form. The signature requirements will be based on the CHS financial policy for approving adjustments. The Patient will be notified immediately and any billing and collection activity will cease.

**11. REPORTING OF FREE CARE**

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

12. **POLICY REVIEW AND APPROVAL**

The below individuals have read and approved this policy: These parties shall assure that controls are in place to assess patient program eligibility in accordance with applicable law, that will track billing and maintain information on patient applications and eligibility for FA, that the Hospital bills eligible patients the same as those with insurance, that monitor referral to collection agencies pursuant to any policy relative to same and that the availability of FA is communicated to the Hospital's patients as provided for herein.

  
\_\_\_\_\_  
Hospital CEO

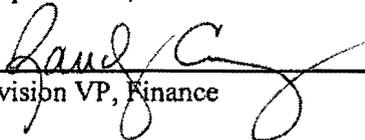
12/9/14  
Date

  
\_\_\_\_\_  
Hospital CFO

12/9/14  
Date

  
\_\_\_\_\_  
Corporate VP, Patient Financial Services

12/9/14  
Date

  
\_\_\_\_\_  
Division VP, Finance

12/10/14  
Date

**Appendix A  
Definitions**

**Affiliates:** Those entities controlled by, controlling, or under common control with Hospital. For purposes of this policy, the term "Affiliates" does not include Hospital affiliates that are legally or otherwise restricted from adopting this policy.

**Amounts Generally Billed:** Charges for medically necessary services shall be limited to no more than amounts generally billed to individuals who have insurance covering such care ("AGB").

- i. In calculating the AGB, the Hospital has selected the "look-back" method whereby the AGB is determined based on actual past claims paid to the Hospital by Medicare fee-for-service together with all private health insurers paying claims to the Hospital.
- ii. The AGB percentage will be calculated at least annually by dividing the sum of all claims that have been paid in full during the prior 12 month period by the sum of the gross charges for those claims. This resulting percentage is then applied to an individual's gross charges to reduce the bill.

- iii. A revised percentage will be calculated and applied by the 45<sup>th</sup> day after the first day of the start of the fiscal year used to determine the calculations.

**Applicant:** An Applicant is the person submitting an Application for Financial Assistance, including the patient and/or the patient's guarantor.

**Application:** A Financial Assistance Application.

**Application Period:** During the Application Period, the Hospital must accept and process an application for Financial Assistance ("Application"). The Application Period begins on the date the care is provided to the individual and ends on the 240<sup>th</sup> day after the Hospital provides the patient with the first billing statement for the care.

**Billed Charge(s):** The fee for a service that is based on the Hospital's master charge schedule in effect at the time of the service.

**Completion Deadline:** The Completion Deadline is the date after which a Hospital may initiate or resume ECAs (as defined below) against an individual who has submitted an incomplete Application if that individual has not provided the Hospital with the missing information and/or documentation necessary to complete the Application. The Completion Deadline must be no earlier than the later of 30 days after the Hospital provides the individual with this written notice; or the last day of the Application Period.

**Cost-of-Care Discount: 30%**

**Discounted Care:** Care provided at less than Billed Charges other than Free Care. Discounts include the Cost-of-Care Discount and the Managed Care Discount.

**Extraordinary Collection Activity:** As defined by the Act, but includes any legal action with respect to a Patient's Account.

**Family Income:** Family Income is defined based on definitions used by the U.S. Bureau of the Census and includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance payments, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources. Non-cash benefits (such as SNAP and housing subsidies) are not considered income.

**Family Size:** The number of individuals listed under "Filing Status" on the Applicant's most recent tax return. If no tax return is available, Family Size shall be the number of individuals permanently residing in the Applicant's household. If another individual claims the Applicant as a dependent on the individual's tax return, then the Family Size shall include household members of the individual claiming dependency.

**Federal Poverty Guideline:** The Federal Poverty Guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of 42 USC 9902(2). Guidelines, attached as Appendix A-1, shall be adjusted annually within thirty (30) days following the issuance of new Federal Poverty Guidelines in the Federal Register and on the U.S. Department of Health and Human Services website.

**Financial Assistance:** Care provided to patients who meet MSMC's criteria for Financial Assistance under various programs (collectively, "Financial Assistance Program" or "Program") and are unable to pay for all or a portion of their health care services. Financial Assistance does not include bad debt or uncollectible charges that have been recorded as revenue but written off due to a patient's failure to pay, or the cost of providing that care to patients; the difference between the cost of care provided under Medicaid or other means-tested government programs or under Medicare and the revenue derived from those programs; or contractual adjustments with any third-party payors.

**Free Care:** A discount equal to one hundred percent (100%).

**Financial Assistance Policy Committee:** That committee comprised of representatives from MSMC Affiliates and which makes recommendations with respect to this Policy and ensures operational alignment in implementing this Policy. If a committee does not exist, the CFO or his/her delegates shall be responsible for this function.

**Household Income:** The sum of a family's annual earnings and cash benefits from all sources before taxes, less payments made for child support. More specifically, Household Income is equal to the adjusted gross income listed on the Applicant's most recent tax return, adjusted to subtract child support payments and to add amounts of tax-exempt interest; non-taxable pension and annuity payments, IRA distributions, and social security; and other income not included in adjusted gross income but available to Applicant. However, if the Applicant indicates that the adjusted gross income listed on the Applicant's most recent tax return is not accurate (e.g., the Applicant is no longer employed or is being paid a different amount), the Household Income shall be calculated on the basis of other available documentation (e.g., pay stubs, unemployment statements, etc.), once again adjusted to remove child support payments and to include tax-exempt interest; non-taxable pension and annuity payments, IRA distributions, and social security; and other income available to Applicant. Household Income includes the income of all members of the household.

**Illinois Resident:** An Illinois Resident includes patients who qualify for Illinois residency under the Illinois Hospital Uninsured Patient Discount Act ("HUPDA"). HUPDA requires that the Uninsured Patient be a resident of Illinois, but does *not* require that the patient be legally residing in the United States. Patients may be required to provide evidence of Illinois residency as provided for under HUPDA. Relocation to Illinois for the sole purpose of receiving health care benefits does not satisfy the residency requirement under this definition. These patients are encouraged to seek treatment at an appropriate facility within their geographic proximity.

**Insured Patient:** A patient covered under a policy of health insurance or a beneficiary under 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.

**Legal Illinois Resident:** A Legal Illinois Resident includes patients legally residing within the United States *and* who have their principal residence within the state of Illinois. With respect to foreign nationals, "legally residing" shall include individuals who have current visas and who are permanent residents and temporary workers. "Legally residing" shall not include foreign

nationals who have visitor or student visas. Relocation to Illinois for the sole purpose of receiving health care benefits does not satisfy the residency requirement under this definition. These patients are encouraged to seek treatment at an appropriate facility within their geographic proximity.

**Medically Necessary:** Any inpatient or outpatient health care service, including pharmaceuticals or supplies, covered under Title XVIII of the federal Social Security Act for beneficiaries with the same clinical presentation as the Patient. A "Medically Necessary" service does not include any of the following: (1) non-medical services such as social and vocational services; or (2) elective cosmetic surgery, but not plastic surgery designed to correct disfigurement caused by injury, illness or congenital defect or deformity.

**Non-Resident:** A Non-Resident is a patient who is neither a Legal Illinois Resident nor an Illinois Resident.

**Uninsured Patient:** A patient not covered under a policy of health insurance or who is not a beneficiary under 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.

**Appendix B**  
**Example of 'Availability of Free Care' Sign-English Version**

**FREE CARE POLICY**

You may be eligible for financial assistance under the terms and conditions the hospital offers to qualified patients. For more information, contact customer service at 618.798.3750.

In order to be eligible for Free Care, you must:

Have no other source of payment such as insurance, governmental assistance or savings;  
or

Have hospital bills beyond your financial resources; and

Provide proof of income and income resources; and

Complete an application and provide information required by the hospital.

Forms and information about applying for Free Care are available upon request.

**Appendix C**  
**Example of 'Availability of Free Care' Sign-Spanish Version**

**REGLAS PARA SERVICIOS DE CARIDAD**

Usted puede calificar para asistencia financiera debajo de los terminus y condiciones de el hospital. Para mas informacion, contacte a el servicio de asistencia a 618.798.3750.

Para obtener derecho a servicios caritativos, se necesita tener los siguientes requisitos:

No tener otro medio de pagar, por ejemplo, seguro medico, asistencia del gobierno federal, o sus propios ahorros o bienes

Tener cuentas de hospital que esten mas alla de sus recursos economicos.

Tambien hay que:

Presentar pruebas de sus ingresos y recursos economicos

Completar la solicitud de servicio y dar la informacion que le pide al hospital.

Formularios con informacion y datos tocante a la solicitacion de servicios caritativos se proveeran. A aquellos individuos interesados.

**Appendix D**  
**Federal Poverty Income Guidelines 2014**

**2014 Poverty Income Guidelines for the**  
**48 Contiguous States and the District of Columbia**

Persons in family/household	Poverty Income Guideline
1	\$11,670
2	15,730
3	19,790
4	23,850
5	27,910
6	31,970
7	36,030
8	40,090

For families/households with more than 8 persons, add \$4,060 for each additional person.

**Appendix E**  
(Attach IRS Form 4506-T blank form and example of completed form)

**SUBJECT: CHARITY**

**PURPOSE:**

This policy is to assist the Business Office Manager in recognizing low-income families. It is intended to comply with all federal guidelines and will create a procedure that follows the poverty guidelines instituted by the Department of Health and Human Services as it pertains to discounting the patient's financial responsibility towards procedure(s) performed in the center.

**PROCEDURE:**

The poverty guidelines are set by the U.S. Department Health and Human services. The guidelines are reviewed and updated annually.

Those patients who are identified as low income or indigent are to complete the application for financial assistance. They are to submit the application to the Business Office Manager for review against the poverty guidelines and for approval prior to their scheduled date of the procedure.

A social security number or immigrant visa, and a picture ID must be provided.

The Business Office Manager will send a letter of confirmation to the patient with the results of the review. A copy of the letter is to be kept on the left side of the patient's chart, as well as noted in the billing record of the health information system.

**GUIDELINES FOR DETERMINING ELIGIBILITY FOR CHARITY**

Patient must complete the Financial Assistance Application.

Social security number or immigrant visa, along with a photo ID must be provided.

Prior year complete Federal tax return must be submitted along with the application. If taxes were not filed, payment check stubs for the prior three months must be submitted.

Determination is made based on the current year Federal Poverty Guidelines, and must be less than twice the guideline amount for the number of persons in the household.

An approval letter will be sent to the patient, and the ordering physician's office will be notified. A copy of the letter is to be kept on the left side of the patient's chart, as well as noted in the billing record of the health information system.

If the application is denied, the patient will be notified by letter of the estimated facility charge. Should they choose to proceed with surgery as a self-pay patient, they will receive a 20% discount. 50% of that amount must be collected on the day of surgery, with the remaining 50% to be paid in full within 90 days.

The Business Office Manager will keep a file of original applications and copies of approval/denial letters.

**SEE EXHIBIT M THRU O**

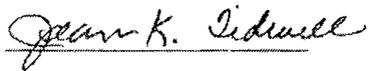
The total estimated project costs will be funded with cash and equivalents, which may include investment securities, unrestricted funds and/or funded depreciation.



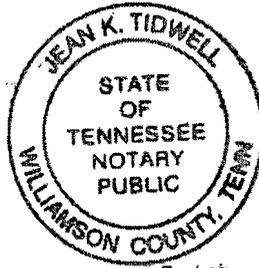
Title: VICE PRESIDENT, ACQUISITIONS + DEVELOPMENT

Subscribed and sworn to before me this

18<sup>th</sup> day of December, 2014.



Notary Public



My Comm. Expires  
March 21, 2016

## Safety Net Impact Statement

1. The applicants, Red Bud Regional Hospital and Monroe Surgery Center, do not believe the change of ownership will have a material impact on any safety net services in the community. The Hospital's financial assistance policies will be in place once the CHOW occurs.
2. There is no opportunity to cross subsidize services. However, the Hospital's investment in the surgery center with physicians should enhance cooperation and facilitation in using the OP surgery center when best to do so.
3. N/A – this project is not for discontinuation.

Safety Net Information per PA 96-0031			
CHARITY CARE - Red Bud Regional Hospital			
Charity (# of patients)	Year 2011	Year 2012	Year 2013
Inpatient	7	10	11
Outpatient	37	70	51
<b>Total</b>	<b>44</b>	<b>80</b>	<b>62</b>
Charity (cost in dollars)			
Inpatient	\$8,722	\$47,181	\$13,821
Outpatient	\$20,319	\$45,800	\$26,031
<b>Total</b>	<b>\$29,041</b>	<b>\$92,981</b>	<b>\$39,852</b>
MEDICAID			
Medicaid (# of patients)	Year 2011	Year 2012	Year 2013
Inpatient	108	84	114
Outpatient	2,219	1,085	3,386
<b>Total</b>	<b>2,327</b>	<b>1,169</b>	<b>3,500</b>

## Charity Care

The ASC has not provided charity care per the Board's definition. The ASC does accept patients with Medicaid. However, Red Bud, which is acquiring the Hospital, provided 0.3% charity care in 2013. Red Bud is a critical access hospital and 73.0% of its inpatients were Medicare recipients and 68.8% of its total revenue is from Medicare. 11.4% is from Medicaid.

CHARITY CARE Red Bud Regional Hospital			
	Year 2011	Year 2012	Year 2013
Net Patient Revenue	\$21,375,261	\$21,765,761	\$22,385,591
Amount of Charity Care (charges)	\$144,881	\$501,623	\$225,902
Cost of Charity Care	\$29,041	\$92,981	\$39,852

Appendix A

**COMMUNITY HEALTH SYSTEMS  
PROFESSIONAL SERVICES CORPORATION**  
4000 Meridian Blvd.  
Franklin, TN 37067

August 14, 2014

Mr. William Rebholz  
Monroe County Surgical Center, LLC  
501 Hamacher Street  
Waterloo, IL 62298

Re: Proposed Purchase of ASC Membership Interest

Dear Mr. Rebholz:

The purpose of this letter of intent is to describe the basis on which an affiliate of Community Health Systems Professional Services Corporation would acquire a membership interest in Monroe County Surgical Center, LLC and enter into an agreement to provide management services to the ASC (the "Transaction"). This letter of intent is divided into two parts. Part One summarizes certain significant proposed terms of the Transaction. Part Two describes certain binding agreements between the parties. While each party acknowledges that Part One represents the basis on which the parties will proceed toward the consummation of the Transaction, except as set forth in Part Two, this letter of intent is not intended to constitute a binding agreement. Except as set forth in Part Two, no party will have any liability to any other party based upon, arising from, relating to, or with respect to the Transaction until a fully integrated, mutually agreeable, definitive agreement (the "Definitive Agreement"), and other related documents, are prepared, authorized, executed and delivered by the parties. The failure of the parties to reach mutually acceptable terms for the Definitive Agreement or any documents ancillary thereto for any reason or no reason shall not be deemed a breach of this letter of intent.

**PART ONE – Proposed Terms of the Transaction**

- Seller:** *Monroe County Surgical Center, LLC* ("Seller") is a freestanding ambulatory surgery center located in Waterloo, Illinois (the "ASC").
- Buyer Parties:** *Community Health Systems Professional Services Corporation* ("CHSPSC") is a Delaware corporation engaged in the business of providing certain management services to its affiliates.
- An affiliate of CHSPSC ("*Buyer*") will purchase the Membership Interest in Seller and enter into a management agreement to provide management services to the ASC.
- Transaction:** Buyer would acquire a 51% or greater membership interest ("Membership Interest") in Seller. The purchase price for the Membership Interest would be paid in cash at closing via wire transfer. As of the closing, Seller would enter into a management agreement with Buyer, under which Buyer would manage the ASC in exchange for a fee equal to 5% of the ASC's net revenue. The foregoing transactions are referred to collectively herein as the "Transaction."
- Purchase Price:** The purchase price for the Membership Interest will be calculated based on a total value of 100% of the Seller equal to \$4,290,000, which includes (i) \$290,000 of estimated Net Working Capital and (ii) consideration for Buyer's right to be the

exclusive provider of management services to the ASC.

Buyer will require 15% of the purchase price to be deposited in an interest-bearing account with a mutually agreeable escrow agent for a period of two (2) years after the closing of the Transaction, to protect against any loss as a result of a breach of a representation or warranty by the Seller or any indemnification claim against Seller pursuant to the Definitive Agreement.

The purchase price includes an amount equal to the Membership Interest percentage multiplied by Seller's total estimated Net Working Capital. "Net Working Capital" shall mean the difference between patient accounts receivable and current liabilities (exclusive of the current and long-term portion of debt and capital lease obligations). To the extent actual Net Working Capital on the closing date is less than the estimated Net Working Capital included in the purchase price, Seller shall pay to Buyer within sixty (60) days following the closing date Buyer's pro rata share of the amount by which estimated Net Working Capital exceeded actual Net Working Capital as of the closing date. To the extent actual Net Working Capital on the closing date exceeds the estimated Net Working Capital included in the purchase price, Buyer shall pay to Seller within sixty (60) days following the closing date Buyer's pro rata share of the amount by which estimated Net Working Capital was less than actual Net Working Capital as of the closing date.

The purchase price is subject, at Buyer's election, to Buyer's receipt, from Somerset CPAs, P.C., or a comparable nationally recognized, independent appraiser selected by Buyer, of an updated appraisal of the fair market value of the Membership Interest that supports the proposed purchase price. If Buyer desires to obtain such an appraisal, it will do so before the execution of the Definitive Agreement.

**Indebtedness:** Buyer and each of the members of Seller would assume their pro rata share of existing Seller indebtedness as of the closing date. The parties may evaluate alternatives to extinguish certain indebtedness during due diligence.

**Non-Compete:** Seller and each of Seller's members shall covenant that until the later of (i) the fifth (5th) anniversary of the closing date, or (ii) two (2) years after a member of Seller ceases to be a member of Seller, Seller and each of Seller's members shall not, directly or indirectly, except as a consultant or contractor to or of, or in collaboration with, Buyer (or any affiliate of Buyer), own, lease, manage, operate, control, develop, or participate in any manner with the ownership, leasing, management, operation, control or development of an Illinois state-licensed, Medicare-certified, or accredited surgery center, hospital, or office-based surgical facility (including an ambulatory surgical center, hospital or office-based or practice-based facility or operating site or room that provides any of the services offered by the ASC immediately prior to the closing date) that provides outpatient surgical services of any of the same specialties that were provided at the ASC immediately prior to the closing date, within a twenty-five (25) mile radius of the ASC, without Buyer's prior written consent (which Buyer may withhold in its sole and absolute discretion).

**Management Agreement:** Upon closing, Buyer would become the manager of the ASC and provide day-to-day management services under the terms of a management agreement with the Seller. The management agreement would provide that the Buyer receive a management fee equal to 5% of the ASC's net revenues, plus reimbursement for direct expenses incurred by

the Buyer on behalf of the ASC.

**Operating Agreement:** Subject to due diligence review of Seller's existing operating agreement, CHSPSC may require Seller to approve an amended operating agreement containing governance rights and covenants applicable to Buyer, including, but not limited to, the following: restrictive covenants (e.g. non-competes); repurchase rights based upon defined "buy/sell" events; and other mutually agreed upon changes.

**Seller's Employees:** Subject to due diligence review, CHSPSC anticipates that all employees who are actively employed and in good standing as of the closing date will be needed to continue ASC operations after closing.

**Closing Date:** The closing of the Transaction will occur as soon as practicable following the execution of the Definitive Agreement and subject to the completion of closing conditions agreed upon by the parties, including obtaining a certificate of need ("CON") or exemption from the Illinois Health Facilities and Services Review Board concerning the Transaction. However, before the Definitive Agreement will be executed by Buyer, the final Definitive Agreement and its exhibits and schedules must be reviewed and approved by certain officers of Buyer and its management company. Accordingly, to close the transaction in a timely manner, the Definitive Agreement and its exhibits and schedules should be finalized no later than ten business days prior to the desired closing date.

**Conditions to Closing:** The closing of the Transaction is conditioned upon, among other things, the following contingencies: (i) completion of satisfactory due diligence of the Seller and the ASC by CHSPSC; (ii) CHSPSC's satisfaction with information discovered through due diligence, including without limitation information concerning the Seller's and the ASC's compliance with any federal or state statute or regulation relating to the submission of false or fraudulent claims to a government program or payments or contractual relationships with referral sources; (iii) approval of the transaction by the governing boards of Buyer and Seller, and Buyer and Seller obtaining of any other necessary approvals, including a CON or exemption from the Illinois Health Facilities and Services Review Board; and (iv) receipt of any material consents from third parties.

Buyer's due diligence will include, without limitation, (i) confirmation of the fair market value of the Membership Interest, (ii) a review of ASC coding, (iii) a malpractice review, (iv) a review of Seller's employees and benefit plans, (v) a review of Seller's contracts and agreements, (vi) inspection of the ASC space and equipment to ensure regulatory and CHSPSC compliance, (vii) validation of the quality of cash collections and conversion of financial statements to accrual basis of accounting, and (viii) a review of accounting, patient billing and electronic medical record systems. To maximize efficiency, CHSPSC will utilize data already provided to the third party appraiser, provided that the due diligence information request might include a request for information from a more recent time period than was submitted to the third party appraiser.

**PART TWO – Binding Provisions**

- Access to Information:** From the date hereof until the closing or the earlier termination of this letter of intent, Seller will permit Buyer and its representatives full and complete access to inspect and appraise the ASC and its business prospects, and will disclose and make available to representatives of Buyer all books, agreements, papers and records relating to the ownership and operation of the ASC. In this regard, Buyer agrees that such inspection shall not interfere with the operations of the ASC.
- No Violation:** Buyer has prepared and delivered this letter of intent in reliance on the Seller's representation that Seller is not currently bound under any binding or enforceable contract or agreement with any third party which would materially interfere with the transactions contemplated hereby. This letter of intent, and the transactions contemplated hereby, will not violate any contract, agreement or commitment currently binding on Seller.
- Confidentiality:** Except as otherwise required by law, the parties agree to keep this letter of intent and all information provided by either party pursuant to this letter of intent and its contents confidential and not disclose the same to any third party (except attorneys or accountants hired by them and except to the applicable governmental agencies in connection with any required notification or application for approval or exemption therefrom) without the written consent of the other party.
- Disclosure:** Except as required by law, any release to the public of information with respect to the matters set forth herein will be made only in the form and manner approved by the parties and their respective counsel.
- Expenses:** Each party shall bear its own expenses in connection with the implementation of this letter of intent, regardless of whether the Definitive Agreement is executed.
- Continuation of Operations:** From the date of this letter of intent until the closing date, Seller shall continue to operate the ASC in the ordinary course of business, including, without limitation, making all normal and planned capital expenditures. Without Buyer's prior written consent, Seller shall not (i) remove or transfer any of the ASC's assets, except in the ordinary course of business (with adequate replacement of any transferred assets), (ii) make any material change in the business or operation of the ASC, or (iii) enter into any other significant contract, commitment or transaction with respect to the ASC.

**No-Shop  
Provision:**

From the date of this letter of intent until the date which is ninety days after the termination of this letter of intent (unless this letter of intent is terminated by Buyer, in which case the ninety-day period shall not be applicable), the Seller will not, without the approval of Buyer: (i) offer for sale the assets of the ASC (or any material portion thereof), or any ownership interest in Seller; (ii) solicit offers to buy the assets of the ASC (or any material portion thereof) or any ownership interest in Seller, (iii) hold discussions with any party (other than Buyer) looking toward such an offer or solicitation or looking toward a merger or consolidation of the Seller; or (iv) enter into any agreement with any party (other than Buyer) with respect to the sale or other disposition of the assets of the ASC (or any material portion thereof) or any ownership interest in Seller or with respect to any merger, consolidation, or similar transaction involving Seller. The Seller will promptly communicate to Buyer the substance of any inquiry or proposal concerning any such transaction.

**Termination:**

Either party may for whatever reason terminate this letter of intent and further negotiations by written notice to the other party.

\* \* \* \* \*

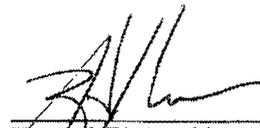
Please indicate your approval of the terms and conditions of this proposal and your intention to enter into these negotiations by dating and executing two copies of this letter of intent in the space provided below and returning one executed copy to me, whereupon we shall proceed promptly with our evaluation and review of the Seller, ASC and business prospects related thereto and with the preparation for your review of a draft Definitive Agreement. Of course the completion of Buyer's due diligence and the finalization of the Definitive Agreement in a timely manner are dependent on your cooperation. Please be advised that this proposal shall expire unless there has been delivered to me a fully executed copy of this letter of intent no later than 5:00 p.m., Franklin, Tennessee time, on August 29, 2014.

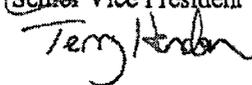
We look forward to a successful and mutually rewarding relationship in respect of the transactions set forth herein.

Very truly yours,

COMMUNITY HEALTH SYSTEMS  
PROFESSIONAL SERVICES CORPORATION

By: \_\_\_\_\_

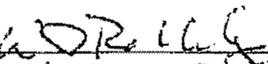
  
~~Kenneth D. Hawkins~~  
Senior Vice President

  
Terry Hendon

Acknowledged and agreed to this  
28 day of August, 2014:

**SELLER:**

MONROE COUNTY SURGICAL CENTER, LLC

By:  \_\_\_\_\_

Name: William J. Kosik

Title: Executive Director

Appendix B

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## MEDICAL OFFICE LEASE

THIS LEASE, made and entered into on the 24 day of November, 2010, by and between Medical Development Company of America, LLC, an Illinois limited liability company, hereinafter called Lessor and Monroe County Surgical Center, LLC, an Illinois limited liability company, hereinafter called Lessee.

In consideration of good and valuable consideration, the adequacy of which is hereby acknowledged, the parties hereto agree as follows:

### GENERAL TERMS AND OCCUPANCY:

1. The Lessor, for an in consideration of the rents, covenants and agreements hereinafter mentioned, and hereby agreed to be paid, kept and performed by the said Lessee, does hereby lease to said Lessee, and said Lessee does hereby lease from Lessor, the premises as shown and described on the floor plan attached hereto as Exhibit A and by this reference incorporated herein, said premises consisting of an office suite having approximately 6,891 gross square feet, more or less, of space, which is part of a single building structure located at 501 Hamacher Street, Waterloo, Illinois (the "Building"), to have and to hold the same, subject to the conditions herein contained, and to use and occupy the same for ambulatory surgical purposes and to use and occupy the same for the following medical services: ambulatory surgical services and related services and for no other use or purpose. The term of this Lease shall be for ten (10) years (or until sooner terminated as herein provided) commencing with the later of 1) the date the building has been completed and a certificate of occupancy may be obtained from the City of Waterloo, Illinois; and 2) the date the convening authority for the State of Illinois certifies licenses or by whatever appropriate means authorizes Lessee to operate an ambulatory surgical center in the State of Illinois. Notwithstanding the foregoing the commencement date shall be no later than September 1, 2011.

### PREMISES FINISHES:

2. Landlord will construct the Premises in substantial accordance with the construction contract and estimate dated January 14, 2010, included as Attachment 1 (the "*Construction Document*"), which have been prepared by Landlord and approved by Tenant.

Any alterations or additions, except trade fixtures, made for Lessee shall be and remain the property of Lessor and be surrendered with the premises as a part thereof upon termination of this Lease.

### RENT:

3. Payments of Rents, Taxes and Other Charges. All of the amounts payable by Lessee pursuant to this Paragraph 3 shall constitute rent under this Lease and are herein referred to collectively as "Rent". All Rent and all other sums, costs, expenses, charges, payments, and deposits which Lessee, pursuant to any provision of this Lease, assumes or agrees to pay, shall

be paid as in this Lease provided, without notice or demand, and without abatement, deduction, counterclaim, or set-off.

Lessee shall also pay all taxes and other charges required pursuant to Paragraphs 3(c) through (k) hereof, all insurance premiums required to pay for insurance required to be provided by Lessee pursuant to Paragraph 4 hereof, and all sums, costs, expenses, payments, and deposits which Lessee in any of the provisions of this Lease assumes or agrees to pay or deposit, and, in the event of any nonpayment of any of said items, Lessor shall have (in addition to all other rights and remedies) all the rights and remedies provided for herein or by law in the case of nonpayment of the next monthly rent.

Lessee shall pay Lessor a net annual rent during the term of this Lease as follows:

(a) *For the first two months* of the term the Lessee shall not be obligated to the Lessor for a rental payment. *For the months 3-12* of the term the Lessee shall be obligated to the Lessor in lawful money of the United States a net rental of \$32.00 per square foot or \$220,512.00 per annum. Rent shall be paid on the first (1<sup>st</sup>) business day of each month during the said term at the address of Lessor provided in Paragraph 23, or at such other place as Lessor may from time to time designate in writing. Such monthly rental payments shall be in the sum of \$18,376.00. Annually, on the anniversary date of the Lease Commencement the annual rent shall increase by the greater of 1) an amount equal to the increase of the Landlord's annual principal and interest payments on its permanent financing of the construction loan for the said building structure and ancillary site improvements for the coming Lease year over the said principal and interest payments for the prior Lease year with the change as calculated based upon the Lessor's most recent monthly mortgage loan payment secured by the leased premises; and 2) \$3,445.50 per year. Said increases shall be prorated over the following twelve (12) month term and the prorated sum shall be added to the monthly rental sums due hereunder.

(b) **Intent for Net Yield.** It is the purpose and intent of Lessor and Lessee that the net annual rent shall be absolutely net to Lessor so that this Lease shall yield net to Lessor the net annual rent specified, and that all costs and expenses and obligations of every kind and nature whatsoever (related to the leased premises) whether now existing or hereafter arising, and whether or not beyond the contemplation of the parties, shall be paid by Lessee.

(c) **Reimbursement to Lessor.** Lessee shall reimburse Lessor for all expenditures and all costs and expenses, including reasonable attorney's fees, made or incurred by Lessor in curing any default by Lessee, as permitted by this Lease, which amounts shall become due upon the making of any such expenditures by Lessor, and Lessee shall also pay the Lessor all amounts due it as reimbursements or indemnities pursuant to this Lease.

(d) **Taxes and Other Charges.** Lessee covenants and agrees to pay, as hereinafter provided, all of the following items: general and special real estate taxes and other taxes (including, without limitation, any personal property taxes, sales taxes, use taxes, and the like), assessments, water and sewer rents, rates and charges, excises, levies, license and permit fees, fines, penalties and other governmental charges and any interest or costs with respect thereto, charges for any easement or agreement maintained for the benefit of the leased premises,

and charges for public and private utilities (including, without limitation, gas, electricity, light, heat, air conditioning, power, and telephone and other communication services), general and special, ordinary and extraordinary, foreseen and unforeseen, of any kind and nature whatsoever which at any time prior to or during the term of this Lease may be assessed, levied, confirmed, imposed upon, or grow or become due and payable out of or in respect of, or charged with respect to or become a lien on, the leased premises, or the roadway in front of or adjoining the leased premises, or any space in, over, or under such roadway, or any other appurtenances of the leased premises, or any personal property, equipment, or other facility used in the operation thereof, or the rent or income received therefrom, or any use or occupancy thereof, or this transaction, or the rent payable hereunder (all such items being herein called "Impositions"). Each such Imposition, or installment thereof, during the term of this Lease shall be paid not later than thirty (30) days prior to the day any fine, penalty, interest, or cost may be added thereto or imposed by law for the nonpayment thereof, if such day is used to determine the due date of the respective item; provided, however, that if, by law, any Imposition may at the option of the taxpayer be paid in installments (whether or not interest shall accrue on the unpaid balance). Lessee may exercise the option to pay the same in such installments, provided that the amount of all installments of any such Imposition, which are to become due and payable after the expiration of the term of this Lease, shall be deposited with Lessor for such payment on the date which shall be two (2) months immediately prior to the date of such expiration.

(e) Taxes and Charges Excluded. Nothing herein contained shall require Lessee to pay municipal, state or federal income, inheritance, estate, succession, transfer or gift taxes of Lessor or any corporate franchise tax imposed upon Lessor or any corporate successor of Lessor; provided, however, that if at any time during the term of this Lease the methods of taxation prevailing at the commencement of the term hereof shall be altered so that any tax, assessment, levy (including but not limited to any municipal, state, or federal levy), imposition, or charge, or any part thereof, shall be measured by or be based in whole or in part upon the leased premises (except in connection with allocation of income among two or more states) and shall be imposed upon Lessor, then all such taxes, assessments, levies, impositions, or charges, or the part thereof to the extent that they are so measured or based, shall be deemed to be included within the term "Impositions" for the purposes hereof, to the extent that such Impositions would be payable if the leased premises were the only property of Lessor subject to such Impositions, and Lessee shall pay and discharge the same as herein provided in respect of the payment of Impositions.

(f) Apportionment of Impositions. Any Imposition, other than an Imposition which has been converted into installment payments as referred to in Paragraph 3(d) hereof, relating to a fiscal period of the taxing authority, a part of which period is included within the term of this Lease and a part of which is included in a period of time after the expiration of the term of this Lease, shall (whether or not such Imposition shall be assessed, levied, confirmed, imposed upon or in respect of or become a lien upon the leased premises, or shall become payable during the term of this Lease) be apportioned between Lessor and Lessee as of the expiration of the term of this Lease, so that Lessee shall pay that portion of such Imposition which that part of such fiscal period included in the period of time before the expiration of the term of this Lease bears to such fiscal period, and Lessor shall pay the remainder thereof, provided, however, that Lessee shall not be entitled to receive any apportionment if Lessee shall

be in default in the performance of any of Lessee's covenants, agreements, or undertakings in this Lease provided.

(g) **Contesting Taxes and Other Charges.** Either Lessee or Lessor shall have the right at Lessee's expense to contest the amount or validity, in whole or in part, of any Imposition by appropriate proceedings diligently conducted in good faith. Such proceedings shall be initiated by Lessee only after payment of such Imposition unless such payment would operate as a bar to such contest or interfere materially with the prosecution thereof, in which event, payment of such Imposition shall be postponed if and only so long as:

(1) Neither the leased premises, nor any part thereof, would by reason of such postponement or deferment be, in the reasonable judgment of the Lessor, in danger of being forfeited or lost; default;

(2) No mortgage would by reason of such postponement or deferment be, in the reasonable judgment of Lessor, in danger of being put in default or foreclosed; and

(3) Lessee shall have deposited with Lessor the amount so contested and unpaid, together with all interest and penalties in connection therewith and all charges that may or might be assessed against or become a charge on the leased premises or any part thereof in such proceedings.

Upon the termination of any such proceedings, it shall be the obligation of Lessee to pay the amount of such Imposition or part thereof as may be finally determined in such proceedings to be due, the payment of which may have been deferred during the prosecution of such proceedings, together with any costs, fees (including counsel fees), interest, penalties, or other liabilities in connection therewith, and, upon such payment Lessor shall return, without interest, any amount deposited with it with respect to such Imposition as aforesaid, provided, however, that Lessor shall, if requested by Lessee, disburse said moneys on deposit with it directly to the imposing authority to whom such Imposition is payable. If, at any time during the continuance of such proceedings, Lessor shall deem the amount deposited as aforesaid insufficient, Lessee shall, upon demand, make an additional deposit, as aforesaid, of such additional sums as Lessor reasonably may request, and upon failure of Lessee so to do, the amount theretofore deposited may be applied by Lessor to the payment, removal, and discharge of such Imposition, and the interest and penalties in connection therewith and any costs, fees (including counsel fees), or other liability accruing in any such proceedings, and the balance, if any, shall be returned to Lessee and the deficiency, if any, shall be paid by Lessee to Lessor on demand.

(h) **Reduction in Valuation for Assessment.** Either Lessee or Lessor shall have a right at Lessee's expense to seek a reduction in the valuation of the leased premises assessed for tax purposes and to prosecute any action or proceeding in connection therewith. Provided Lessee is not then in default, Lessee shall be authorized to collect any tax refund obtained by reason thereof and to retain the same subject to Lessee's obligation to pay to Lessor Lessor's pro rata share thereof pursuant to the provisions of Paragraph 3(f) hereof. In the event Lessee shall be in default and Lessor should, by reason thereof, collect any tax refund, then

Lessor shall retain same subject to Lessor's obligation to pay to Lessee lessee's pro rata share thereof, pursuant to the provisions of Paragraph 3(f) hereof, less any offsets or deductions constituting the damages sustained by Lessor by reason of the default of Lessee.

(i) Joinder of Parties. Neither Lessor nor Lessee shall be required to join in any proceedings referred to in Paragraph 3(h) hereof unless provisions of any law, rule, or regulation at the time in effect shall require that such proceedings be brought by or in the name of Lessor, Lessee, or any owner of the land, in which event Lessor or Lessee shall join in such proceedings or permit the same to be brought in their name or the name of either of them. Lessor shall not ultimately be subject to any liability for the payment of any costs or expenses in connection with any such proceedings, and Lessee will indemnify and save harmless Lessor from any such costs and expenses.

(j) Covenant of Cooperation. Lessor and Lessee agree that whenever Lessor's or Lessee's cooperation is required in any of the proceedings brought as aforesaid, each will reasonably cooperate therein. Lessor's cooperation will be required, however, only if same shall not entail any cost or expense to Lessor and if Lessor shall be adequately indemnified against same.

(k) Evidence of Imposition. Any certificate, advice or bill of the appropriate official designated by law to make or issue the same or to receive payment of any Imposition, or nonpayment of such Imposition, shall be prima facie evidence that such Imposition is due and unpaid at the time of the making or issuance of such certificate, advice or bill, at the time or date stated therein.

#### INSURANCE:

4. During this Lease, Lessee shall maintain, or cause to be maintained, policies of insurance as follows:

(a) Fire Insurance. Insurance against loss or damage to the leased premises by fire and extended coverage and from such other hazards as may be covered by the form of all-risk insurance then in effect, all in an amount sufficient to cover full replacement cost (without depreciation) of the leased premises and to prevent any co-insurance provision from becoming effective, but in any event in an amount not less than one hundred percent (100%) of the then insurable value of the building. For the purpose of determining the amount of insurance hereunder, Lessor may request a written appraisal furnished by an insurance company insuring the leased premises not more frequently than once every three years, and, except as provided in the last sentence of Paragraph 4 (g), such appraisal shall be binding upon Lessor and Lessee. Lessee shall bear the expense, if any, of such appraisals.

(b) Rent Insurance. Rent insurance, with extended coverage, in such amount as is equal to an amount not less than Two Hundred Thirty Five Thousand Dollars \$235,000.00. In any event, the amount of such coverage shall be no less than the amount required to prevent any co-insurance provisions from becoming effective.

(c) Machinery Insurance. Boiler and machinery insurance inclusive of coverage for pressure vessels and air conditioning compressors of over 50 h.p. with such limits as from time to time may reasonably be required by Lessor but not less than the full building replacement cost without depreciation.

(d) General Liability Insurance. Comprehensive general liability insurance (containing the so-called "occurrence clause") against claims for bodily injury, death, and property damage occurring in or about the leased premises, including but not limited to all sidewalks or parking areas, passageways, or common areas adjoining or appurtenant to the Premises. Such insurance shall afford minimum protection of One Million Dollars (\$1,000,000.00) with respect to the personal injury or death occurring or resulting from one occurrence and Three Million Dollars (\$3,000,000.00) with respect to property damage.

(e) Contingent Liability Insurance. Contingent Liability Insurance against losses arising due to damages sustained in the improvements located on adjacent real estate commonly described as 509 Hamacher Street, Waterloo, Illinois which render said improvements at least thirty percent (30%) unoccupied in excess of a continuous twenty-four (24) hour period. Said policy shall be limited to One Hundred Thousand Dollars (\$100,000.00) in coverage to be paid Lessor, and in a form which is reasonably acceptable to Lessor.

(f) Other Insurance Required. Such other insurance and in such amounts as may from time to time be reasonably required by Lessor or any mortgagee against other insurable hazards which at the time are commonly insured against in the case of premises similarly situated.

(g) Increase in Policy Limits. If by reason of changed economic conditions the insurance amounts referred to above become inadequate, Lessee agrees to increase the amounts of such insurance promptly upon Lessor's request. All policies of insurance carried pursuant to Paragraphs 4 subparagraphs (a) through (f) shall name as insureds Lessor and Lessee, and, if required, any mortgagee, as their respective interests may appear; provided, however, that rent insurance shall provide that the proceeds thereof shall be paid to Lessor solely and said proceeds shall then be held by Lessor as security for the payment of the rent provided for herein until restoration of the leased premises by Lessee. To the extent Lessor receives and applies the proceeds of rent insurance, Lessee shall receive a credit against net annual rent payable hereunder. Anything contained herein to the contrary notwithstanding, the insurance required by Paragraph 4 in all events shall comply with the requirements of all mortgages against the leased premises.

(h) Negotiations of Loss Claims. Subject to the rights of mortgagee, all claims for losses under the policy or policies required under Paragraph 4 shall be negotiated or adjusted by Lessor and Lessee jointly except that Lessee may negotiate claims for losses not in excess of Ten Thousand Dollars (\$10,000.00) and the proceeds thereof shall be paid to Lessee for restoration as provided herein. If the loss exceeds Ten Thousand Dollars (\$10,000.00), the proceeds (hereinafter called insurance proceeds) shall be payable to lessor and shall be disbursed by Lessor pursuant to the provisions of Paragraph 4(r). The insurance proceeds shall be held by Lessor in a segregated account.

(i) **Responsibility for Premiums.** All premiums on policies referred to in this Lease shall be paid by Lessee. The originals of such policies shall be delivered to Lessor except when such originals are required to be held by any mortgagee, in which case certificates of insurance shall be delivered to Lessor. Policies or certificates with respect to renewal policies shall be delivered to Lessor by Lessee not less than thirty (30) days prior to the expiration of the original policies, or succeeding renewals, as the case may be, together with receipts or other evidence that the premiums thereon have been paid for at least one year. Premiums on policies shall not be financed in any manner whereby the lender, on default or otherwise, shall have the right or privilege of surrendering or cancelling the policies; provided, however, that Lessee may pay premiums in annual installments so long as such method of payment does not constitute a default under any mortgage.

(j) **Limitation of Obligation and Cancellation.** Each policy of insurance required under this paragraph shall have attached thereto an endorsement that such policy shall not be cancelled or modified without at least ten (10) days' prior written notice to the Lessor, and, if required, to each mortgagee. Each such policy shall contain a provision that no act or omission of Lessee shall affect or limit the obligation of the insurer to pay the amount of any loss sustained.

(k) **Satisfaction of Insurer's Requirements.** Lessee shall so perform and satisfy the requirements of the companies writing any insurance policies referred to in this Lease so that at all times insurers of good standing satisfactory to Lessor shall be willing to write or continue such insurance.

(l) **Separate Insurance.** Neither Lessor nor Lessee shall carry separate insurance (other than personal liability insurance) concurrent in form or contributing in the event of loss with that required by this Lease to be furnished by Lessee, unless both parties are included therein as insureds with loss payable as in this Lease provided.

(m) **Approved Insurers.** All insurance provided for in this paragraph shall be effected under valid and enforceable policies issued by insurers of recognized responsibility which are licensed to do business in the state in which the leased premises are located, and have been reasonably approved in writing by Lessor. All such insurance shall be rated "A" or better by AM Best.

(n) **Blanket Policies.** Any insurance provided for in this paragraph may be effected by a policy or policies of blanket insurance; provided, however, that the amount of the total insurance allocated to the leased premises shall be such as to furnish in protection the equivalent of separate policies in the amounts herein required, and provided further that in all other respects, any such policy or policies shall comply with the other provisions of this Lease, except that no such policy shall be submitted to Lessor less than thirty (30) days prior to expiration of an existing policy. In any such case it shall not be necessary to deliver the original of any such blanket policy to Lessor, but Lessor shall be furnished with a certificate or duplicate of such policy reasonably acceptable to Lessor.

(o) Waiver of Subrogation. Each policy of insurance provided for in this paragraph shall contain the standard form of waiver of subrogation.

(p) Failure to Secure Insurance. If Lessee, at any time during the term hereof, should fail to secure or maintain the foregoing insurance, Lessor shall be permitted to obtain such insurance in Lessee's name or as the agent of Lessee and shall be compensated by Lessee for the cost of the insurance premiums. Lessee shall pay Lessor interest on paid insurance premiums at the rate equal to five hundred basis points (500 bp) over the prime commercial interest rate being charged by Bank of America per annum computed from the date written notice is received by Lessee that the premiums have been paid by Lessor.

(q) Lessee's Obligation to Repair. If the leased premises shall be destroyed or damaged in whole or in part by fire or other casualty (including any casualty for which insurance was not obtained or obtainable) of any kind or nature, ordinary or extraordinary, foreseen or unforeseen, Lessee shall give to Lessor immediate notice thereof, and Lessee, at its own cost and expense, whether or not such damage or destruction shall have been insured, and whether or not insurance proceeds, if any, shall be sufficient for the purpose, shall promptly repair, alter, restore, replace and rebuild the same, in the same condition as existed immediately prior to such occurrence; and Lessor shall in no event be called upon to repair, alter, replace, restore or rebuild such premises, or any portion thereof, nor to pay any of the costs or expenses thereof. If Lessee shall fail or neglect to restore, repair, replace and rebuild with reasonable diligence the premises, or portion thereof, so damaged or destroyed, or having so commenced such restoration, repair, replacement and rebuilding shall fail to complete the same with reasonable diligence in accordance with the terms of this Lease, or if prior to the completion of any such restoration, repair, replacement and rebuilding by Lessee, this Lease shall expire or be terminated for any reason, Lessor may complete the same at Lessee's expense, and Lessor's expense in so doing shall be due and payable by Lessee to Lessor immediately with interest thereon at the rate per annum equal to five hundred basis points (500 bp) over the prime commercial interest rate established from time to time by the Bank of America or its successor, from the date of each payment by Lessor. All work shall be done in accordance with the provisions of this Lease.

(r) Disposition of Insurance Proceeds. Subject to the provision of Paragraph 4(s) hereof, Lessor agrees to pay over to Lessee, from time to time, upon the following terms, any moneys which may be received by Lessor from insurance provided by Lessee (but in no event to any extent or in any sum exceeding the amount actually collected by Lessor upon the loss); provided, however, that Lessor before paying such moneys over to Lessee shall be entitled to reimburse itself therefrom to the extent, if any, of the necessary and proper expenses paid or incurred by Lessor in the collection of such moneys:

(1) Lessor shall pay to Lessee, as hereinafter provided, the aforesaid insurance proceeds, for the purpose of repairs or restoration to be made by Lessee to restore the leased premises to the same condition as existed immediately prior to such fire or other casualty. Prior to the making of any repair, Lessee shall furnish Lessor with an estimate of the cost of such repairs, prepared by a licensed architect reasonably approved by Lessor, and such insurance proceeds shall be paid to the Lessee from time to time thereafter in installments as the making of such repairs or restorations progresses upon

application to be submitted by Lessee to Lessor showing the cost of labor and material incorporated in such repair or restorations, or incorporated therein since the last previous application, and paid for by Lessee.

(2) If any Illinois mechanics' lien is filed against the leased premises, Lessee shall not be entitled to receive any further installment until such lien is satisfied or otherwise discharged, unless Lessor holds back funds equal to one hundred fifty percent (150%) of the claimed lien until such lien is satisfied or otherwise discharged.

(3) The amount of any installment to be paid to Lessee shall be such proportion of the total insurance proceeds received by Lessor as the cost of the labor and materials theretofore incorporated by Lessee in such repairs or restorations, or incorporated therein since the payment of the last previous installment, bears to the total estimated cost of such repairs or restoration, less ten (10) percent of the installment to be paid. Upon the completion of and payment for such repairs or restorations by Lessee, the balance of any and all insurance proceeds held by Lessor shall be paid over to Lessee.

(4) The following shall be conditions precedent to each payment made by Lessor to Lessee:

(i) There shall be submitted to Lessor the certificate of the aforesaid architect setting forth that the sum then requested to be withdrawn either has been paid by Lessee or is justly due to contractors, subcontractors, materialmen, engineers, architects or other persons (whose names and addresses shall be stated), who have rendered or furnished certain services or materials for the work, and giving a brief description of such services and materials and the principal subdivisions or categories thereof and the several amounts so paid or due to each of said persons in respect thereof, and stating the progress of the work up to the date of said certificate; that no part of such expenditures has been or is being made the basis, in any previous or then pending request, for the withdrawal of insurance proceeds or has been made out of the proceeds of insurance received by Lessee; and that the sum then requested does not exceed the value of the services and materials described in the certificate;

(ii) There shall be furnished to Lessor an official search, or a certificate of a title company satisfactory to Lessor, or other evidence showing that there has not been filed any vendor's, Illinois mechanics', laborer's or materialman's statutory or other similar lien affecting the leased premises which has not been discharged of record, except such as will be discharged upon payment of the amount then requested to be withdrawn. If any such liens are disclosed, no payment shall be made by Lessor unless the Lessor holds back funds as required by this paragraph;

(iii) At the time of making such payment Lessee is not in default in the payment of rent and there is no existing and unremedied default on the part of the Lessee under any of the other agreements, terms, covenants and conditions of this Lease on the part of Lessee to be performed as to which Lessor shall have served notice upon Lessee.

(s) **Restoration of Damage or Destruction Exceeding Specified Amount.** If, in the event of any loss, damage or destruction, the cost of restoration and repairs exceeds Twenty Five Thousand Dollars (\$25,000) in aggregate, Lessee agrees, at least ten (10) days before the commencement of any work of demolition upon the leased premises or before the commencement of any work necessary to repair, alter or renew the leased premises, or any part thereof, to furnish to Lessor the following:

(1) Complete plans and specifications for the demolition, construction, repair, replacing, renewing or altering of the leased premises prepared by an architect whose qualifications shall meet with the reasonable satisfaction of Lessor and which plans and specifications shall meet with reasonable approval of Lessor, together with the approval thereof by any governmental board, bureau or body then exercising jurisdiction with regard to such work, plans and specifications, which plans and specifications shall be and become the sole and absolute property of Lessor in the event that for any reason this Lease shall be terminated;

(2) A fixed-sum contract in assignable form made with a reputable and responsible builder, providing for the erection, completion and terms of payment for all work, labor and materials necessary to repair and restore the said premises as depicted in said plans and specifications or, in the alternative, a cost-plus contract in assignable form made with a reputable and responsible builder, providing for the erection, completion and terms of payment for all work, labor and materials necessary to construct and complete the repair and restoration depicted in said plans and specifications within a fixed period, together with the certificate of an architect who shall meet with the reasonable satisfaction of Lessor, estimating in reasonable detail the cost of repair and restoration as depicted in said plans and specifications within the fixed period in said contract provided;

(3) An assignment of the contract so furnished, duly executed and acknowledged by Lessee, by its terms to be effective upon any termination of this Lease, or upon Lessor's reentry upon the leased premises following a default by Lessee, prior to the complete performance of such contract. Such assignment shall also include the benefit of all payments made on account of said contract, including payments made prior to the effective date of such assignment; and

(4) In the event the estimated cost of repair and restoration is in excess of the net insurance proceeds, Lessee shall, before proceeding with the repair and restoration, deliver to Lessor a surety company bond or other security acceptable to Lessor, for the amount or such excess, guaranteeing the completion of the work and payment therefor, free of Illinois mechanics' liens. The premium therefor shall be borne by Lessee.

(t) **Lessee's Property.** (a) The Lessor assumes no liability for and will not provide insurance against loss of or damage of any sort to fixtures and equipment which are the property of the Lessee. Protection by insurance or other means against such loss or damage is therefore the Lessee's responsibility. (b) Notwithstanding anything herein to the contrary, the Lessor and

the Lessee and all parties claiming under them hereby mutually release and discharge the other from all claims and liabilities arising from or caused by any hazard covered by insurance on the Building or leased property, or covered by insurance in connection with the property on or activities conducted at the Building or leased property, regardless of the cause of the damage or loss. This release shall apply only to the extent that such loss or damage is covered by insurance and only so long as the applicable insurance policies contain a clause to the effect that this release shall not affect the right of the insured to recover under such policies.

DEFAULT BY LESSEE:

5. In the event of Lessee's default under the terms of this Lease, Lessee shall be liable for the following:

(a) Charge for Late Rent Payment. In the event that the Lessee fails to make any rent payment provided for in this Lease at the time when the payment becomes due under the provisions of this Lease and the payment shall become overdue for a period in excess of ten (10) days, Lessee promises to pay a late charge of \$500.00 for each payment overdue, and such late charge shall be considered additional rent hereunder.

(b) Default by Lessee. The occurrence of any one of the following events shall constitute a default by Lessee: (i) if Lessee's rental payments are late for three (3) months within any consecutive twelve- (12) month period, or (ii) Lessee defaults in the payment of any other monetary obligation hereunder, for three (3) months within any consecutive twelve- (12) month period, regardless of whether notice of such default is given, or (iii) if Lessee defaults in the performance of any other covenant, agreement, condition, rule or regulation herein contained or provided for, or hereafter established, for more than twenty (20) days after written notice of such default is given by the Lessor, then (in addition to all other legal remedies) Lessor shall have the right either (a) to terminate this Lease and Lessee's right to possession of the leased property or (b) to terminate only the Lessee's right to possession of the leased property; and in either such event Lessor shall have the right to re-enter and/or repossess the leased property, either by force, summary proceeding, surrender or otherwise, and dispose and remove therefrom the Lessee, or other occupants thereof, and their effects, and alter the locks and other security devices at the leased property, all without being liable for any prosecution or damages therefor. In either event the Lessor shall be entitled to recover from the Lessee, in addition to the rent, all expenses and damages incurred in connection with or by reasons of such default or the enforcement of the provisions hereof, including repossession costs, legal expenses and attorney's fees (whether or not suit is filed and all expenses incurred in connection with efforts to relet the property, including cleaning, altering, advertising and brokerage commissions; and all such expenses, damages, costs and fees shall be reimbursed by Lessee as additional rent, whether or not such default is subsequently cured. If Lessor elects to terminate only the Lessee's right to possession, then the Lessor may, at its option, accelerate the entire amount then remaining unpaid under the Lease and recover same forthwith from Lessee, together with all other charges recoverable hereunder, and thereafter Lessor shall pay over to Lessee the net proceeds of any total or partial reletting. If Lessor terminates only the Lessee's right to possession, then the Lessor may, at its option, either relet the leased property for the account of the Lessee (either in the name of the Lessor or Lessee), or may allow the leased property to remain vacant. Lessee's delinquent payments hereunder shall bear interest at the highest lawful rate from the date of

delinquency until paid; but if there is no legal rate limitation, then at five hundred basis points (500 bp) over the prime commercial rate being charged by Bank of America. Except as herein otherwise provided, Lessee waives demand for rent, demand for possession, notice of forfeiture, notice of termination and any and all other demands or notices required by law. If, after termination of its tenancy or after this Lease had expired, the Lessee holds over and fails to deliver possession to the Lessor when due, the Lessee will pay a double proportionate rate of rent for each day which Lessee shall hold possession of said premises.

ASSIGNMENT OF LEASE:

6. This Lease shall not be assigned in whole or in part nor shall the premises or any part thereof be rented or subleased or used or permitted to be used for any purpose other than above mentioned without the written consent of the Lessor. If the premises are so assigned, rented, subleased, used or permitted to be used, without such written consent, or if the Lessee shall become insolvent or bankrupt or make an assignment for the benefit of creditors, such unauthorized act shall become void if the Lessor shall so determine and elect. In that event the Lessor may re-enter the premises, and may exercise rights and effectuate remedies in the same manner as provided in Paragraph 5(b) hereof. Furthermore Lessee shall not act or seek to act as a representative or agent of the Building or of the Lessor in connection with any leasing or lease assignment efforts.

SURRENDER OF PREMISES:

7. The Lessee shall quit and surrender the premises at the end of the term in as good condition as the reasonable use thereof will permit, and shall not make any alterations, additions, redecorating or improvements in the premises, without written consent of the lessor. Unless and to the extent otherwise specifically agreed between Lessor and Lessee in writing, all such alterations, additions, redecorating or improvements (except movable office furniture and equipment of the Lessee, including pictures and the like) shall become the property of the Lessor and shall remain upon and be surrendered with the premises as a part thereof at the termination of this Agreement.

RULES AND REGLATIONS:

8. The Lessor shall, from time to time, have the right to make, establish and promulgate reasonable rules and regulations for the Building, occupants and lessees thereof, and the Lessee shall observe, keep and comply with such rules and regulations which shall be uniformly applied to other lessees in like circumstances in the Building. The Lessee will not allow, permit or suffer any noise, smoke or odor to escape from the leased property in a manner which will disturb other occupants of the Building, or occupy the leased property in such a manner as to disturb the peaceful and quiet occupancy of the other lessees of the Building or constitute a public or private nuisance, or keep open any exterior or corridor door, or permit any portion of the leased property visible from the exterior thereof to become unsightly or in disrepair. No sign, fixture, advertisement or notice shall be displayed, inscribed, painted, or affixed by Lessee on any part of the inside or outside of the Building without the prior written consent of the Lessor, and such consent shall not be unreasonably withheld by the Lessor.

Lessee shall not install any draperies, shades or venetian blinds visible from the exterior of the Building, unless the color, materials, shape and size have been approved by the Lessor, and such approval shall not be unreasonably withheld by the Lessor. Movement in and out of the Building of furniture or office equipment shall be done only during the hours designated by the Lessor and by means of exit designated by the Lessor.

NONPERFORMANCE OF RULES AND REGULATIONS:

9. Lessor shall not be responsible to Lessee for the nonperformance by any other lessee or occupant of the Building of any part of said rules and regulations, but agrees to take reasonable measures to assure such other lessee's performance.

NOTICE OF DAMAGED PREMISES:

10. The Lessee shall give the Lessor or Lessor's agent prompt written notice of any damage to or defects in the ducts, pipes, lines, wiring or other parts of the air conditioning, heating, electrical and plumbing systems, so that Lessor, at its expense, may repair or correct same with due diligence.

LIABILITY FOR DAMAGE TO PREMISES:

11. The Lessor shall not be liable to Lessee for any damage to any property at any time in or about said premises or Building, from water, rain, snow, ice, gas, electricity or steam which may leak into, issue or flow from any part of the Building, including the roof of the same, or from any other place or quarter. Lessor shall not be liable to Lessee for any damage or injury due to the act or neglect of any other lessee, occupant, visitor or patron of the Building, or of any employee, agent, visitor or patron of Lessee, or for any inconvenience, discomfort or interruption of business or practice resulting from the making of repairs, additions or improvements to the Building, or any part thereof.

SURGICAL SERVICES:

12. The Lessee agrees that should the Lessor, or any entity under common control with Lessor, provide within the Building, other medical services, the Lessee will not perform the same or similar services for patients within the premises, without the prior approval and consent of Lessor. The Lessee further agrees that neither Lessee nor any of Lessee's employees, agents or invitees shall perform any abortions within the Building.

UTILITIES AND PREMISES-RELATED EXPENSES:

13. Lessee agrees to the terms and conditions of payment of utilities and premises-related expenses as set forth below:

(a) Electricity. Lessee shall be responsible for paying one hundred percent (100%) of the electricity on the premises. Lessor shall furnish electric current for lighting and other ordinary uses such as the use of minor electrical appliances in said premises. All electrical

consumption for the premises shall be metered separately and shall be billed to Lessee monthly, in arrears.

(b) Other Utilities and Services. Lessee shall be responsible for paying fuel oil, gas, water, sewer and trash-collection services, telephone, internet, and the like, janitorial services, building maintenance, and commercial general liability insurance. Lessee may request particular janitorial and maintenance services such as window washing, carpet cleaning, floor waxing and washing of walls, which Lessor will provide at reasonable intervals.

(c) Utility payments for the previous month are due and shall be paid on the first (1<sup>st</sup>) business day of each month during the said term at the address of Lessor provided in Paragraph 22, or at such other place as Lessor may from time to time designate in writing. Payments pertaining to other non-utility services and expenses provided by the Lessor shall be paid within ten (10) days of receipt of invoice.

(d) If Lessee fails to pay any such utility charge before it becomes delinquent, Lessor may (but is not required to) pay the utility charge, in which case Lessee must immediately reimburse Lessor for such payment as additional rent and must pay interest accruing thereon from the date of Lessor's payment of such utilities at the maximum contract rate of interest allowed by law or at the rate of five hundred basis points (500 bp) over the prime commercial rate being charged by Bank of America.

#### CONDEMNATION:

14. If all of the leased property is taken by condemnation, this Lease shall terminate on the date when the leased property shall be so taken, and the rent shall be apportioned as of that date. If part of the building or leased property is taken by condemnation and the remaining part is thereby rendered not reasonably suitable for continued use by Lessor or Lessee, taking into consideration the nature, size and scope of such business immediately prior to the taking, then either party may elect by giving written notice to the other, to terminate this Lease, and in the event of such termination, all charges and rentals shall be apportioned as of the date of taking. If the taking involves a part of the leased property and if neither party elects to terminate this Lease, then with respect to the part not taken, the rent shall be reduced by the value that the condemned part bears to the total value of the leased property, in which event the Lessor shall restore the leased property to an architecturally complete unit. No part of any award shall belong to the Lessee.

#### WAIVER OF RIGHT – NO DEFAULT:

15. A waiver of Lessor of any breach or default by Lessee of any covenant, agreement or condition of this Agreement shall not be deemed to waive or impair any right or remedy which Lessor may have with respect to any subsequent breach or default by Lessee. Receipt of rent by Lessor, with knowledge of any breach or default, shall not constitute a waiver thereof.

AGREEMENT OF TERMS:

16. It is understood that this Agreement is upon the terms and conditions included herein, all and each of which Lessor and Lessee covenant and agree to and with each other to keep and perform. The words "Lessor" and "Lessee", whenever used herein, shall be construed to include and bind the successors and assigns of Lessor and the heirs, executors, administrators and legal representatives of Lessee, and Lessee's successors and assigns, if such are consented to by the Lessor, subject to the restrictions herein contained. The word "Lessee" shall include and bind all and each of the individuals who may execute this Agreement as Lessees, individually, jointly and collectively.

SUBJECT OF LEASED PREMISES:

17. It is understood that the Lessee will not have the privilege of subletting the leased premises to any person without the Lessor's written consent.

PARKING:

18. Lessor shall provide, in connection with the building, reasonable parking facilities for Lessee, Lessee's employees, and Lessee's patients.

ENFORCEMENT AND BINDING PROVISION:

19. If any provision of this Agreement, or the application thereof to any person or circumstances, is held invalid, the remainder of this Agreement and the application of such provision to other persons or circumstances shall not be affected thereby. Further, should any provisions within this Agreement ever be reformed or rewritten by a judicial body, the rewritten provisions will be binding upon the parties.

GOVERNING LAW:

20. This Agreement shall be construed under the laws of the State of Illinois.

ARBITRATION/MEDIATION:

21. The parties to this Lease share a common interest in preventing and resolving any misunderstandings or differences that may arise between them. The parties further share a common interest in avoiding the high cost of litigation, not only in dollars, but also in time and energy. Accordingly, in the event a dispute may arise between the Lessor and the Lessee, the parties shall submit the circumstances and issues of the dispute for mediation and arbitration as follows:

(a) Private Resolution. The parties first in good faith shall seek resolution of the conflict personally, confidentially, and directly with each other. Such process should include (a) statement by each person, explaining and clarifying the issues involved; (b) opportunities for the other person to respond; (c) a discussion of each party's responsibility; (d) application of

relevant objective principles; (e) a discussion of appropriate solutions; and (f) agreement on a solution.

(b) **Mediation.** If the parties cannot satisfactorily resolve a conflict privately, then either party to the conflict may request mediation.

(1) The parties shall promptly retain a mutually agreed-on neutral mediator. The goal of the mediation process and the mediator is to bring about an amicable, voluntary resolution of the dispute, and the parties shall make a good-faith effort to work with one another and the mediator to effect such a resolution of their dispute.

(2) The mediator shall be retained from a reputable source or organization such as one who is used in United States Arbitration & Mediation Midwest, Incorporated.

(3) In the event that the parties cannot agree on a mediator, then each party shall select a mediator. The two individually selected mediators shall jointly identify a third mediator, who then will be responsible for facilitating a binding resolution of the parties' dispute at a mutually agreed-on time and place.

(4) The mediation shall be conducted in accordance with the rules of the organization from which the mediator who facilitates the parties' dispute is retained. Notwithstanding the foregoing, any and all mediation conferences shall be private and all communications therein confidential unless the parties otherwise agree.

(5) The fees and costs of the mediator who facilitates the mediation shall be borne equally by the parties. The fees and costs of any mediator whom a party retains individually shall be borne by that party.

(6) The mediator shall have sole discretion to make the determination that the parties have reached an impasse and no voluntary resolution will be forthcoming.

(c) **Arbitration.** If the parties cannot reach a resolution through mediation and the mediator makes the determination that the parties have reached an impasse and no resolution will be forthcoming, the parties shall submit the conflict to the United States Arbitration & Mediation Midwest, Incorporated for arbitration in accordance with its rules. Notwithstanding the foregoing, at the appropriate hearing, the arbitration case shall be presented by the parties involved. In addition, each party agrees hereby to be bound by the majority decision of the arbitration panel. The parties also further agree to bear equally the costs and fees of the arbitration panel and otherwise bear individually the cost of presenting each party's case.

These methods shall be the sole legal remedy for any controversy or claim arising out of this Lease. No party shall bring any dispute under this Lease to any court of law or chancery except to enforce a mediation agreement or arbitration decision.

NOTICES:

22. All notices and other writings required or permitted to be given by either party to the other under the terms of this Agreement shall be deemed given in accordance with the provisions of this Agreement if mailed by United States registered or certified mail, return receipt requested, postage prepaid, properly addressed as follows:

Lessee: Monroe County Surgical Center, LLC  
William R. Reilly, Managing Member  
509 Hamacher Street, Suite 300  
Waterloo, Illinois 62298

Lessor: Medical Development Company of America, LLC  
William J. Rebholz, Managing Member  
509 Hamacher Street, Suite 300  
Waterloo, Illinois 62298

23. This Lease and the Exhibits and Rider attached hereto constitute the entire agreement between the parties respecting the subject matter hereof and supersede all prior understandings or contracts.

IN WITNESS WHEREOF, Lessor has hereunto set its hand and caused to be affixed hereto its seal, by the proper officers and agents of Lessors, the Lessee has executed this Agreement the day and year first above written.

LESSOR: MEDICAL DEVELOPMENT COMPANY OF AMERICA, LLC

By: WJ Rebholz  
WILLIAM J. REBHOLZ  
Managing Member

Date: 11-24-2010 Time: 12:00 pm

LESSEE: MONROE COUNTY SURGICAL CENTER, LLC

By: William R. Reilly, M.D.  
WILLIAM R. REILLY, M.D.  
Managing Member

Date: 11-24-10 Time: 1600

lcases\mdca-monroe county surgical center.medical office lease

**FIRST AMENDMENT TO LEASE**

This First Amendment to Lease ("First Amendment") is made and entered into effective as of March 13, 2013, by and between Monroe County Surgical Center, LLC, an Illinois limited liability company ("Lessee") and Medical Development Company of America, LLC, an Illinois limited liability company ("Lessor").

RECITALS:

WHEREAS, Lessor and Lessee are parties to a certain Medical Office Lease dated November 24, 2010 ("Effective Date") for premises located at 501 Hamacher Street, Waterloo, Illinois 62298 ("Lease");

WHEREAS, the Lease is part of a project to develop the surgical facility described in that certain Confidential Private Placement Memorandum for Monroe County Surgical Center, LLC dated on or about April 26, 2010 ("PPM") which caused each member of Lessee to guaranty the Lease on a pro-rata basis ("Prorata Guaranty"); and

WHEREAS, the parties desire to amend the Lease consistent with the Prorata Guaranty component of the PPM as described in, and in accordance with, this First Amendment.

NOW, THEREFORE, in consideration of the RECITALS, the Prorata Guaranty, the mutual covenants and agreements contained herein and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties hereto do hereby agree as follows:

1. The Lease is hereby amended by adding the following new Paragraph 24 to the Lease:

24. Prorata Guaranty. As further consideration for Lessor's agreement to lease the premises to Lessee and as a material inducement to Lessor to enter into this Lease with Lessee, Lessee shall exercise diligent efforts in good faith to cause each of the members of Lessee to execute and deliver to Lessor a Limited Prorata Guaranty of Lease in the form attached hereto as Exhibit B and incorporated herein by this reference.

2. Paragraph 24 of the Lease is effective as of the Effective Date of the Lease just as if Paragraph 24 had been originally included in the Lease on the Effective Date and Paragraph 24 is and has been in full force and effect on, from and after the Effective Date.

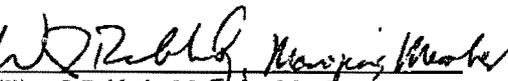
3. All of the terms and provisions of the Lease, as amended by this First Amendment, are hereby fully and completely ratified and confirmed and are in full force and effect.

4. Except as specifically amended by this First Amendment, all terms and conditions of the Lease shall remain in full force and effect unmodified hereby. In the event of any inconsistency between the terms of this First Amendment and the terms of the Lease, the terms of this First Amendment shall supersede and control. All capitalized terms used herein shall have the same meanings as defined in the Lease unless otherwise specifically defined herein.

IN WITNESS WHEREOF, the parties hereto have executed this First Amendment effective as of the date first above written.

Medical Development Company of America, LLC

Monroe County Surgical Center, LLC

By:   
William J. Rebholz, Managing Member

By:   
William R. Reilly, M.D., Chairperson

**Exhibit B**  
**LIMITED PRORATA GUARANTY OF LEASE**

This Limited Prorata Guaranty of Lease ("Guaranty") is made and entered into effective as of the Effective Date by the undersigned Guarantor to and for the benefit of Medical Development Company of America, LLC, an Illinois limited liability company ("Lessor").

WHEREAS, Lessor and Monroe County Surgical Center, LLC, an Illinois limited liability company ("Lessee") are parties to a certain Medical Office Lease dated November 24, 2010 ("Effective Date") for premises located at 501 Hamacher Street, Waterloo, Illinois 62298 ("Lease") and the Lease is part of a project to develop the surgical facility described in a certain Confidential Private Placement Memorandum for Monroe County Surgical Center, LLC dated on or about April 26, 2010 ("PPM") and a certain Amended Operating Agreement for Lessee dated effective as of January 9, 2007 and adopted on or about April 24, 2010 ("Operating Agreement") which cause each member of Lessee to guaranty the Lease on a prorata basis ("Prorata Guaranty"); and

WHEREAS, the undersigned Member of Lessee ("Guarantor") desires to execute and deliver this Guaranty in accordance with the PPM and the Operating Agreement.

NOW, THEREFORE, in consideration of the foregoing recitals and the Prorata Guaranty component of the PPM and the Operating Agreement, execution of the Lease by the parties thereto, and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the undersigned Guarantor hereby covenants and agrees as follows:

1. Subject to the Prorata Limitation hereinafter described, Guarantor absolutely, unconditionally and irrevocably guarantees to Lessor the full and prompt payment of all rents, additional rents and any and all other charges payable by Lessee under the Lease, when due, whether by acceleration or otherwise, and the full, faithful and prompt performance and observance of all the covenants, terms, conditions and agreements of the Lease to be performed and observed by Lessee, and Guarantor is a surety to Lessor, its successors and assigns, for and with respect to all of Lessee's obligations under the Lease. Guarantor's liability under this Guaranty is expressly limited to Guarantor's Percentage Interest as a Member of Lessee as defined in Section 2.1.41 of the Operating Agreement ("Prorata Limitation").

2. This Guaranty is a continuing guaranty, and (whether or not Guarantor shall have notice or knowledge of any of the following) the liability and obligation of Guarantor hereunder shall be absolute and unconditional irrespective of: (a) any amendment or modification of, or supplement to, or extension or renewal of the Lease or any assignment or transfer thereof or sublease of the Premises; (b) any exercise or non-exercise of any right, power, remedy or privilege under or in respect to any of the covenants, terms, conditions or agreements contained in the Lease including, without limitation, termination of the Lease, or any settlement, compromise, release, indulgences, forbearance or extensions of time for performance or observance allowed to Lessee from time to time, at any time and for any length of time, or any exchange, release or surrender of any security, or any waiver of compliance with respect to any of the covenants, terms, conditions or agreements contained in the Lease; (c) any lack of validity or enforceability of the Lease or any other agreement or instrument relating thereto; (d) any bankruptcy, insolvency, reorganization, arrangement, readjustment, composition or liquidation or similar proceedings relating to Lessee, or its properties or creditors; (e) any impairment, modification, change, discharge, release or limitation of liability or obligation of Lessee under the Lease (including, but not limited to, any disaffirmance, rejection, or abandonment of the Lease by a trustee of Lessee), resulting from the operation of any present or future provision of the U.S. Bankruptcy Code or any other similar federal or state statute, or from the decisions of any court; and (f) any other circumstances which might otherwise constitute a defense available to, or a discharge of, the Lessee in respect of the Lease or the Guarantor in respect of this Guaranty.

3. Guarantor's liability hereunder is direct and may be enforced immediately without Lessor being required to resort to any other right, remedy or security and this Guaranty shall be enforceable immediately against Guarantor, without the necessity for any suit or proceedings on Lessor's part of any kind or nature whatsoever against Lessee, and without the necessity of any notice of non-payment, non-performance or non-observance or the continuance of any such default or of any notice of acceptance of this Guaranty or of Lessor's intention to act in reliance hereon or of any other notice or demand to which Guarantor might otherwise be entitled, all of which Guarantor hereby expressly waives. The validity of this Guaranty and the obligations of Guarantor hereunder shall in no manner be terminated, affected, or impaired by reason of the assertion or the failure to assert by Lessor against Lessee of any of the rights or remedies reserved to Lessor pursuant to the provisions of the Lease.

4. This Guaranty shall continue to be effective or be reinstated, as the case may be, if at any time any payment of any rents, additional rents and any and all other charges by Lessee, under the Lease, or performance and observance of any and all of the covenants, terms, conditions, and agreements of the Lease to be performed and observed by Lessee, under the Lease are rescinded, cancelled or otherwise must be returned by Lessor upon the insolvency, bankruptcy or reorganization of the Lessee, all as though such payment had not been made and/or such performance and observance had not occurred.

5. All of the Lessor's rights and remedies under the Lease and under this Guaranty are intended to be distinct, separate and cumulative and no such right and remedy therein or herein mentioned is intended to be in exclusion of or a waiver of any of the others. Guarantor shall and does hereby waive trial by jury. Guarantor agrees to pay Lessor's reasonable attorneys' fees and all costs and other expenses incurred in any collection or attempted collection or in any negotiations relative to the obligations hereby guaranteed or in enforcing this Guaranty against the Guarantor. Anything herein to the contrary notwithstanding, Guarantor hereby expressly waives and releases any rights of subrogation that Guarantor may have against Lessee, any rights of contribution that Guarantor may have against any other guarantor of, or other person secondarily liable for the payment or performance of the obligations of Lessee, and any rights of reimbursement that Guarantor may have against Lessee. The terms and provisions of this Guaranty shall be binding upon and inure to the benefit of the respective heirs, personal representatives, successors and assigns of the parties herein named.

Guarantor: \_\_\_\_\_

Witness: \_\_\_\_\_

Print Name: \_\_\_\_\_

Print Name: \_\_\_\_\_